NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HUMAN SERVICES COMMITTEE

Tuesday and Wednesday, May 10-11, 2016
Memorial Room, Sixth Floor, Grand Forks Office Building
Grand Forks, North Dakota

Representative Kathy Hogan, Chairman, called the meeting to order at 10:00 a.m.

Members present: Representatives Kathy Hogan, Bert Anderson, Alan Fehr, Curt Hofstad, Gail Mooney, Naomi Muscha, Kylie Oversen, Jay Seibel, Peter F. Silbernagel; Senators Tyler Axness, Dick Dever, Oley Larsen, Judy Lee, Tim Mathern

Members absent: Representatives Dick Anderson, Chuck Damschen, Dwight Kiefert

Others present: Senator Ray Holmberg, Grand Forks, member of the Legislative Management
Representative Eliot Glassheim, Grand Forks and Senator Tom Campbell, Grafton
See Appendix A for additional persons present.

It was moved by Senator Mathern, seconded by Representative Fehr, and carried on a voice vote that the minutes of the March 8-9, 2016, meeting be approved as distributed.

STUDY OF BEHAVIORAL HEALTH NEEDS

Chairman Hogan called on Ms. Cynthia Pic, Grand Forks County Commissioner, to present information (Appendix B) regarding "Team Grand Forks - Human Services." Ms. Pic said the team is a collaboration of communitywide organizations, including city, county, and school governments; health care organizations; and nonprofit service providers. She said the mission of "Team Grand Forks - Human Services" is to ensure a collaborative discussion to address communitywide needs and opportunities; to develop communitywide priorities for areas of human services; and to provide clear and consistent communication about needs, opportunities, and priorities. She said the team has organized three separate tours for the committee.

The interim Human Services Committee divided into three groups to conduct the following tours:

- **Tour 1** - Including Prairie Harvest Mental Health; Development Homes, Inc.; and the Northeast Human Service Center;
- **Tour 2** - Including Community Violence Intervention Center; Third Street Clinic; Inspire Pharmacy; and Valley Community Health Centers; and
- **Tour 3** - Including Centre, Inc.; Grand Forks Public Health Department - Social Detoxification; and Northlands Rescue Mission.

Mr. Pete Haga, Mayor's Office, City of Grand Forks, provided additional information regarding the three tours. He said Ms. Debra Johnson, Chief Executive Officer, Prairie Harvest Mental Health, Grand Forks, will lead tour 1. He said Ms. Kristi Hall-Jiran, Executive Director, Community Violence Intervention Center, Grand Forks, will lead tour 2. He said Ms. Debbie Swanson, Director, Grand Forks Public Health Department, will lead tour 3. In addition, Mr. Haga invited committee members to a community forum and documentary presentation entitled *Deadly Dose: The Realities of Fentanyl and Drug Overdose in Our Community*.

Mr. Bret Weber, Grand Forks City Council, presented information regarding "Team Grand Forks - Human Services." He provided the following seven recommendations:

- Require the Department of Human Services (DHS) to seek a Medicaid waiver for behavioral health services;
- Provide incentives for medication assisted treatment;
- Expand funding for permanent supportive housing;
- Encourage support for continuing Medicaid Expansion and of the federal Affordable Care Act;

- Expand funding for statewide social detoxification programs;
- Support a school-based mental health system with funding and policy; and
- Support suicide prevention, including supporting mental health questions on health screenings.

Ms. Johnson presented information (Appendix C) regarding Prairie Harvest Mental Health. She said Prairie Harvest Mental Health provides permanent supportive housing, work opportunities, and various services to serve individuals with serious mental illness. She said Prairie Harvest Mental Health has 42 permanent supported housing units with various levels of support. She provided the following recommendations:

- Establish a training center to assist individuals with finding a job, and recovery skills training;
- Increase permanent supportive housing units;
- Increase peer support services;
- Enhance integrated behavioral health services; and
- Provide adequate staffing levels and quality training for employees of DHS.

Ms. Swanson presented information (Appendix D) regarding efforts of the Grand Forks Public Health Department to enhance behavioral health services in Grand Forks County. In addition, she provided supplemental information (Appendix E) regarding a study entitled *Prescription and Synthetic Drug Use and Abuse: A Collaborative Analysis to the Magnitude of the Problem in Grand Forks County, North Dakota and Polk County, Minnesota*. She recommended providing funding to ensure social detoxification services are sufficient and available in all regions of the state.

Mr. Terry Hanson, Executive Director, Grand Forks Housing Authority, presented information regarding homelessness in the state and chronic homelessness. He said the Grand Forks Housing Authority administers 1,265 housing choice vouchers, including 20 vouchers for the United States Department of Housing and Urban Development's (HUD) Veterans Affairs Supportive Housing program and 25 vouchers for HUD's Family Unification Program. In addition, he said the Grand Forks Housing Authority administers 798 individual and multifamily housing units. He said homelessness exists in the state and is increasing. He said chronic homelessness is defined as an individual or family that has a disabling disability and has been homeless for 12 consecutive months, or has been homeless four times over the past 3 years. He said the Region 4 Supportive Housing Development Collaborative was formed 2 years ago to determine the needs of supportive housing in the state and the needs in Region 4. He said the Region 4 Supportive Housing Development Collaborative determined that Region 4 should provide a permanent supportive housing facility for the chronic homeless in Grand Forks. He said permanent supportive housing combines housing with voluntary intensive support services to assist individuals with complex needs so they can continue with independent housing. He said a national program that addresses chronic homelessness includes the National Alliance to End Homelessness' Housing First program. He said the program provides homeless individuals with a home prior to any contingencies of attending meetings or meeting certain criteria. He said services are provided to the individual onsite after the individual is established in a home. He said Grand Forks anticipates developing a permanent supportive housing facility utilizing a Housing First option.

Mr. Hanson said services are lacking for permanent supportive housing. He said the Cooper House in Fargo is the only permanent housing service in the state. He provided the following recommendations:

- Consider requesting waivers through the federal Centers for Medicare and Medicaid Services for permanent supportive housing services, including the 1915(c) Home and Community-Based Services Waiver, the 1915(i) state plan option, and the 1115 waiver through demonstration projects provided by Medicaid;
- Provide permanent housing services throughout the state similar to the services provided by the Cooper House in Fargo; and
- Require human service centers to provide temporary onsite services to accommodate the needs of individuals in permanent supportive housing.

Ms. Hall-Jiran presented information (Appendix F) regarding the Community Violence Intervention Center's 2-Generation Plan to End Violence. In addition, she provided supplemental information (Appendix G) regarding *The next 2 generations without intervention in Grand Forks County*. She said the 2-Generation Plan to End Violence was developed after researching the impact of violence, evidence-based solutions, and preventable measures. She said the plan includes providing safety for all people and guidance toward positive relationships, healing for every child in dire need, and healthy relationship education for every child in grades K-12. She said additional funding would be used to complete a capital campaign and for a shelter, ensure safety, hire additional therapists for traumatized kids, expand New Choices treatment groups, and continue an education program for healthy relationships.

Ms. Kate Kena, Director, Northeast Human Service Center, provided a summary of "Team Grand Forks - Human Services" priorities. She provided the following priorities:

- Recognize leaders for behavioral health needs;
- Provide incentives for medication assisted treatment;
- Expand funding for permanent supportive housing;
- Encourage support for continuing Medicaid Expansion;
- Expand funding for statewide social detox programs;
- Support funding for school-based mental health; and
- Support suicide prevention.

STUDY OF FAMILY CAREGIVER SUPPORTS AND SERVICES

Family Caregiver Supports and Services Study

Dr. Jane Strommen, Extension Gerontology Specialist, North Dakota State University Extension Service, presented information (Appendix H) regarding the final report (Appendix I) for the study of family caregiver supports and services. She said the five areas of the study included:

1. Current resources for family caregivers in North Dakota;
2. Barriers and challenges of family caregiving;
3. Best practices for family caregiver support programs;
4. Emerging practices and technology to enhance caregiver supports; and
5. Conclusions and recommendations.

Dr. Strommen said categories of services and resources include the following:

- **Managing caregiving logistics** - Including advocacy services, assistive technology and equipment, care management, and information and referral services;
- **Direct support in providing care** - Including adult day care, dementia care, home health care, homemaker and chore, hospice, and personal care services;
- **Improving caregivers' ability to provide care** - Including meal services, training and education, transportation, and volunteer services; and
- **Fostering caregivers' well-being** - Including emotional support and respite services.

Dr. Strommen said data from family caregivers across the state identified challenges of caregiving, which include the lack of sufficient respite services, the need for help finding available services and resources, the lack of knowledge and training relating to providing care, caregiver stress and burdens, and financial burdens of caregiving. She said data from stakeholders of family caregiving across the state identified major recommendations which include additional funding, education and training, respite care, foster outreach and awareness, and an overall increase of services available.

Dr. Strommen said best practices for family caregiver support programs include the following:

- **Availability of help and support** - Including telephone-based psycho-educational interventions, virtual care, and community nurses;
- **Financial cost of care and funding** - Including sliding fee scales and vouchers, increasing access to paid family medical leave, and long-term care planning;
- **Knowledge and ability to provide needed care** - Including interactive training, comprehensive discharge planning, long-term educational programming, and preventive care; and
- **Respite and well-being of caregiver** - Including in-home care, and health education programs.

Dr. Strommen said emerging practices and technology to enhance caregiver supports include the following:

- **Availability of help and support** - Including person-centered care, mobile adult day care, working with college students, technology, socially assistive robots, and smart wear;
- **Financial cost of care and funding** - Including telemedicine reduced hospitalization, co-op models, and tax credits for caregiving;

- **Knowledge and ability to provide needed care** - Including home visits upon discharge, virtual learning modules in hospital waiting rooms, use of social media to increase awareness, training for employers about eldercare, and mobile apps for long distance care; and
- **Respite and well-being of caregiver** - Including online emotional support groups, and the Behavioral Risk Factor Surveillance System's caregiver module to detect caregiver burden.

Dr. Strommen said the study has determined the high cost of care and lack of funding for services to support caregiving provides challenges for caregivers. She said both caregivers and stakeholders have identified insufficient access to respite care as a major gap of service. She said caregivers have identified difficulty with finding, connecting to, and navigating available services and resources. She said family caregivers lack training relating to logistics and management of caregiving, including a provision of support in activities of daily living. She said both caregivers and stakeholders have identified challenges with a lack of available and appropriate services, including rural regions of the state.

Dr. Strommen said key recommendations of the study include:

- Improving the approach for sustainable funding for family caregivers and programs that support family caregivers;
- Increasing access to respite care services across the state;
- Improving outreach programs and resources that help family caregivers find, connect to, and navigate available services;
- Creating programs and policies that encourage training and education of both informal and professional caregivers;
- Reducing gaps in caregiver support services in rural areas of the state;
- Developing a family caregiving taskforce, including caregivers, service providers, and community leaders to create recommendations to address the service gaps identified in this study;
- Exploring ways to address restrictive eligibility criteria, or expanding funding opportunities to include individuals not currently financially eligible;
- Increasing service availability for respite care, care management, training and education, emotional support, volunteer programs and various direct care supports, including adult day care, homemaker and chore, dementia care, and personal care; and
- Improving resources to address caregiver well-being, including preventative, screening, and intervention care.

In response to a question from Representative Fehr regarding the use of long-term care insurance, Dr. Strommen said many long-term care policies now include home- and community-based services, which provides access to services that many families could not pay for without insurance coverage. Dr. Strommen said the insurance may provide access to services that could allow an individual to remain in their home longer before the need for a nursing home or assisted living.

Senator Lee said the state also provides a tax credit for eligible long-term care insurance.

In response to a question from Senator Lee, Dr. Strommen said many individuals do not address long-term care planning soon enough. Dr. Strommen said individuals usually wait until health problems begin to develop. She said many individuals lack the awareness and education for planning. She said current insurance policies are more attractive today than 10 or 20 years ago. She said some policies now combine long-term care benefits with life insurance benefits.

In response to a question from Representative Hofstad, Dr. Strommen said many individuals expressed concern regarding finding available services. Dr. Strommen said individuals may not know what questions to ask regarding services they might need. She suggested adding a caregiver resource center within the North Dakota Aging and Disability Resource-LINK. She said a caregiver resource center could help family caregivers identify needed resources.

In response to a question from Representative Mooney, Dr. Strommen said DHS offers options counseling in each region of the state to provide information and referral of services available.

Chairman Hogan said the 2-1-1 hotline also provides resources.

In response to a question from Senator Mathern, Dr. Heather Fuller, Assistant Professor, North Dakota State University Extension Service, said more undergraduate students specialize in children's services than aging services.

Committee Discussion Regarding the Study of Family Caregiver Supports and Services

Chairman Hogan provided comments regarding the study of family caregiver supports and services. She said the committee should identify six to eight areas to address based on the recommendations provided in the *North Dakota Caregiver Supports and Services Study Final Report* (Appendix I). She said some recommendations may be addressed without legislation. She said the committee may ask DHS's Aging Services Division or other state agencies to address selected recommendations. She requested the Legislative Council staff identify recommendations that may be implemented without legislation.

Representative Mooney suggested the committee address issues relating to restrictive policies and guidelines that are difficult for caregivers to understand.

Senator Mathern suggested the study consultants identify the funding needed for specific recommendations.

Chairman Hogan requested the Legislative Council staff work with DHS and the consultants to identify key areas that may be addressed by the committee for consideration at the next committee meeting.

Senator Lee suggested the committee review history and funding guidelines for community-based services, including home- and community-based services, service payments for elderly and disabled (SPED), expanded SPED, and Medicaid waivers.

Senator Mathern provided comments regarding technology enhancements. He suggested the committee review technology that may be used to assist with family caregiving.

Representative Mooney suggested the committee consider reviewing the DHS general fund budget allotment for homemaker services. She said there are fewer services available in rural areas. She said elderly individuals and vulnerable populations will be affected by this funding reduction.

Representative Oversen suggested the committee review tax credits for employers providing paid family leave.

Hospital Discharge Policies

The Legislative Council staff presented a bill draft [17.0124.02000] relating to hospital discharge policies. The bill draft was prepared for committee discussion. The bill draft includes components that must be included in hospital discharge policies.

Chairman Hogan requested the Legislative Council staff review the affect of reference to a patient's residence in the bill draft.

Mr. Dan Hannaher, Legislative Affairs Director, Sanford Health, and Executive Director, Health Policy Consortium, presented information (Appendix J) regarding hospital discharge policies. In addition, he submitted supplemental information regarding hospital discharge planning (Appendix K); and patient's rights (Appendix L). He said the Centers for Medicare and Medicaid Services, through its Conditions of Participation rule, require the following to be documented in a patient's medical record:

- Patients have a written discharge plan developed;
- Patients have specific discharge instructions provided in writing;
- Patient's goals and preferences for their discharge plan are taken into account;
- Patient's caregivers and support persons are active partners in the discharge plan and care;
- Hospitals consider the availability and capability of the caregiver to provide home care;
- Discharge planning begins within 24 hours of admission;
- Discharge planning process is completed prior to discharge; and
- Discharge instructions are presented in a way that the patient and the caregiver can understand.

Mr. Hannaher said the goals of the model legislation drafted by AARP, which is referred to as the Caregiver Advise, Record, Enable (CARE) Act, is already being met with the rules established by the Centers for Medicare and Medicaid Services, the federal Joint Commission standards, and pursuant to North Dakota Administrative Code Chapter 33-07-01.1 relating to licensing rules for hospitals.

In response to a question from Representative Oversen, Mr. Hannaher said patients that have been discharged from a hospital may subsequently communicate with the hospital to receive information that they believe may be

lacking. Mr. Hannaher said patients also have an option to file a complaint if they believe they did not receive adequate instructions when they were discharged.

Senator Lee suggested the discharge plan include a phone number consumers may call to receive clarification of any instructions after being discharged.

In response to a question from Senator Mathern, Mr. Hannaher said the bill draft will not change the level of care a hospital provides. Mr. Hannaher said the level of care is already being regulated by the Centers for Medicare and Medicaid Services and the Joint Commission. However, he said, the bill draft will add state regulations that may increase potential litigation for hospitals.

Senator Dever suggested the committee review information that patients receive when being discharged from a hospital. He said hospitals should simplify the information that is provided to patients.

Mr. Josh Askvig, Advocacy Director, AARP North Dakota, presented information (Appendix M) regarding hospital discharge policies. He said AARP has drafted model legislation which they refer to as the CARE Act to address supports for family caregivers during a patient's transition from a hospital. He said other states have adopted the CARE Act or similar legislation. He said the CARE Act model recommends the following:

- **Designation of the caregiver in the medical record** - Allows a patient or legal guardian the ability to designate a caregiver when being admitted to the hospital.
- **Notification to the caregiver of discharge** - Provides for a hospital to notify a family caregiver if a patient is being discharged or transferred to a different facility.
- **Instruction of aftercare tasks** - Creates a framework for a family caregiver to receive instructions for tasks the family caregiver will perform once a patient is discharged from the hospital.

Mr. Askvig said AARP has been actively participating in discussions with hospitals and providers to address concerns regarding the CARE Act. He said AARP has shared information regarding bills passed by other states relating to the CARE Act. He said AARP has agreed to consider language included in the Oregon version of the CARE Act because of suggestions from hospital representatives. He said AARP has been as accommodating to meet the concerns of hospital representatives while ensuring that family caregivers receive adequate instructions to safely care for the patient after discharge.

In response to a question from Representative Mooney, Mr. Askvig said, even though AARP would prefer the provisions of 2015 House Bill No. 1279 for the CARE Act, AARP does support the provisions in the bill draft [17.0124.02000].

Comments by Interested Persons

Mr. Derek Dewbre expressed support for adequate autism services. He discussed his experiences with autism services.

Ms. Lynelle Fraser, Home and Community Based Services Case Manager, Pembina and Cavalier County Social Services, presented information (Appendix N) regarding the reimbursement of homemaker services. She suggested more home- and community-based services be provided and increasing payment levels for services. She expressed concerns regarding general fund budget allotment changes to DHS for homemaker services.

Ms. Melissa Johnson, President, Service Providers for Seniors, and owner, Home Care Companion, Grand Forks, presented information regarding reimbursement of homemaker services. She expressed concerns regarding general fund budget allotment changes to DHS for homemaker services and the negative effect the reductions will have on services.

Ms. Sue Peterson presented information regarding homemaker services. She expressed concern regarding general fund budget allotment changes to DHS for reimbursements of homemaker services and the negative effect the reductions will have on services.

Dr. Yvonne Jonk, Assistant Professor, Department of Population Health, University of North Dakota School of Medicine and Health Sciences, presented information regarding the study of family caregiver supports and services. She expressed support for the study and offered assistance to the committee. She discussed her experiences working for the University of North Dakota School of Medicine and Health Sciences Center for Rural Health. She said additional resources are also available on the Rural Health Information Hub website. In addition, she said support programs for caregivers decrease nursing home placements and health care costs. She

suggested the committee review a report prepared by the Robert Wood Johnson Foundation relating to effects of the Medicaid Expansion on state-level finances.

Testimony was also submitted by Ms. Laura Alkofer regarding information (Appendix O) relating to the family caregiver supports and services study. The testimony expressed support for more family caregiver supports and services.

The committee recessed at 5:15 p.m. and reconvened at 8:00 a.m. on Wednesday, May 11, 2016.

STUDY OF BEHAVIORAL HEALTH NEEDS

Federal Mental Health Parity and Addiction Equity Act

Ms. Rebecca Ternes, Deputy Commissioner, Insurance Department, presented information (Appendix P) regarding the federal Mental Health Parity and Addiction Equity Act of 2008, including the legal framework of the Act, the implications of the Act for the state, and requirements of the Act. She said the Mental Health Parity Act of 1996 restricted large group health insurance plans of 50 or more employees from having aggregate annual or lifetime limits on mental health that did not exist in major medical coverage. She said the Mental Health Parity and Addiction Equity Act of 2008 applied to fully and self-insured plans with large groups of 50 or more employees. She said the Act prohibited differences in treatment limits, including frequency, number of visits, days of coverage; financial requirements, including deductibles, copayments, coinsurance, other out-of-pocket expenses; and in-network and out-of-network coverage between mental health and major medical benefits. She said the Affordable Care Act Rule of 2013 extended the Mental Health Parity and Addiction Equity Act to nongrandfathered small group and individuals health insurance plans, and to individual grandfathered plans. She said the rule addresses how mental health benefits are substantially similar to major medical benefits under specific classification of benefits and how an insurer may aggregate the out-of-pocket costs. She said the implementation date of the rule was January 1, 2015. She said all insurance plans that have renewed after January 1, 2015, have complied with the changes.

Ms. Ternes said there are also state requirements for coverage of mental health and substance abuse, including specific allowances that can restrict coverage. She said medical necessity must exist for coverage to be applied.

In response to a question from Senator Lee, Ms. Ternes said the state has limited authority relating to self-funded insurance plans. Ms. Ternes said the federal government has more regulatory authority for self-funded insurance plans.

In response to a question from Senator Mathern, Ms. Ternes said the Affordable Care Act requires standard language to be included in each plan. Ms. Ternes said issues often arise due to individuals not reading the provisions of their policies.

In response to a question from Representative Seibel, Ms. Ternes said family members are usually not eligible to be reimbursed as a caregiver under a long-term care insurance plan unless they are licensed.

In response to a question from Senator Larsen, Ms. Ternes said an individual that purchases a qualifying long-term care insurance policy included in the Long-Term Care Partnership Program may qualify for a tax credit.

Ms. Megan Houn Smith, Director of Government Relations, Blue Cross Blue Shield of North Dakota, introduced Dr. Elizabeth Faust, Senior Director for Behavioral Health, Health Network Innovation, Blue Cross Blue Shield of North Dakota, and Mr. Robert Stroup, Deputy General Counsel, Blue Cross Blue Shield of North Dakota, to present information (Appendix Q) regarding the Mental Health Parity and Addiction Equity Act.

Dr. Faust provided an overview regarding mental health parity. She said a 2002 study estimated the economic burden of mental illness and substance abuse at $562.7 billion in direct care, mortality, crime, and workplace costs. She said the World Health Organization has identified depression as the leading cause of disability. She said there is evidence regarding the relationship between physical illness and behavioral illness. She said physical conditions become less effective and more costly when behavioral health conditions are ignored. She said the goal of Blue Cross Blue Shield of North Dakota and the underlying goal of mental health care is to provide the right care, at the right place, at the right time.

Mr. Stroup said North Dakota has had robust coverage for mental health and substance abuse benefits since 1975. He said prior to federal requirements, the state has required coverage of behavioral health services in all group health insurance plans, including benefits for substance abuse coverage pursuant to North Dakota Century Code (NDCC) Section 26.1-36-08, and benefits for behavioral health coverage pursuant to Section 26.1-36-09. He said the state has allowed partial hospitalization benefits as an alternative treatment since 2003. He said Blue Cross Blue Shield of North Dakota has been complying with federal parity requirements since the Mental Health

Parity Act of 1996. He said only minor changes were needed to comply with federal requirements because of requirements the state had already enacted, including the requirement of benefits to be of the same type offered for other illnesses for the diagnosis, evaluation, and treatment of behavioral health services. He said the Mental Health Parity and Addiction Equity Act of 2008 supplemented the Mental Health Parity Act of 1996. He said the only change that was required, other than administrative changes, was to remove the day limit for inpatient, and partial and outpatient services. He said the Patient Protection and Affordable Care Act of 2010 extended parity requirements to all small group and individual health plans. He said the Mental Health Parity Act of 1996 does not require benefits and services offered through a health plan to be equal. He said the Act requires assurance of a fair comparison of benefits. He said compliance includes analyzing financial requirements, quantitative treatment limitations, and establishing standards to measure nonqualitative treatment limitations.

In response to a question from Senator Mathern, Mr. Stroup said there has been a reduction of behavioral health benefits offered for plans through the exchange because the benchmark plan that was adopted for the exchange did not include as robust of benefits that a standard individual health plan includes. Mr. Stroup said Blue Cross Blue Shield of North Dakota had to reduce behavioral health benefits for plans offered through the exchange to be able to compete in the marketplace.

Dr. Faust said benefits are broadly defined and depend on what services are available for a specific insurance plan. She said the evidence base for effectiveness of treatments for mental health and substance use disorders is satisfactory and is equal to or better than the evidence that is available for many standard treatments including cardiac diseases or cancers. She said there is not yet a standard system to ensure individuals with a behavioral health disorder receive effective medical, psychosocial or psychotherapy interventions, and therefore, there is variability between behavioral health providers for diagnosis, type and length of treatment provided, the clinical efficacy and how well treatment works, and adherence to empirically based standards of treatment. She said national studies provide that between 30 and 55 percent of patients with behavioral health disorders do not receive recommended evidence-based care. She said this is because of the gap between what is known and the lack of available decision support tools for clinicians.

Dr. Faust said the use of reasonable utilization management tools for behavioral health services are designed to protect members so they receive services that are medically necessary and appropriate; to protect members from incurring unnecessary charges, and provides the fiduciary responsibility Blue Cross Blue Shield of North Dakota has to its members as a steward of members' premium funds. She said the use of medical necessity tools are not to reduce costs or limit care. She said the purpose of the tools are to improve care and ensure value of services that are provided to members. She said Blue Cross Blue Shield of North Dakota uses evidence-based medical necessity standards based on scientific evidence, professional standards of care, and expert opinion. She said the use of guidelines include the American Society of Addiction Medicine, the American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, Substance Abuse and Mental Health Services Administration (SAMHSA), and foundational guidelines.

Mr. Stroup said a review process of behavioral health decisions should include communication and collaboration between stakeholders including the medical staff at Blue Cross Blue Shield of North Dakota, providers, and members. He said a health care provider review process is included with every health care provider participating contract. He said the process includes an initial review and a right to appeal. He said providers may request an independent review pursuant to NDCC Section 26.1-36-44. He said every health insurance benefit plan offered by Blue Cross Blue Shield of North Dakota for members includes a benefits review and a right to an appeal provision. He said the member review process is required pursuant to NDCC Section 26.1-36-47 and federal law. He said the process requires a review of a member's right to an independent external appeal. He said the independent external appeal review for health insurance plans is requested from the Insurance Department.

In response to a question from Senator Mathern, Mr. Stroup said many of the behavioral health care provider contracts have a preservice, preapproval, or preauthorization component that includes a provider seeking prior approval, but a decision for care should be between an individual and the health care provider. Mr. Stroup said health care decisions should not be determined based on whether an insurance company will pay for the service.

Dr. Faust said for a benefit to be determined necessary, a service must meet the medical necessity criteria. She said there are misconceptions relating to providers informing patients that the insurance company will not cover a benefit. She said often in those situations the service a provider is proposing usually does not meet the medical necessity standard of care for that particular service level of intensity. She said an insurance company will usually cover services, but at a different level of intensity.

In response to a question from Chairman Hogan, Ms. Houn Smith said telehealth services are covered for any practitioner in a traditional setting.

Ms. Lisa Carlson, Senior Director of Planning and Regulation, Sanford Health Plan, presented information (Appendix R) regarding the Mental Health Parity and Addiction Equity Act. She said a parity test is completed on an annual basis from an external actuary to ensure nondiscriminatory design of a benefit package. She said if mental health and substance abuse benefits are provided in a package, they must be equal to or better than medical and surgical benefits. She said the 2017 plan filing submitted to the Insurance Department includes a parity test for each federal benefit plan sold on the market. She said there has been coverage expansion of services including group therapy, family therapy, partial hospitalizations, and intensive outpatient services because of parity rules. She said mental health and substance abuse services include a medical component and a social component. She said a service must have a medical component to determine medical necessity. She said many insurance companies do not cover mental and substance abuse services with a social component, including long-term residential care, supervised living, and halfway houses. She said services that may be covered must include a treatment plan with a medical component. She said if mental health and substance abuse benefits are denied, members may request written policy regarding the standards used to determine medical necessity. She said the policy must be provided within 30 days of the request. She said basic business plan operations of one insurance company compared to another insurance company may affect a member's experience. She said Sanford Health requires prior authorization for nonemergency patient stays. She said the process protects members from unexpected denials in the middle of a review. She said this process has increased member satisfaction and has reduced the number of denials.

In response to a question from Chairman Hogan, Ms. Carlson provided information (Appendix S) regarding the Sanford Health Plan network analysis of North Dakota Medicaid Expansion.

Dr. Stephen Nelson, Senior Director of Medical Services, Sanford Health Plan, and practicing Neonatologist, Sanford Health, Fargo, presented information (Appendix T) regarding the Mental Health Parity and Addiction Equity Act and how Sanford Health Plan applies mental health parity to a utilization review. He said a utilization review process is a set of formal techniques designed to evaluate the clinical necessity and appropriateness of efficient health care services, procedures, or facilities. He said a review includes patient complaints, relevant history, medications, previous treatment, mental health and substance use disorder history, treatment plans, and recommendations. He said medical necessity includes health care services that are appropriate for type, frequency, level, setting, and duration of a diagnosis, or condition and diagnostic testing. He said medical necessity is determined by ensuring that the proposed care:

- Must be consistent with generally accepted standards of medical practice;
- Helps restore or maintain a member's health;
- Is required for reasons other than convenience of the covered person, physician, or for custodial, comfort, convenience, appearance, educational, recreational, or vocational purposes;
- Prevents deterioration of the member's condition;
- Prevents the onset of a health problem; and
- Is not considered experimental unless part of an approved clinical trial.

In response to a question from Representative Mooney, Dr. Nelson said Sanford Health Plan has a robust appeals process. In addition, Ms. Carlson said that a peer-to-peer review process generally resolves a treatment plan that will be acceptable to both parties.

In response to a question from Chairman Hogan, Dr. Nelson said Sanford Health Plan does have a policy for reimbursement of telemedicine services. He said services must be determined to be medically necessary.

In response to a question from Representative Fehr, Ms. Carlson said a provider must have credentials to provide telemedicine services. Ms. Carlson said a provider must have the information technology infrastructure to prepare documentation and medical records of a visit according to Medicare certified telemedicine program requirements.

Chairman Hogan commented regarding Certificate of Need and medical necessity. She said Certificate of Need is a term that is generally used with Medicaid. She said medical necessity is a term that is generally used with private insurance. She said the process for Certificate of Need and medical necessity is similar.

Department of Human Services - Opioid Drug Abuse

Chairman Hogan called on Ms. Pamela Sagness, Director, Behavioral Health Services Division, Department of Human Services, to present information (Appendix U) regarding DHS's initiatives to address prescription drug and opioid drug abuse. Ms. Sagness said DHS, in collaboration with the Reducing Pharmaceutical Narcotics in Our Communities Task Force, has identified the following three goals to address opioid drug abuse in the state:

- Decrease access to unused and unneeded prescription drugs;

- Increase infrastructure and capacity to provide effective services for individuals with an opioid addiction; and
- Increase evidence-based overdose prevention in the state.

Ms. Sagness presented information regarding what communities and other stakeholders can do to prevent prescription drug and opioid abuse.

Department of Human Services - Future Role of Human Service Centers and the State Hospital

Chairman Hogan called on Dr. Rosalie Etherington, Superintendent/Administrator, State Hospital, to present information (Appendix V) regarding DHS's vision for the future role of the regional human service centers and the State Hospital for meeting the state's behavioral health needs. Dr. Etherington said the public behavioral health system fulfills its statutory role through public and private contract services for individuals eligible for services. She said the human service centers are required to provide emergency services and chronic disease management sufficient to prevent institutionalization. She said a public behavioral health system must make decisions regarding chronic disease management and providing the best care at the lowest level of intervention to meet the person's needs and to allow that person to live in the community.

Dr. Etherington said regional human service centers provide the following services:

- **Emergency services** - 24-hour services manage and resolve crises in the least restrictive setting necessary, with referral to community services, in lieu of the State Hospital, whenever appropriate. Services include open access assessment, 24-hour crisis line, mobile crisis services, social detoxification services, crisis residential services, and emergency services to jail.
- **Regional intervention services** - Regional intervention services refer to appropriate community service in lieu of State Hospital admission. Services include assessment and screening services, community hospital services, and resource management.
- **Chronic disease management** - An integrated, multidisciplinary continuum of services for chronically mentally ill individuals to be provided in the least restrictive setting. Human service centers have an addiction program that meets requirements of North Dakota Administrative Code Articles 75-05 and 70-9.1. Services include self-management support, rehabilitation and recovery services, targeted case management, medication management services, and residential services.

Dr. Etherington said DHS anticipates further defining and standardizing how emergency services are operating to help identify thresholds of care within communities to meet those needs. She said the first step has been with the open access assessment process. She said the open access assessment process identifies individuals as needing emergent, urgent, or routine care when they enter a human service center.

Dr. Etherington said the State Hospital provides chronic disease management, specialized sex offender treatment, and specialized addiction treatment.

Dr. Etherington said DHS anticipates making changes in the following areas:

- Clinical director assignment;
- Quality management development;
- Accreditation preparation;
- Electronic health record development;
- Professional training partnerships; and
- Telehealth expansion.

Dr. Etherington said DHS is considering well-defined roles between clinical and administrative directors at each regional human service center. She said clinical directors will have expectations of enhancing clinical practice, guidelines, clinical practice procedures, and clinician peer reviews, and developing quality measurements to achieve positive outcomes for the clients. She said the clinical directors will have a role with internship and residency partnerships. She said changes will allow regional directors to have more time available for contract management, community partnerships, regional advisory councils, business policies and procedures, and regulation. She said the regional advisory councils will be expected to evaluate the availability and effectiveness of care for planning and enhancing services.

Behavioral Health Issues Under Consideration at the Federal Level

Ms. Gail Hand, Northeast Regional Director, Office of United States Senator Heidi Heitkamp, presented information (Appendix W) regarding current behavioral health issues under consideration at the federal level, including an update on the United States Senate efforts to address the opioid crisis including the Comprehensive Addiction and Recovery Act (CARA); the Mental Health Awareness and Improvement Act; and the Mental Health Reform Act.

Ms. Hand said CARA, which has been approved by the United States Senate and is pending consideration by the United States House of Representatives, includes the following:

- Directs the United States Department of Health and Human Services to convene an interagency task force to develop and disseminate best practices for prescription of pain medication;
- Provides for eligiblity of funding for opioid and other substance abuse treatment, prevention, education, and rehabilitation activities through the Crime Control and Safe Streets Act;
- Allows the United States Department of Health and Human Services to provide addiction treatment funding to specific geographic areas;
- Removes questions relating to the possession or sale of illegal drugs from the Free Application for Federal Student Aid (FAFSA) application forms;
- Creates a task force to review collateral consequences for individuals with a drug conviction that are in a recovery program; and
- Provides for a report on the impact of a Medicaid Institutions for Mental Diseases (IMD) exclusion of access to treatment for individuals with a substance use disorder.

Ms. Hand said the Mental Health Awareness and Improvement Act, which was approved by the United States Senate and is pending consideration by the United States House of Representatives, includes the following:

- Provides for SAMHSA to advance, through its current programs, education and awareness to providers, patients, and other stakeholders regarding Food and Drug Administration (FDA) approved products to treat opioid use disorders; and
- Provides for a report that includes the role of adherence for the treatment of opioid use disorders, and recommendations regarding priorities and strategies to address co-occuring substance use disorders and mental illness.

Ms. Hand said the Mental Health Reform Act under consideration by the United States Senate includes the following:

- Creates a Chief Medical Officer position at SAMHSA, and provides for the development of a strategic plan to create measurable outcomes for a strategic priority plan;
- Addresses the mental health and substance use disorder block grants by allowing states more flexibility;
- Provides more access to integrated mental health care, including at-risk individuals, through workforce training programs and increased coordination of emergency responders, law enforcement, health care providers, and courts;
- Addresses mental health and substance abuse treatment disorders for women, children, and adolescents;
- Addresses mental health parity protections though enforcement of existing parity requirements and through federal and state coordination efforts; and
- Addresses the opioid epidemic by requiring the FDA to review new opioid drugs, the National Institutes of Health to address pain research, and the federal Centers for Disease Control and Prevention to issue best practices for prescribing.

Comments by Interested Persons

Mr. Luke Schaefer, Student Services Committee Member, North Dakota Association of School Administrators - Legislative Focus Group, presented testimony (Appendix X) relating to addressing student behavioral health needs in North Dakota schools. He said the focus group is tasked with finding solutions to priority areas in education. He said school districts lack funding and expertise to support students and families with behavioral health issues. He recommended creating pilot project grants to create partnerships between school districts and state agencies to develop and coordinate resources in communities to allow students and families to receive needed support.

Ms. Jen Smart, Fraser Ltd., Fargo, presented information (Appendix Y), that was submitted by Ms. Sandra Leyland, Chief Executive Officer, Fraser Ltd., relating to the challenges of transitional youth and young adults ages

16 to 26 years old. She said other communities may benefit from a pilot program similar to a program Fraser Ltd., started in May 2014. She said the program provides permanent supportive housing for youth that may be at risk of homelessness, human trafficking, suicide, or incarceration.

Ms. Erin Rocheleau, Fraser Ltd., presented information (Appendix Z) relating to mental health care. Ms. Rocheleau discussed her experiences with mental health services, working as a case manager for young adults, and her brother's experiences with a mental illness. She expressed support for increasing funding for community mental health services.

Ms. Binaka Beciraj, Fargo, presented information (Appendix AA) relating to personal experiences of depression and homelessness. Ms. Beciraj discussed her experiences with the Transitional Living Program at Fraser Ltd., and counselors that assisted her with developing skills to manage symptoms and overcome mental health issues.

Ms. Jordan May, Fraser Ltd., presented information (Appendix BB) relating to the correlation between homelessness and mental health for transitional youth ages 18 to 21 years old. She recommended increasing access to mental health and other related services that improve educational outcomes for transitional youth, including implementation of services that identify and connect with transitional youth, increase awareness of local resources, and connect transitional youth to services and supports.

Ms. Carlotta McCleary, Executive Director, Mental Health America of North Dakota, and Executive Director, North Dakota Federation of Families for Children's Mental Health, presented information (Appendix CC) relating to the Mental Health Advocacy Network. In addition, she submitted supplemental information (Appendix DD) relating to *The Mental Health Advocacy Network* and *Schulte Consulting, LLC Behavioral Health Planning - Final Report*. She said the Mental Health Advocacy Network advocates for a consumer and family driven mental health system of care that provides various service choices that are timely, responsive, and effective. She expressed concern regarding the state's behavioral health system. She said priorities to assist with correcting the state's behavioral health system include additional peer-to-peer and family support, consumer choice, diversion from corrections, a core services zero-reject model, and an independent appeals process.

Mr. Jim Vetter, Vice President of Partner and Community Relations, Dakota Boys and Girls Ranch, presented information regarding emergency care for children and adolescents. He expressed concern regarding emergency care relating to mental health. He said one of the items used to determine medical necessity or a Certificate of Need is that an individual has exhausted the use of community services. He said sometimes the community services do not exist. He recommended the committee work with DHS and the insurance companies to define emergency care. He recommended allowing an individual to be placed into a treatment center during the emergency review process.

In response to a question from Chairman Hogan regarding other states' processes, Mr. Vetter said Louisiana has a presumptive necessity for emergency situations for residential mental health services.

Representative Muscha distributed information (Appendix EE) that was submitted by Ms. Briana Schjea, relating to the 4.05 percent general fund budget allotment for DHS and the budget reductions to Child Care Aware of North Dakota grants. Ms. Schjea's testimony discussed her experiences as co-owner of an in-home day care that provides childcare to children with special needs. She said the day care was a recipient of Child Care Aware of North Dakota grants that were reduced as part of the 4.05 percent general fund budget allotment. She expressed support for a special legislative session to restore funding for DHS.

Representative Muscha distributed information (Appendix FF) that was submitted by an individual with autism. The testimony expressed support to restore funding for autism services that was reduced from the DHS budget as part of the 4.05 percent general fund budget allotment.

Representative Muscha distributed information (Appendix GG) that was submitted by Ms. Shannon Sobolik relating to another individual's experiences with autism. The testimony expressed support to restore funding for autism services that was reduced from the DHS budget as part of the 4.05 percent general fund budget allotment.

Recommendations Provided to the Interim Human Services Committee

The Legislative Council staff presented a memorandum entitled *Recommendations Provided to the Interim Human Services Committee*. The Legislative Council staff said the memorandum summarizes the recommendations provided to the committee relating to its assigned studies.

Categories of Recommendations Provided to the Interim Human Services Committee - Behavioral Health Needs Study

The Legislative Council staff presented a memorandum entitled *Categories of Recommendations Provided to the Interim Human Services Committee - Behavioral Health Needs Study*. The Legislative Council staff said the memorandum sorts recommendations provided to the committee into categories including policy issues, program expansion with costs, workforce issues, DHS roles and responsibilities, and administrative and coordination. He said the memorandum assigns recommendations into specific categories and subcategories, and identifies whether additional funding may be required.

Chairman Hogan provided comments regarding potential bill drafts. She said the committee will begin developing the following bill drafts:

- A policy bill draft relating to the role and function of DHS relating to behavioral health services;
- Policy changes that do not require additional funding; and
- Program expansion that may require additional funding.

Chairman Hogan requested the Legislative Council staff include in the bill draft relating to DHS's role, the recommendation to develop a definition regarding who may be served under behavioral health services.

Bill Drafts - Policy Changes Without Additional Funding

Chairman Hogan requested the Legislative Council staff amend the bill draft [17.0036.01000] relating to the definition of addiction counseling, to include assessments of persons for use or abuse of gambling as part of a licensee's scope of practice for the committee's consideration at the next meeting.

In response to a question from Senator Dever, Ms. Sagness said licensed addiction counselors may not treat behavioral addictions including gambling, nicotine, and tobacco because NDCC Section 43-45-01 only defines alcohol or an illicit substance in the scope of practice for a licensed addiction counselor.

Chairman Hogan requested the Legislative Council staff prepare a bill draft with the recommendations to extend the state's holding period for emergency involuntary commitments from 24 hours to 72 hours for individuals with behavioral health issues and severe medical conditions for the committee's consideration at the next meeting.

Chairman Hogan requested the Legislative Council staff prepare a bill draft relating to mental health training requirements pursuant to Section 2 of 2015 Senate Bill No. 2048 to require 2 of the 13 hours of training requirements to be in a behavioral health-related area, and to allow acceptable "behavioral" health training areas to include behavioral disorders; social and emotional needs of students; suicide prevention; behavioral and mental health; bullying; other categorical issues including depression, eating disorders, drug abuse, stress, and trauma; and other proven evidence-based strategies that reduce risk factors for students; and to allow training programs to be more specialized to address specific needs of a school or district for the committee's consideration at the next meeting.

Representative Silbernagel suggested the Legislative Council staff include, as part of the bill draft, mental health training requirements pursuant to Section 2 of 2015 Senate Bill No. 2048 relating to providing information to teachers regarding behavioral health services that are available.

Chairman Hogan requested the Legislative Council staff include provisions that require child care providers to obtain at least 2 hours of behavioral health training each year to maintain licensure.

In response to a question from Representative Oversen regarding whether case management services are covered by private insurance, Ms. Houn Smith said Blue Cross Blue Shield of North Dakota provides internal case management services for members.

Representative Fehr provided comments regarding case management services. He said the committee should also review the effectiveness of case management services when one organization is providing treatment and another organization is providing case management.

Chairman Hogan said there may be potential to redirect funding from public case management services to private case management services. She requested the Legislative Council staff include in the bill draft relating to DHS's role, the recommendation to allow private case management services.

Bill Draft - Program Expansion With Additional Funding

In response to a question from Chairman Hogan regarding detoxification services, Dr. Etherington said DHS considers detoxification services a core service of the department.

Mr. Jeff Stenseth, Director, Southeast Human Service Center, said the crisis residential unit in Fargo provides three specific types of services including psychiatric stabilization, short-term residential for individuals with addiction residential needs, and withdrawal management services.

Senator Mathern suggested allowing DHS to review detoxification services provided in the state and to determine appropriate needs. He said funding needs for detoxification services should be included in the department's 2017-19 budget request bill if DHS considers detoxification services a core service.

Chairman Hogan requested the Legislative Council staff work with DHS and other groups already providing recovery support and peer support services to determine funding needs and a program structure, and include in the bill draft relating to program expansion, funding necessary for recovery support and peer support programs.

In response to a question from Representative Oversen, Mr. Hannaher said Sanford Health Plan does not cover peer support services.

Senator Mathern suggested that although the program could be administered by DHS, there are private providers that are willing to provide the educational services.

In response to a question from Chairman Hogan, Ms. Janell Regimbal, Vice President, Children's Services and Behavioral Health, Lutheran Social Services of North Dakota, said the recommendation to implement a minor in possession education course is intended to divert more youth from the correctional system. Ms. Regimbal suggested the use of an educational evidence-based program that will involve an assessment rather than just an educational class being offered.

Chairman Hogan said, that if, at the end of the minor in possession program, it is determined through an assessment that the individual needs more services, the individual could be placed into a diversion program.

Chairman Hogan requested the Legislative Council staff include, as part of the program expansion bill draft, a standard minor in possession education course similar to the Prime for Life Driving Under the Influence program.

Senator Dever commented regarding community efforts in the Bismarck-Mandan area related to behavioral health. He said one project, called Mindfulness and Schools, is teaching students how to reduce stress.

Representative Oversen provided comments regarding toxic stress. She suggested adding additional resources to address children suffering from toxic stress resulting from trauma and violence.

Representative Mooney said the committee needs to identify resources that will assist both rural and urban areas of the state.

Chairman Hogan requested the Legislative Council staff work with DHS and other peer support providers that work with children and include, as part of the program expansion bill draft, the recommendation relating to children's prevention and early intervention services. She suggested committee members review the integration of a trauma informed system of care for children for discussion at the next committee meeting.

Representative Silbernagel suggested expanding the use of 2-1-1 services to create a comprehensive database that integrates various systems. He said the state has numerous phone numbers individuals may call for various services. He said the various phone numbers could be redirected to the 2-1-1 hotline. He said, rather than providing new funding for expanding the 2-1-1 services, funding that is being used for the various phone numbers could be redirected to expand the 2-1-1 services.

Chairman Hogan suggested in addition to expanding the 2-1-1 services, the behavioral health services database be expanded to include both public and private providers.

Senator Lee suggested federally mandated numbers also be linked to the 2-1-1 hotline. She said marketing efforts to inform individuals to use 2-1-1 services is important. She said many individuals are not aware of the 2-1-1 services.

Senator Dever suggested reviewing information with FirstLink prior to approval of any bill draft to ensure they have the capacity to expand 2-1-1 services.

Chairman Hogan said there will need to be partnership between DHS and FirstLink to create a comprehensive centralized database for all behavioral health services for both public and private services.

Chairman Hogan requested the Legislative Council staff include, as part of the expansion program bill draft, the expanded use of 2-1-1 services and to provide for expanding the behavioral health provider database to include both public and private providers.

Chairman Hogan requested the Legislative Council staff combine all recommendations relating to housing and suggested that DHS and the North Dakota Housing Finance Agency develop a statewide plan to address housing issues for presentation at a future meeting.

Representative Oversen suggested the committee develop a recommendation for permanent supportive housing, including a collaboration among private and public providers, housing agencies, and DHS. She said lack of access to housing provides challenges and may cause other behavioral health services to be less effective for the individual.

In response to a question from Senator Lee regarding landlord risk mitigation funds, Ms. Jessica Thomasson, Chief Executive Officer, Lutheran Social Services of North Dakota, said there was a pilot project in the Fargo-Moorhead area to create a landlord risk mitigation fund to provide an incentive for landlords to rent to households with challenges, including poor credit, criminal history, and eviction history. She said there are efforts to expand to a statewide program.

Chairman Hogan requested the Legislative Council staff include a recommendation under the administrative and coordination category for permanent supportive housing, including a collaboration among private and public providers, housing agencies, and DHS.

Senator Mathern suggested including the recommendation relating to a school-based mental health training program be included in a bill draft if the various groups can agree on a training program.

Chairman Hogan suggested the Department of Public Instruction and DHS organize a meeting with interested organizations regarding development of a school-based mental health training program. She said the organizations should include local area public health organizations, regional education associations, teacher groups, local school boards, and school administrators. She said the Department of Public Instruction and DHS should present the committee with a proposal to include in a bill draft at the committee's next meeting.

Chairman Hogan said workforce-related recommendations will be addressed by the interim Health Services Committee.

Role and Function of Behavioral Health Services for the Department of Human Services

Chairman Hogan said DHS should review the recommendations relating to the role and function of DHS relating to behavioral health services and determine those that are appropriate; and based on the department's determination, the Legislative Council staff prepare a bill draft to implement those recommendations.

Committee Discussion

Chairman Hogan requested the Legislative Council staff update the list of all recommendations provided to the committee and identify those that may require additional funding.

Chairman Hogan said the next meeting is tentatively scheduled for Monday and Tuesday, July 25-26, 2016, in Bismarck.

No further business appearing, Chairman Hogan adjourned the meeting at 3:45 p.m.

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Michael C. Johnson
Fiscal Analyst

ATTACH:33