TESTIMONY BEFORE THE HOUSE HUMAN SERVICES COMMITTEE

REGARDING HOUSE BILL 1459

JANUARY 25, 2005

Chairman Price, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding this bill.

This proposed legislation is a result of a study of the Medicaid program by the Medicaid Working Group. While the Department provided information, the report represents the work of the committee and the recommendations are the result of their deliberations. We were not involved in the final outcome of the report.

This bill would establish a special fund that would be utilized by providers, health care cooperatives, or health care consortia to develop and implement integrated systems of care including managed care, and other risk sharing options. It would allow these entities to use the funds to build the infrastructure necessary to move into a managed care arena. Many entities are hesitant to move to a risk sharing payment process, and this bill is designed to encourage these entities to develop the internal processes necessary for the implementation of managed care in North Dakota.

Currently, the Department does have one fully "capitated" managed care contract in North Dakota. It is with Noridian Mutual Insurance Company. It operates in Grand Forks, with Walsh and Pembina counties, with the Altru network, as the primary deliverer of services. Medicaid recipients have a choice of joining this organization or selecting a primary care provider to manage their care. If the recipient chooses the "capitated" plan, the Department pays a monthly premium based on the age and gender of a recipient. The process encourages the entity to manage the delivery of care, and promote preventive health services in order to

ensure that enrollees receive appropriate care in a cost effective manner. We believe the process has saved about 2% over fee for service payments, since it was implemented in 1997.

The bill directs the Department to carry out several initiatives as outlined in Section 1 of the bill. Paragraph 1 requires Medicaid to establish a statewide-targeted case management program for all recipients with two or more diagnosis, and requires a pharmacy management component. The Department is also interested in improving the quality outcomes for our recipients that will result in potential cost savings to the program. As such we have included $200,000 in our operating budget for the next biennium to begin the process. At this time we are exploring how best to approach the need for disease management. We have examined data for the most expensive 500 recipients exclusive of institutional care such as nursing facility services. We have concluded that we must extend the review further to get a better picture as to where we need to concentrate our resources.

The Department reviewed our claims data for the last year and noted that about 68% of all recipients have two or more diagnosis. Over the course of a biennium more than 50,000 individuals would be affected. The costs to case manage this large group of recipients would be very expensive. We would suggest that the language in Paragraph 1 be changed to direct the Department to develop a disease management process that may include the use of targeted case management, which could include a primary pharmacy component.

Paragraph 2 requests the Department to develop a process to limit the number of individuals in out of state nursing facilities. Currently the Department has a reciprocal agreement with the state of Minnesota. If an individual living in Minnesota chooses to live in a North Dakota nursing facility, the state of Minnesota is responsible for that resident for two years. The same applies to individuals in North Dakota who choose a Minnesota nursing facility. The vast majority of out of state nursing facility payments are the result of this agreement.

Over the years we have concluded that this arrangement is cost neutral, and reduces the problems for county staff that are required to determine residency for purposes of Medicaid eligibility. The Department could end the agreement; but we do not believe it would result in any savings to the state of North Dakota.

Paragraph 3 requires the Department to review and develop recommendations for the improvement of mental health treatment and services in the state. Many of the individuals who are eligible for Medicaid do have mental illness diagnoses. We have noted that many individuals with chronic diseases also have a mental illness diagnosis. We agree that this will continue to be a need, and have no problem in reviewing our current program to determine where improvements could be made, for individuals on the program who are diagnosed with a mental illness.

Paragraph 4 requests that we review post office addresses to determine what are proper mailing addresses for recipients. While we cannot prevent the use of post office boxes, we try to use the most appropriate address for recipients. In some cases a post office box may be the most appropriate address. For example, residents of nursing facilities or group homes may have the address of the facility, which may be a post office box number.

Paragraph 5 requires that the Department have providers use appropriate diagnostic and procedure codes when submitting claims to the Department for payment. We are cognizant of the importance for providers to submit appropriate claims data. However, in some instances it is not practical to obtain. For example, we do not expect qualified service providers who are untrained in the diagnosis coding process to enter these codes. Also we do not require nursing facilities and other group homes to submit diagnosis on claims. If needed, diagnosis codes for nursing facility residents can be obtained from the Minimum Data Set that we maintain for each individual residing in a nursing facility. We believe that we do require providers to submit diagnosis and procedure codes

when it is necessary to properly adjudicate a claim. We have no problem reviewing our current policies to determine if it would improve our operations to require more providers to enter these codes.

Paragraph 6 indicates that the Department should implement a prescription drug formulary based on Medicare Part D. The Department will still be unable to enact a drug formulary under current federal Medicaid regulations. However, we do recognize that we need to plan for the implementation of the Medicare drug prescription program that will begin on January 1, 2006. We will be working with the federal government and others to assist our dual eligible recipients to access this new program.

Paragraph 7 requires medical services to seek preauthorization for certain high-cost medical procedures. The Department prior authorizes a variety of services at this time. However, we are also aware of criticism we receive from providers and others when it is perceived that we are interfering with the physician/patient relationship. Our initial review of the number and costs associated with expensive diagnostic scans indicates that the cost of prior authorization may exceed the expected savings. Perhaps additional review may be necessary to determine if prior authorizing these services could realize savings.

Paragraph 8 requires that we develop a system for the use of photo identification cards for Medicaid recipients. We have estimated the cost of converting the cards currently used by recipients, and the ongoing costs for new recipients. The cost does not include the cost of obtaining the actual photograph. In addition, we would need guidance on how often the card would need to be renewed. For example, when would a newborn need a new card?

Paragraph 9 requires medical assistance providers to use tamper-resistant prescription pads. It is our opinion that if tamper-resistant prescription drug pads are a good idea the process should apply to all prescriptions not just for

those prescriptions written for Medicaid recipients. We would suggest a broader application than just the Medicaid program.

I would also like to take this time to acknowledge my staff for the excellent work they do. As you heard this morning the Medicaid program in North Dakota operates in an efficient and effective manner. This is a result of the hard work of the dedicated public servants that work with me. We operate as a team to get the job done for our clients from the workers in the mailroom to the managers of the program. It would be shame to break up this team by outsourcing some of the vital functions that are important to the overall success of this program.

I would be happy to respond to any questions you may have.

The Department believes that managed care can be a partial solution to the increasing costs of delivering services to recipients of the Medicaid program. Many states have adopted this concept in their programs.

Section 2 of the bill appropriates $1.0 million that would be used for the purposes outlined in Section 1 of the bill. The Executive budget does not include funding for this project and therefore the Legislature would need to increase the Department's budget in order to implement the provisions of this bill.

I would be happy to respond to any questions you may have.