Testimony
Department of Human Services
Health Care Reform Review Committee
Representative George Keiser, Chairman
July 25, 2012

Chairman Keiser, members of the Health Care Reform Review Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I appear before you to provide information regarding the status of the Department's implementation of the Affordable Care Act (ACA) and the issues related to the state's option to expand Medicaid under the ACA.

Program Integrity

Provider enrollment and screening

Section 6401(a) of the Affordable Care Act, as amended by section 10603 of the Affordable Care Act, amends section 1866(j) of the Social Security Act (the Act) adds a new paragraph "(2) Provider Screening." Section 1866(j)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health and Human Services' Office of the Inspector General, to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP. Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider or supplier. Section 1866(j)(2)(C) of the Act requires the Secretary to impose a fee on each institutional provider of medical or other items or services or supplier, to be used by the Secretary for program integrity efforts. Section 6401(b) of the Affordable Care Act amends section 1902 of the Act to add paragraph (a)(77) and (kk), which include requirements for States to comply with the process of screening

providers and suppliers and imposing temporary enrollment moratoria for the Medicaid program as established by the Secretary under 1866(j)(2) and (7) of the Act.

The Department will be issuing a Request for Proposal for a vendor to assist with the implementation of the screening requirements (licensing lists, checking Social Security Administration Death Master File, site visits, etc.).

Termination of Provider Participation

Section 6501 of the Affordable Care Act amends section 1902(a)(39) of the Social Security Act (the Act) and requires State Medicaid agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan.

The Department checks the two federal exclusion lists for newly-enrolling providers and will be issuing a Request for Proposal for a vendor to check the federal exclusion lists and the list of individuals and entities terminated under Medicare and other State Medicaid plans, for all Medicaid providers on a monthly basis.

Recovery Audit Contractor (RAC)

Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a)(42) of the Social Security Act (the Act) and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments.

The Department has entered into a contract with Cognosante. It is expected that Cognosante will begin their audits of North Dakota Medicaid providers in September 2012.

Increase in Physician Reimbursement

Section 1202 of the Affordable Care Act, provides increased payments for certain Medicaid primary care services. Under this provision, certain physicians that provide eligible primary care services would be paid the Medicare rates in effect in calendar years (CY) 2013 and 2014 (or if greater, the Medicare rate in effect in 2009) instead of their usual state-established Medicaid rates, which may be lower than federally established Medicare rates. States will receive 100 percent Federal financial participation (FFP) for the difference between the Medicaid State plan payment amount as of July 1, 2009 and the applicable Medicare rate.

The Department does not expect to receive the 100 percent FFP, as the North Dakota Medicaid physician fees were greater than the Medicare fees as of July 1, 2009. The analysis of the payments for vaccine administration will be completed once the final rule is published.

Medicaid Expansion and Affiliated Areas Impacts

On June 28, 2012, the Supreme Court upheld the 2014 Medicaid expansion; however, they struck down the mandate indicating that the federal government could not withhold all federal Medicaid funding if a state chooses to not expand Medicaid. Therefore, the decision about whether to expand the Medicaid program will be left to each state.

This opinion has resulted in a number of questions that need to be addressed. Both the Department and the National Association of Medicaid Directors have submitted numerous questions to the Centers for Medicare and Medicaid Services (CMS).

Examples of questions that have been submitted:

- *Can a state choose to expand Medicaid to 100 percent of the Federal Poverty Level (FPL) rather than the 133 percent (plus 5 percent income disregard)?*
  If a state expands to a level lower than 133 percent of the FPL, is the state still eligible for the enhanced federal funding?

- *Can a state phase-in an expansion to 133 percent of the FPL?*
  Is the state still eligible for the enhanced federal funding?

- *If the state chooses to not expand in 2014, but at a later date, is the enhanced federal funding available?*

- *Can CMS confirm that individuals with income between 100 percent FPL and 133 percent FPL will be eligible for cost sharing subsidies and tax credits to purchase coverage through the Exchange?*

Once we have the answers to the questions submitted, the Department will be reanalyzing the impact of the Medicaid expansion and affiliated areas that was prepared in 2010. We expect the analysis with various scenarios to be available for the 2013 Legislative Assembly.

Even if North Dakota chooses not to expand Medicaid, there will still be impacts to the Medicaid program and the Medicaid expenditures. Last week, the Congressional Research Service issued a Memorandum which provides an analysis of the effect of the Supreme Court's decision on the Medicaid expansion.

<u>This analysis notes:</u>

"The Court's decision only limited this new grant program's *enforcement* mechanism; it did not specifically affect, change or limit any other Medicaid or ACA provisions."

"…all other provisions of the Medicaid statute, both current and in the ACA are "severed" from this remedy, and so remain "fully operative" as provided in the law and should 'function in a way consistent with Congress' basic objectives in enacting the statute.'"

"Following the Supreme Court's decision in NFIB, some have argued that the states are no longer required to comply with the ACA maintenance of effort provision (MOE), and the modified adjusted gross income provision (MAGI) because these requirements should be considered part of the ACA Medicaid expansion…..A careful reading of the Court's holding supports the conclusion that these two provisions are unaffected by the Supreme Court's ruling, and are enforceable under the current Medicaid statute."

"If states choose not to participate in the Medicaid expansion, given the Court's severability analysis, the MAGI standards would still be applicable to other parts of the state's Medicaid program, CHIP program and for determining an individual's eligibility for federal subsidies toward the purchase of private health coverage through the state exchanges."

Therefore, even though the expansion is now a state option, moving to Modified Adjust Gross Income (MAGI) does not appear to be a state option. The policy and information technology changes that will be needed to support conversion to MAGI in Medicaid and CHIP are underway and will continue. The Department expects other affiliated areas to be impacted because the Affordable Care Act was upheld. We still expect an increase in enrollment due to the individual mandate and the outreach efforts that are expected as part of the Act. In addition, the Act calls for strengthening of program integrity efforts, and includes provisions to improve quality of care and access. We hope to know more in the weeks and months to come and will be better able to quantify the affiliated impacts on the Medicaid program and the Medicaid expenditures.

I would be happy to answer any questions.