Testimony
Engrossed House Bill 1012 – Department of Human Services
Senate Appropriations
Senator Holmberg, Chairman
March 12, 2013

Chairman Holmberg, members of the Senate Appropriations Committee, I am Maggie Anderson, Director of Medical Services for the Department of Human Services (Department) and will provide an overview of the Traditional Medicaid and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers two programs in this budget area; they are Medicaid and the Children's Health Insurance Program (Healthy Steps). This area of the budget provides health care coverage for qualifying families and children, pregnant women, the elderly, and disabled citizens of North Dakota. Attachment A lists the Medicaid Mandatory and Optional Services, and Attachment B lists the services that have a limit or a co-payment.

Caseload

Attachment C shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for the last 24 months. To review Medicaid recipient information in more detail, Attachment D and Attachment E are included. Attachment D shows the unduplicated count of Medicaid cases and recipients by county for State Fiscal Year (SFY) 2012, and Attachment E shows the unduplicated count of recipients by age group for SFY 2012.

Attachment F shows the number of children enrolled each month in Healthy Steps for the last 24 months, and also provides the number of children enrolled in Medicaid for the same time period.

Program Trends/Program Changes

The following items were authorized by the 2011 Legislative Assembly and were implemented during the 2011-2012 Interim:

- House Bill No. 1152 authorized a supplemental payment for critical access hospitals. The supplemental payment afforded payments to the critical access hospitals up to their cost for laboratory and certified registered nurse anesthetist services. The Executive Budget recommends extending this funding for the 2013-2015 Biennium.
- House Bill No. 1320 created a new statute (50-24.1-02.10) allowing a deduction for real estate taxes from rental income for individuals screened as requiring, and receiving, nursing care services. The deduction was limited to the amount of real estate taxes the individual is responsible for paying on the property. The statute became effective August 1, 2011.
- Senate Bill No. 2024 allowed medical providers who render services to inmates of county jails to submit the claims directly to the Department for processing. This allows the county jails the benefit of using the Medicaid fee schedule for pricing the claims and reduces the administrative work required of county jail staff. A secondary provision of the bill allows for the inpatient hospital bills of inmates who are otherwise eligible for Medicaid to be submitted to the Department. Federal Medicaid participation is available for payments made on the inpatient claims. This provision will be

implemented with the new Medicaid Management Information System (MMIS).

Children's Health Insurance Program Reauthorization Act

The Department applied for a Children's Health Insurance Program Reauthorization Act (CHIPRA) outreach and enrollment grant in the spring of 2011. The two-year grant was approved at $1.7 million. Through the use of these funds, the Department launched an online renewal system for Medicaid and Healthy Steps, Temporary Assistance to Needy Families and the Supplemental Nutrition Assistance Program on September 1, 2012. The online renewal system allows individuals and families that are currently participating in one of the programs to renew their coverage online and, if necessary, attach supporting documentation.

The CHIPRA grant funds are also being used to develop an electronic verification system to allow more efficient verification of information for applicants and recipients. The new "ND-Verify" system will search multiple interfaces, which will simplify processes for applicants as they will not have to provide verification of information that is available electronically. The system will also save county eligibility workers time as they will no longer wait for verifications or search multiple interfaces and the system will also eliminate potential errors due to missed searches. The "ND-Verify" system is expected to be operational in August 2013.

Dental Access Project

While the Department has observed increased access to dental services for the Medicaid population, we also recognize that additional efforts are needed to improve access to dental services. To accomplish this, the Department initiated a Medicaid and CHIP Dental Access project. The

intention of the project is to increase the number of dentists practicing in private non-profit dental clinics by awarding funds to support the recruitment of dentists by assisting them with repayment of their dental school loans. I am excited to announce that the first of the awards was made last week and the award will be used to assist Bridging the Dental Gap in hiring an additional dentist. In exchange for the award, Bridging the Dental Gap will increase outreach efforts to the Medicaid and CHIP population and also plans to expand their catchment area from a 50-mile radius to a 100-mile radius.

Program Integrity

In an effort to improve and enhance the efforts to identify and investigate suspected fraud or abuse and address Medicaid Program Integrity, the Medicaid Program Integrity staff members have enhanced the fraud and abuse policies and procedures, strengthened audit activities, updated North Dakota Administrative Code 75-02-05 (Provider Integrity), developed a fraud reporting mechanism for ease of reporting, and developed an annual fraud and abuse on-line training session for all staff who have involvement with the Medicaid program.

To further strengthen program integrity efforts, the Department is also requesting a change to state statute (Senate Bill No. 2114) to allow for the collection of civil monetary penalties.

Money Follows the Person Demonstration Grant

In 2007, the Department was awarded a Money Follows the Person (MFP) Demonstration Grant. The grant funding is provided to North Dakota for the purpose of assisting individuals in nursing facilities and institutions that serve individuals with developmental disabilities in transitioning to

home and community-based settings. The passage of the Affordable Care Act extended the grant through 2020. The Centers for Medicare and Medicaid Services (CMS) has authorized 100 percent federal administrative funding to address a variety of services to support the MFP efforts. I will cover the MFP activities in detail within the Long-Term Care Continuum budget testimony.

Medicaid Pharmacy Services

Drug rebate collection percentages have continued to grow to record highs. The Department awaits final rules from CMS to determine the impact of rebate changes included in the Affordable Care Act.

The volume of individual prescriptions costing more than $1,000 continues to rise.

Year	Number above $1,000 per prescription
Calendar Year 2006	1,321
Calendar Year 2007	1,422
Calendar Year 2008	1,620
Calendar Year 2009	1,766
Calendar Year 2010	2,137
Calendar Year 2011	2,737

In total dollars, these large claims have risen from $2.6 million in 2006, to $6.2 million in 2011. In 2012, one Medicaid client started a medication that costs $295,000 per year.

On January 1, 2013, Medicare Part D started covering benzodiazepines and barbiturates for dual eligibles (individuals who qualify for both

Medicare and Medicaid). The Department expects to see future increases to the Clawback payment to cover the cost of this change.

Affordable Care Act (ACA) ~ Health Care Reform

The Executive Budget includes $9.1 million to cover the expected costs of the "previously eligible" individuals. This is a group that is expected to apply for coverage – **regardless of whether there is a Medicaid expansion**. These are individuals who are eligible for Medicaid today, but have not applied for coverage – perhaps because they did not know they qualified, perhaps because they did not have a medical need. In 2014, when the individual mandate within the ACA is in force and considerable federal outreach occurs, it is expected that these individuals will apply for coverage. Those found eligible based on eligibility rules currently in place, will be enrolled in Medicaid and the services they receive will be eligible for 50 percent federal match (which is the Federal Medical Assistance Percentage, effective October 1, 2013) rather than the 100 percent federal funding for the expansion population.

The Executive Budget also accounts for the changes expected due to moving Medicaid and Healthy Steps eligibility determinations for all non-disabled and non-elderly individuals to modified adjusted gross income. Currently, North Dakota uses net income for eligibility determination purposes; however, the ACA requires the transition to a modified adjusted gross income (MAGI) test. There are expected implications of this change, including children who will move from Medicaid to Healthy Steps and children who will move from Healthy Steps to Medicaid. The Department expects to have to accommodate these changes in the Medicaid and CHIP State Plans and in the technology systems that

support the programs. We await final information on how the conversion to MAGI will impact coverage for children.

Other ACA-Related Provisions

Provider enrollment and screening

The ACA requires the Secretary of Health and Human Services, 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. 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. 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, 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 ACA 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 has released a Request for Proposal for the implementation of the screening requirements (licensing lists, checking Social Security Administration Death Master File, site visits, etc.). The Department currently checks the two federal exclusion lists for newly-enrolling providers. The eventual contract will include checking 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

The ACA requires states to establish a Recovery Act Contractor (RAC) program to enable the auditing of claims for services furnished by Medicaid providers. Pursuant to the statute, Medicaid RACs must: (1) identify overpayments, (2) recoup overpayments, and (3) identify underpayments. The Department has entered into a contract for the RAC program with Cognasante. The vendor has received claims information and is working with staff to understand payment policy and reimbursement requirements so they can begin their audits.

Increase in Physician Reimbursement

Section 1202 of the ACA 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 2013 and 2014 (or if greater, the Medicare rate in effect in 2009). 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 for physician services, as the North Dakota Medicaid physician fees were greater than the Medicare fees as of July 1, 2009.

Based on the requirements of the ACA, and in accordance with the final rule published on November 6, 2012, the Department will be increasing Medicaid vaccine administration fees. The incremental increase for eligible provider types will be financed with 100 percent federal funds, for Calendar Year 2013 and Calendar Year 2014. There is no incremental increase in funding for providers not defined as "eligible"; however, the Department plans to increase the vaccine administration fees for all providers to minimize information system changes and to ensure consistent and continued access to vaccine administration for Medicaid recipients. The estimated cost of the increase for the providers not eligible for the incremental federal increase is approximately $167,000 in general fund for the first eighteen months of the 2013-2015 biennium. It is important to note: there is no indication as to what happens with the increased federal financing of the fees for eligible provider types in subsequent years.

Overview of Budget

Description	2011 - 2013 Budget	Increase / Decrease	2013 - 2015 Executive Budget	House Changes	To Senate
Salary and Wages	7,563,195	1,030,334	8,593,529	-	8,593,529
Operating	33,883,524	5,216,311	39,099,835	(491,735)	38,608,100
Grants-Medical Assistance	659,018,818	(13,555,668)	645,463,150	(6,745,598)	638,717,552
Total	700,465,537	(7,309,023)	693,156,514	(7,237,333)	685,919,181
General Funds	235,840,610	56,325,513	292,166,123	(3,327,564)	288,838,559
Federal Funds	428,567,639	(69,412,232)	359,155,407	(3,909,769)	355,245,638
Other Funds	36,057,288	5,777,696	41,834,984	-	41,834,984
Total	700,465,537	(7,309,023)	693,156,514	(7,237,333)	685,919,181
FTE	54.50	2.00	56.50	-	56.50

Budget Changes from Current Budget to the Executive Budget

The Salary and Wages line item increased by $1,030,334 and can be attributed to the following:

- $187,536 in total funds of which $100,628 is general fund is to fund the Governor's benefit package for health insurance and retirement for state employees.
- $201,240 in total funds of which $131,430 is general fund needed to fund the employee increases approved by the last Legislative Assembly.
- $317,772 in total funds of which $141,194 is general fund needed to fund the continuation of the FTE authorized during the 2011 special Legislative session.
- $195,567 of which $88,165 is general fund needed to fund two FTE needed to assist with the additional workload resulting from the Affordable Care Act, regardless of a Medicaid expansion. The two positions consist of a Pharmacy Technician and a Coding Specialist. These two FTE were transferred from other areas of the Department. This budget is not requesting the authorization of any additional FTE.
- The remaining $128,219 is a combination of increases and decreases needed to sustain the salary of the 56.50 FTE in this area of the budget.

The Operating line item increased by $5.2 million (15.4 percent) and is a combination of the increases and decreases expected next biennium. The majority of the increase is due to the changes in operating fees and services as follows:

- $3.2 million of the operating increase is due to the Medicare Part D Clawback, which is funded with general fund dollars and estate collections.

- $316,000 in total funds of which $158,000 is general fund for additional contracted services to address the increased expectations for Medicaid program integrity.
- $262,000 in total funds of which $131,000 is general fund needed to fund the Division's development and tracking of quality assurance measures.
- $1.8 million in total funds of which $88,661 is general fund needed to fund the increase in Money Follows the Person contracts.
- Decrease of $126,051 in total funds of which $55,160 is general fund in the Children's Health Insurance Program External Quality Review contract.
- Decrease of $100,000 of which $55,160 is general fund for a Utilization Review contract that was anticipated in the previous budget, but was determined to not be needed.
- The remaining $151,949 is a combination of increases and decreases made to contracts within the Medical Services Division.

The Executive Budget for Medical Grants is $645.5 million, which is a **decrease** of $13.6 million. Please refer to Attachment G for a walk-through of each service area, which has been updated with the House changes.

Attachment H is a cost and caseload comparison of the Traditional Medical Grants from the 2011-2013 Appropriation to the 2013-2015 Budget to the House and the 2013-2015 Budget to the Senate for the top twelve services. These services represent 92 percent of the Traditional Medical Grants.

Attachment I shows each Traditional Medicaid Service comparing the 2011-2013 Budget, the 2011-2013 Projected Need, the 2013-2015 Executive Budget request, and the 2013-2015 Budget to the Senate.

To provide perspective on "where the money goes," please see Attachment J, which provides the number of providers by county and total dollars paid to those providers for dates of service in State Fiscal Year 2012.

House Changes:

- Removed Section 3 which was the authority for the Department to implement the Medicaid Expansion authorized in the Affordable Care Act. The House placed the Medicaid Expansion in House Bill 1362, which passed the House and will be heard in Senate Human Services tomorrow morning.
- Reduced funding for previously eligible individuals (woodwork effect) who are expected to apply for Medicaid coverage due to the Affordable Care Act individual mandate and outreach efforts. This reduction is $4,536,598 in total funds, of which $2,268,289 is general fund.
- Removed funding for professional medical expert services of $84,000 in total funds, of which $42,000 is general fund.
- Removed funding for program integrity contract services of $316,000 in total funds, of which $158,000 is general fund.
- Removed funding to contract with a vendor for prescreening of Medicaid providers of $240,000 in total funds, of which $120,000 is general fund.

- Removed funding for the oversight for qualified service provider mileage differential of $100,000 in total funds, of which $78,040 is general fund.
- Reduced funding for caseload projections for the following: CHIP, durable medical equipment, private duty nurses, premiums and transportation of $2,209,000 in total funds, of which $909,500 is general fund.
- At the request of the Department, increased funding for Medicare Part D clawback payments of $248,265 in general fund.

This concludes my testimony on the 2013-2015 budget request for the Traditional Medicaid and Children's Health Insurance Programs. I would be happy to answer any questions.