North Dakota Department of Human Services
Interim Human Services Committee
Representative Kathy Hogan, Chairman
July 26, 2016

Chairman Hogan and members of the Human Services Committee, I am Erik Elkins, Assistant Director, Medical Services Division for the Department of Human Services (DHS/Department). I appear before you to provide a report on the outcomes of the Medicaid and Medicaid Expansion cost-sharing provisions study and the associated legislative recommendations and related draft legislation pursuant to Section 1 of 2015 House Bill No. 1037.

The information in my testimony is compiled from materials prepared by the Medicaid and CHIP Learning Collaborative, by the Centers for Medicare and Medicaid Services, from various reports and studies regarding Medicaid cost-sharing and from current North Dakota Medicaid cost sharing.

Current Medicaid Co-payments

Service	Co-Payment
For office visit/consultation codes 99201-99215 and 99381-99429 that are performed by providers authorized within their scope of practice to perform these services	$2.00 for each office visit
Brand name prescription drugs	$3.00 for each prescription
Dental clinic appointment – oral examination	$2.00 for each appointment
Optometry appointment – visual examination	$2.00 for each appointment
Spinal manipulation received during a chiropractic appointment	$1.00 for each appointment
Outpatient speech therapy	$1.00 for each visit
Outpatient physical therapy	$2.00 for each visit
Outpatient occupational therapy	$2.00 for each visit
Outpatient psychological appointment	$2.00 for each appointment
Outpatient hearing test	$2.00 for each visit
Hearing aid dispensing service	$3.00 for each
Rural Health Clinic or Federally Qualified Health Center	$3.00 for each appointment
Podiatry office appointment	$3.00 for each appointment

Emergency room visit that is not an emergency**	$3.00 for each visit
Inpatient hospital stay	$75.00 for each stay

Background and Requirements

Cost Sharing may include co-payments and premiums.

Cost sharing may be imposed on outpatient services, inpatient services, non-emergency use of the emergency room and prescription drugs.

Cost sharing may be imposed on individuals in the following eligibility groups: single adults, parents, and aged, blind and disabled (some exceptions).

The Medicaid agency is required to reduce the provider payments by the amount of the co-payment obligation, regardless of whether the copayment is collected.

Services Exempt from Cost Sharing

- Emergency Services
- Family Planning Services
- Preventative Services provided to children
- Pregnancy-related services
- Services resulting from provider preventable services

Mandatory Exempt Populations

- Children under 18 (limited exceptions –premiums for the Medicaid Buy in Children) (***Optional*** *exemption for individuals 19 and 20.*)
- Pregnant Women
- Individuals living in an institution who are required to contribute nearly all of their income toward the costs of their care.
- Individuals receiving hospice

- American Indians/Alaskan Natives who have ever received a service from an Indian health care provider.
- Women enrolled under the Breast and Cervical Cancer Treatment Program (Women's Way)

Medicaid Cost Sharing Limits

Aggregate Limits on Premiums and Cost Sharing

Medicaid premiums and copayments are limited to 5% of family (household) income.

States must track beneficiary premium and copayments. This system used for tracking must:

1. Be an effective mechanism that does not rely on beneficiary documentation.

2. Include a mechanism for notifying beneficiaries and providers when the aggregate limit has been reached.

3. Track the amount of cost sharing and premiums incurred, not paid.

4. Determine whether each beneficiary's cost sharing and premiums exceed the aggregate limit on either a monthly or quarterly basis (state option).

Maximum Medicaid cost sharing, by federal poverty level (FPL)

	< 100% FPL	100% to 150% FPL	>150% FPL
Outpatient Services	$4	10% of the fee paid by the state	20% of the fee paid by the state
Inpatient Services	$75 per stay	10% of the amount paid by the state per stay	20% of the amount paid by the state per stay
Prescription Drugs	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: 20% of the amount paid by the state
Non-Emergency ER	$8	$8	No limit (but subject to 5% cap)
PREMIUMS	Not Allowed	Not Allowed	Permitted, subject to 5% cap
Aggregate Cost Sharing Cap	5% Household Income	5% Household Income	5% Household Income

Variation of Cost Sharing

Cost sharing may be less for primary care; to encourage utilization and cost sharing may vary by income level as long as cost sharing is not higher for beneficiaries with lower incomes.

Cost sharing may not vary based on whether beneficiaries are enrolled in fee-for-service or managed care; however, a managed care organization may charge lower cost sharing to beneficiaries.

What if beneficiaries do not pay cost sharing?

If the beneficiary is in a household whose income is at 100% FPL or less, a provider may not refuse to provide a service if the beneficiary cannot pay their cost sharing.

If the beneficiary is in a household whose income is above 100% FPL, the provider may refuse to provide a service if the beneficiary cannot pay their cost sharing.

Cost Sharing for Emergency Room (ER) Services**:

The Department is in the process of removing the $3.00 copayment for non-emergent use of the emergency room due to the requirements Hospitals would have before charging the copayment. These requirements are:

1. Provide a screening at the ER as required by EMTALA.
2. Inform the beneficiary of the amount of cost sharing for non-emergent use of the ER.
3. Provide the beneficiary with the name and location of an available non-emergency service provider.
4. Determine that an alternative provider can provide services in a timely manner with lesser or no cost sharing.
5. Provide a referral to coordinate treatment by the alternative provider.

In addition, the Centers for Medicare and Medicaid Services (CMS) will require states to provide the following information to allow copayments on non-emergent use of the ER:

A. State's definition of non-emergency services.

B. Guidelines to help ER staff distinguish between emergency and non-emergency care.

C. Who in the hospital discuses with the patient the cost sharing consequence of obtaining non-emergency care in the hospital

D. Whether alternate sources of care are available in the geographic area with after hours and next day availability.

E. Whether beneficiaries have appeal rights if they disagree with the state's determination that the ER visit was for non-emergency care.

F. The estimated savings from implementing the cost sharing.

G. The extent of stakeholder input for the copayment.

Medicaid agencies are NOT allowed to impose any cost-sharing for emergency services.

Premiums

Without a waiver, the Medicaid agency may not impose premiums under the state plan for individuals with incomes below 150% FPL (some exceptions such as Workers' with Disabilities and Children with Disabilities Buy-In programs).

For individuals with incomes above 150% FPL, state may impose premiums through as state plan amendment, limited by the aggregate 5% cap.

Waiver of Cost Sharing Limits

Cost sharing waivers may be imposed under a demonstration project (1115 Waiver). A waiver under this authority is limited to a two-year

period (or less) and requires that all 1115 Waiver requirements be followed. Examples of premiums waivers approved by CMS can be reviewed on **Attachment A**.

Tracking and Monitoring of Cost Sharing

The Medicaid agency must inform each beneficiary/household of their cumulative cost-sharing maximum, and be able to track and monitor all cost sharing based on both individual and household income. This requires integration of the eligibility and claims payment systems. While both of the recently-implemented systems (MMIS and SPACES) will support this integration, the current CMS requirements surrounding calculating and tracking cost sharing were not contemplated in the original requirements for the systems. To provide a bit of perspective on the requirements, please reference **Attachment B** for a subset of slides CMS prepared to provide training to State Medicaid agencies. The Department is working with the vendors for both systems to determine a timeline for the necessary integration of the two systems.

Reports and Studies on Medicaid Cost Sharing

Co-payments can assist health care payers (such as Medicaid) in controlling utilization of services, thus hoping to control (reduce) overall costs. Premiums are assessed before someone being enrolled in coverage; therefore, do not generally control utilization of services. From the information provided on the Michigan waiver, premiums may also be waived for certain "healthy" behaviors.

There are also many historical studies and papers addressing cost sharing in Medicaid. Some of the results/opinions from those documents are summarized in **Attachment C**.

The Department has reviewed all of information in this testimony with the Medicaid Medical Advisory Committee and sought their input on current copayments, the possibility of increasing copayments, and the possibility of adding a premium for the Medicaid Expansion population. Their input is summarized in **Attachment D**.

In October of 2015 the Department implemented the Medicaid Management Information System (MMIS) and four months later, followed that with the implementation of Phase I of the Eligibility System (SPACES). The combination of work effort still needed to ensure eligible individuals are enrolled in coverage as quickly as possible and to ensure that provider claims are paid timely and accurately is significant. The effort needed to implement (and manage) any cost sharing that exceeds federal maximums (thus requiring a waiver) would require staff to be diverted from current efforts.

In addition, if there would be cost sharing (premium) changes to the Medicaid Expansion product that would require additional tracking by the contracted health plan (Sanford Health Plan), the Department, Sanford Health Plan, and the actuaries would need to determine if there would be an impact on the per member per month payments, including the administrative component of the payment. The interim Health Care Reform Review Committee has been discussing the future of Medicaid Expansion. Depending on the recommendations from that committee and the actions of the 2017 Legislative Assembly, the addition of premiums could be considered for the Medicaid Expansion population. To provide perspective on premium efforts from one of our neighboring states, we spoke to staff from Montana about the premiums they have included in their recently-implemented Medicaid Expansion product. Please reference **Attachment E** for a summary of the Montana premium.

Based input from the Medicaid Medical Advisory Committee regarding the impacts of cost sharing on providers and beneficiaries, and in consideration of the impacts of the budget allotment changes and the costs to providers involved in the collection of copayments, the Department is not recommending any increases to current cost copayments or the addition of premiums. In addition, if premiums are considered for the Medicaid Expansion population, there will be impacts on existing county and state staff and information technology systems. There are also early results from Montana that premiums have impacted the disenrollment of some individuals for failure to pay premiums.

I would be happy to address any questions that you may have.