Testimony
House Bill 1072 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
January 11, 2017

Chairman Pollert, members of the House Appropriations Committee – Human Resources Division, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here to provide an overview of the Traditional Medicaid, Medicaid Expansion, and the Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division.

Programs

The Medical Services Division currently administers three programs in this budget area: Medicaid, Medicaid Expansion, and the Children's Health Insurance Program (CHIP or Healthy Steps). This area of the budget provides health care coverage for qualifying families and children, adults that are under the age of 65 with incomes up to 138% of the federal poverty level, pregnant women, and the elderly and disabled.

Caseload

Attachment A shows the Medicaid Enrollment (eligibles) and the unduplicated count of recipients for the last 24 months.

Attachment B provides perspective on "where the money goes". The map provides the number of providers by county and total dollars paid to those providers for dates of service in State Fiscal Year 2016.

Federal Impacts on Medicaid Administration

Medicaid is a federal-state partnership. While the State can design (and legislate) program services, eligibility, and operational protocols, the federal government dictates minimum standards, sets requirements for various program operations, and continues to make program changes that increase the resources States must invest to continue to accept federal Medicaid funding. Within the Department, these federal requirements impact the Medical Services Division, the Fiscal Administration Division, the Legal Advisory Unit, the Developmental Disabilities Division and the Aging Services Division.

These federal influences have impacted the administration of the program including staff priorities and workload. Following are several examples to illustrate the variety and magnitude of the various requirements:

Provider Enrollment

The ACA mandated that the State Medicaid Agency (SMA) perform heightened provider screenings to safeguard Federal funds and to ensure that recipients are offered care by healthcare providers that are qualified to provide services and/or supplies. Any provider or supplier that enrolls is subject to the mandated screening procedures that includes "risk" based screening.

The screening required for ***limited risk*** providers includes:

- verifying providers/supplier-specific requirements established by Medicare;
- conducting license verification (may include licensure checks across States);

- performing database checks (to verify social Security Number (SSN); the National Provider Identifier (NPI); the National Practitioner Data Bank (NPDB) licensure; an Office of Inspector General (OIG) exclusion taxpayer identification number; and death of individual practitioner owner, authorized official, delegated official, or supervising physician.

The SMA also has to ensure that the enrolling provider is not excluded by another SMA. In addition to screening requirements for limited risk providers, ***moderate risk*** providers require unannounced site visits. Additionally, for **high risk** providers, fingerprint-based criminal background checks (FCBC) are required (2017 Senate Bill 2117).

Providers are required to revalidate their enrollment no less frequently than once ***every five years***. Once enrolled, the SMA is also responsible for ensuring that providers are screened on a monthly basis to ensure that the provider is still licensed, not deceased and not excluded by the OIG or another SMA.

In addition to providers, the requirements also impact those with 5% or greater direct or indirect ownership interest in the provider. The Department is also required to collect application fees (new enrollments and upon revalidation) for any institutional providers that have not paid an application fee to Medicare or another SMA. The application fee for 2017 is $560. There are also other requirements related to "ordering/prescribing" providers.

All of these additional requirements have impacted staff capacity needs in the provider enrollment area. The Division had one FTE processing

traditional Medicaid provider applications until 2013; when another position was repurposed to assist. To keep up with the provider enrollment demand and to meet the federal requirements, the Division currently has the two, full-time FTE and six temporary staff processing provider enrollment applications. As of January 9, 2017, there was a backlog of 940 provider applications for enrollment.

The Department has over 17,000 enrolled providers and on average receives 135 new applications a month. The Department will start revalidating enrolled providers in 2017. Because the Department is able to capture more data points specific to enrollments, there is also the continued responsibility for keeping all of those areas updated.

In addition, as a result of the federal managed care rules that were issued in 2016, responsibilities for the agency will increase under managed care contracts.

Medicaid Access Monitoring

The Centers for Medicare and Medicaid Services (CMS) published a final rule in November 2015 (effective January 2016) related to Medicaid Access Monitoring. This final rule requires (1) each SMA to prepare and submit a Medicaid Access Monitoring Plan; (2) SMAs to follow specific requirements when Medicaid rate reductions are proposed; and (3) SMAs to monitor program services impacted by rate reductions for three years after any rate reduction. While this new requirement added significant work for the Division, having the rule effective about one month before the State's February 2016 budget allotment has created substantial work, which still continues.

Electronic Visit Verification (EVV)

In late 2016, the "21st Century Cures Act," was signed into law. While the “Cures” legislation largely focuses on pharmaceuticals, the bill also contains various components that will impact Medicaid and Long-Term Services and Supports.

Section 207 of the Act requires Electronic Visit Verification (EVV) of Medicaid home health and personal care services, and reduces a state’s Federal Medical Assistance Percentage (FMAP) for such services provided without EVV beginning in:

January 1, 2019 for personal care services; and

January 1, 2023 for home health services.

Fair Labor Standards Act (FLSA) – Home Care Final Rule

Under the requirements of the FLSA, the Department will need to compensate Qualified Service Providers (QSPs) time and a half for time over forty hours per week in which they are caring for individuals receiving Department-funded home and community-based services and when traveling between client locations. The Department has been reviewing requirements and developing an implementation plan. In order to ensure we can track the hours of services provided by individual QSPs, the Department will need to have a system to accurately track information; and this information will need to eventually interface with the Medicaid Management Information System to ensure claims are processed accurately. The Department has completed a thorough analysis of the impact of the FLSA on Medicaid grants; and in this area of the budget, you will see the projected impact on the operating costs.

Update on items authorized by the 2015 Legislative Assembly:

2015 Senate Bill 2043 directed the Department to adopt rules pertaining to coverage of services provided by community paramedics to individuals enrolled in the North Dakota Medicaid program. The Department has adopted the rules; however, the Division will still need to secure approval from the CMS to cover the services under the State plan. The Division plans to secure the CMS approval by July 1, 2017, and coverage will be consistent with what was included in the Administrative Rules adopted. Due to the budget allotment for the current biennium, and the budget restrictions for 2017-2019, the Department plans to limit the services that can be covered to those already available under the state plan. The Division plans to allow community paramedics to administer vaccines and immunizations, which expands access to these currently-covered services, but does not expand services.

2015 Senate Bill 2046 required the Department to enroll Licensed Marriage and Family Therapists (LMFTs) as Medicaid providers. The Medicaid State plan has been updated to include LMFTs and to date, 23 LMFTs have enrolled with ND Medicaid.

2015 Senate Bill 2320 directed the Department to establish a medication therapy management program for the Medicaid population. To date, in the biennium, the Department has not been able to implement this service. SECTION 2 of 2015 SB 2320 requires the Department to report to the appropriations committee of the sixty-fifth legislative assembly regarding the costs and benefits of the medication therapy management program. The Department plans to implement this program within Calendar Year 2017, but does not have a cost-benefit report at this time.

Other Program Updates

Children's Health Insurance Program (CHIP or Healthy Steps)

The Department continues to contract with Blue Cross and Blue Shield of North Dakota for the Health and Vision services and with Delta Dental of Minnesota for Dental services for the children enrolled in Healthy Steps.

The ACA included a 23% increase in the federal match for CHIP and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended funding for the program through Federal Fiscal Year 2017. Congressional action will be needed to continue CHIP funding, including the 23% increase in CHIP FMAP, before September 30, 2017.

Medicaid Pharmacy Services

The Medicaid Drug Program provides payments to pharmacies for prescribed drugs. In order for medications to be covered, the manufacturer must participate in the Medicaid Drug Rebate Program which requires the manufacturers to pay rebates back to states, and the states must provide coverage for their drugs. As authorized by the 2015 legislative assembly, ND Medicaid has now joined a multi-state supplemental rebate program to collect additional rebates to decrease the net expenditures. To date during the 2015-2017 biennium, approximately $800,000 has been collected as a result of the supplemental rebates, of which about $400,000 is state general fund savings.

Currently, the mix of medications being prescribed for ND Medicaid recipients include many typical medications for children (ADHD and asthma) as well as other medications for the Medicaid population as a whole (antidepressants, antipsychotics, hepatitis C, and diabetic medications). In previous years, increasing costs of brand name drugs

were offset by the number of medications coming off of patent. With the ND Medicaid generic rate of 85-87%, there is no longer any ability for generics to offset the increasing costs of the brands. With the costs of some treatments reaching $5,000 every two weeks for life for enzyme deficiency, $200,000 plus yearly for life for phenylketonuria, or $125,000 for three months of hepatitis C treatment, ND Medicaid is striving to ensure all medications are used in the most efficient manner possible.

With the help of the Drug Utilization Review (DUR) Board, the Department has implemented a number of edits to ensure narcotic utilization is as safe and appropriate as possible. Also, the DUR Board input helped form edits to improve asthma inhaler utilization to a more clinically appropriate level. The DUR Board has also assisted in utilizing the supplemental rebate program to streamline the products requiring prior authorization.

Attachments C, D, and E provide various detail regarding Medicaid prescription drug usage and cost.

As we noted during last session, the Medicare Part D clawback reached the end of the "Phasedown" portion of the calculation in 2015. To refresh, the Part D clawback is the payment states make to the Federal government for dual eligibles, which, in theory, represents the state general fund amount that would have been spent for drug coverage if Part D did not exist. The Phasedown portion of the clawback started at 90% in 2006, and it phased down 1 2/3% every year to 75% in 2015. In short, this means that previous inflation in Part D costs have been offset by this Phasedown, and starting in 2015, the clawback now simply inflates as Part D costs inflate (Note: Annual percentage increase for Part

D expenditures for CY 2017 was 11.75%). The Executive Budget includes an increase of $7.8 million (all general funds) to cover the estimated cost increase for the Part D clawback. The total Executive Budget request in this area is $40.4 million.

Autism Services and Medicaid Coverage

The Division has been working with CMS to secure approval of the expansion of the Medicaid Autism Waiver (to cover children to 9 years of age) and corresponding approval for services under the Medicaid state plan. CMS is requiring states to remove certain services from existing Autism waivers and ensure those services are covered under the state plan. You will note a specific line item for the state plan service as we go through the walk-through later in my testimony.

Medicaid Expansion

2013 House Bill 1362 authorized the Department to expand the Medicaid Program to adults under age 65 with incomes up to 138% of the federal poverty level. Medicaid Expansion in North Dakota was implemented January 1, 2014 as managed care through a contract with Sanford Health Plan. 2013 HB 1362 included a sunset clause on Medicaid Expansion of July 31, 2017.

Slightly over half of the Expansion enrollees are female 54%; approximately 48% were ages 19-35, 18% were ages 36-44, and 34% were ages 45-64. The majority, 58%, are rural. These trends have remained consistent since enrollment began in January 2014. Medicaid Expansion was estimated to provide coverage to 20,500 low-income North Dakotans. Enrollment has been fairly stable during 2016 and as of September 2016 there were 19,358 enrolled in Medicaid Expansion.

Attachment F shows the Medicaid Expansion premiums paid from January 1, 2014, through October 2016.

The ACA provided 100% federal funding for the Expansion population in Calendar Years 2014, 2015, and 2016. Starting January 1, 2017 the federal match began to decrease and will taper to 90% by 2020 according to the following schedule:

Calendar Year	Federal Match Percentage
2014, 2015, and 2016	100%
2017	95%
2018	94%
2019	93%
2020 and future years	90%

The Executive Budget includes several changes to Medicaid Expansion: (1) removal of the sunset clause (Section 13 of 2017 House Bill 1072), (2) reduction of the fee schedule from a commercial level to the Traditional Medicaid level (included in the cost "step" of the budget-building process), and (3) transition of the operation of Medicaid Expansion from a managed care arrangement to a fee-for-service operation (Section 14 of 2017 House Bill 1072). Traditional Medicaid is operated via fee-for-service (FFS). The change from managed care to fee-for-service is estimated to save about $650,000 in state general fund for the period of January 1, 2018 through June 30, 2019. As part of this transfer, 15 FTE were transferred from other parts of the Department to cover resulting staffing needs in the Medical Services and Information Technology Services budget areas. The FTE are needed for those areas that would see increases in efforts by transferring the Medicaid Expansion enrollees (19,358 as of September 2016) to FFS. The FTE include: Claims Processing Staff (10 Claims Processing Staff); Medicaid Utilization

Review (Nurses and Transportation Coordination); and Medicaid Program Integrity, including Third Party Liability (TPL). There would be decreasing and increasing operational costs. Decreases would include savings from Actuarial Services and External Quality Review contracts ($1.2 million). Increases include Medicaid ID Cards, Drug Prior Authorization, Hospital Utilization Review, Primary Care Case Management, TPL Location Services and printing/postage for various mailings. Transferring the program to FFS will also allow the Department to save an estimated $3.4 million for a change request to MMIS so the system can accept and process Medicaid Expansion managed care encounter claims, which is a federal requirement. Currently, the Department has approval from CMS to defer work on the change request, pending the outcome of the legislative session.

Attachment G provides the analysis completed by the Department to calculate the savings of transitioning the Medicaid Expansion operation from managed care to fee-for-service.

In April of 2016, CMS issued final regulations that revise and significantly strengthen existing Medicaid managed care rules. According to the Kaiser Family Foundation summary: "… the regulatory framework and new requirements established by the final rule reflect increased federal expectations regarding fundamental aspects of states' Medicaid managed care programs. Major goals of CMS' in revising the regulations were to align Medicaid and CHIP managed care requirements with other major health coverage programs where appropriate; enhance the beneficiary experience of care and strengthen beneficiary protections; strengthen actuarial soundness payment provisions and program integrity; promote quality of care; and support efforts to reform the delivery systems that

serve Medicaid and CHIP beneficiaries." The breadth of the 405 page managed care final rule is significant. The increased State costs to comply with the requirements of the final rule if Medicaid Expansion remained managed care are not included in the estimated $650,000 savings as it would be difficult, at this time, to accurately predict the increased costs associated with the final rule.

Medicaid Expansion and Estate Collections

During the 2015 session, amendments were adopted on Senate Bill 2050 to restrict estate collection to certain expenditures made on behalf of Medicaid Expansion enrollees. The amendments adopted were specific to payments made on behalf of a recipient who received coverage through a private carrier (N.D.C.C. 50-24.1-07). With the Executive Budget request to operate Medicaid Expansion as Fee-for-service, the existing law would no longer restrict the Department from estate collections for the Medicaid Expansion population. The Department would be willing to draft an amendment if the Human Resources Division is interested in extending the restriction on estate collections.

Home Health Face-to-Face

Section 11 of 2017 House Bill 1072 contains intent language related to Medicaid requirements for Home Health. In February 2016, CMS issued a final rule requiring physicians to document face-to-face visits with Medicaid members to authorize home health services. The language gives the Department the authority to adopt administrative rules and subsequently, enforce the new requirements related to home health services.

Overview of Budget Changes

Description	2015 - 2017 Budget	2017 - 2019 Executive Budget	Increase / (Decrease)
Salary and Wages	8,839,829	10,171,149	1,331,320
Operating	44,587,773	53,001,967	8,414,194
Grants-Medical Assistance	1,215,896,867	1,070,760,453	(145,136,414)
Total	1,269,324,469	1,133,933,569	(135,390,900)
General Fund	312,492,650	303,793,510	(8,699,140)
Federal Funds	913,625,268	739,276,873	(174,348,395)
Other Funds	43,206,551	90,863,186	47,656,635
Total	1,269,324,469	1,133,933,569	(135,390,900)

FTE	47	53	6

Budget Changes from Current Budget to the Executive Budget

The Salary and Wages line item increased by $1,331,320 and can be attributed to the following:

- $188,613 in total funds, of which $91,487 is general fund, needed to fund the Governor's compensation package for state employees.
- $166,526 in total funds of which $83,263 is general fund needed to sustain the employee increases approved by the last Legislative Assembly.
- Increase of $37,951 in Fringe Benefits due to providing health insurance for identified temporary staff.
- Increase of $866,124, of which $338,144 is general fund for 5 FTE that were transferred from within the Department. The FTE would be needed for Medicaid Expansion being operated as fee-for-service rather than managed care. While there is an increase in this line item of the budget, there are other changes that result in an overall

decrease of approximately $650,000 in general fund to operate Medicaid Expansion as fee-for-service.

- Increase of $189,836, of which $94,918 is general fund for an FTE to provide medical utilization review as a result of Medicaid reimbursing Opioid Treatment Programs for services related to and the dispensing of methadone.
- The remaining decrease of $117,730 is a combination of increases and decreases needed to sustain the salary of the 53.0 FTE in this area of the budget.

The Operating line item increased by $8,414,194 and is comprised of:

- Increase of $1 million of which $500,000 is general fund for a contract to complete the cost-settlements for Developmental Disability provider rates.
- Increase of approximately $7.8 million in general fund for Medicare Part D Clawback payments.
- Increase of approximately $1.7 million, of which $1.2 million is general fund for a vendor to assist with verifying and tracking units/hours worked by individual Qualified Service Providers (QSPs) in order to ensure compliance with the Fair Labor Standards Act and the Electronic Visit Verification requirements mentioned earlier in my testimony.
- Decrease of $550,000 due to no longer needing actuarial services for Medicaid Expansion.
- Decrease of $650,000 for Dakota Medical Foundation CHIP outreach contract which is no longer needed due to healthcare coverage outreach occurring with the Affordable Care Act.
- Decrease of $403,301 for other contracted services that are not expected to be needed.

- Decrease of $318,464 for Money Follows the Person (MFP) contracts with MFP transitions ending in 2017.

The Executive Budget for Medical Grants is $1.1 billion, which is a decrease of $145 million. Please refer to **Attachment H** for a walk-through of each service area for detail on the decrease in this area.

The changes in the Medical Grants includes $3.6 million for Medicaid to cover medication and associated costs to support Medicaid-eligible individuals who need treatment for an opioid addiction. The non-federal share is funded with Tobacco Prevention Control Funds.

The general fund request decreased by $8,699,140 which is made up of an $8,862,312 increase to salary and operating changes as described above, along with a decrease of $17,561,452 to grants. The decrease in grants is a combination of increases in caseload and Federal Medical Assistance Percentages (FMAP), along with offsetting decreases attributed mainly to a funding shift in state dollars being replaced with special funds, and Medicaid Expansion being reimbursed based on fee-for-service as of July 1, 2017.

The net change of the federal funds and other funds is mainly due to Medicaid Expansion and a decrease due to reducing the professional fee schedule to 100 percent of Medicare rates.

This concludes my testimony on the 2017–2019 budget request for the Medical Services Division of the Department. I would be happy to answer any questions.