TESTIMONY BEFORE THE BUDGET COMMITTEE ON HUMAN SERVICES
MEDICAL SERVICES UPDATE
MARCH 9, 2006

Chairman Dever, members of the committee, I am Maggie Anderson, Director of Medical Services for the Department of Human Services. I appear before you to provide information on Medicaid prescription drug expenditures, medical assistance related expenditures, initiatives related to House Bills 1459 and 1460, activities of the Prescription Drug Monitoring program, status of the MMIS project, and the status of Medicare Part D Implementation.

Medical Assistance Related Expenditures – see Attachment A

House Bill 1459

<u>Targeted Case Management / Disease Management Efforts</u>

A Request for Proposal (RFP) will be released in mid-March with proposals due from vendors by the end of April. Medical Services has completed extensive research on other State Medicaid disease management programs and has requested input from the Health Department, home health agencies, Federally Qualified Healthcare Centers (FQHCs) and Rural Healthcare Centers (RHCs) throughout program planning. There is interest in a "home grown" program delivered by local health care providers. The RFP was developed to allow for proposals from either Disease Management Organizations or local entities.

The health management program will be available to Medicaid Recipients with select chronic conditions (diabetes, asthma, chronic obstructive pulmonary disease and congestive heart failure) depending on the number of conditions the vendor will be able to include in the program within the available budget. These

conditions were identified among the conditions resulting in the highest Medicaid costs.

Recipients enrolled in the health management program will receive disease management services at an appropriate level based upon their need (as determined through a claims-driven risk stratification process) and will have access to nurse case managers through a telephone health information line available during and after clinic hours. All activities will be conducted within evidence-based clinical practice guidelines and with physician oversight.

The design of the proposed health management program will require the Department to submit a 1915(b) waiver to the Centers for Medicare and Medicaid Services (CMS), and receive CMS approval prior to entering into a contract with a vendor. Waiver development, submission and approval will take a minimum of 4 months. Therefore, the earliest contract "start date" would be September 1 with a program "start date" dependent upon the vendor's ability to efficiently develop and rollout the program.

This proposed health management program reflects a program that Medical Services feels can be conducted within the available budget. If this program proves effective in improving the health of enrolled Recipients and reducing Medicaid costs, program expansion could be considered. Therefore, the RFP requests vendors to submit two budgets: (1) one reflecting the cost of the requested program and (2) a second showing the cost of program expansion to provide comprehensive health management to the entire Medicaid population; including depression (the highest cost condition) and obesity (a prevalent co-morbidity) among the targeted conditions.

Mental Health Treatment

It is the Department's understanding that when HB1459 was written that prescription drug use of nursing home residents was one of the concerns. With the implementation of Medicare Part D, review of nursing home utilization of medications can no longer occur through Medicaid payment information.

Medicaid continues to have a very active physician education process through Retrospective Drug Use Review and Comprehensive NeuroScience letters that are sent to physicians that are prescribing mental health medications outside of current practice guidelines.

The Medical Services Division works closely with the Mental Health and Substance Abuse Division on various projects and issues. If the committee wishes to have additional information from the Mental Health and Substance Abuse Division, the Director of the Division would be willing to provide that information at an upcoming meeting of this committee.

Post Office Addresses or Street Addresses – See Attachment B

Risk Sharing Agreements

PACE (Program for All-Inclusive Care for the Elderly)

A full-risk, dual capitation (Medicaid/Medicare) program for those 55 and above. Provides a comprehensive package of acute and long-term care services through an interdisciplinary team of professionals (social and health services). The State has contracted with an Actuarial vendor to develop PACE rates by mid-March.

Potential PACE agencies will use the rates to complete "feasibility" studies. One potential PACE agency is planning for submission of a PACE application to CMS within the next several months. Medicaid will be the "State Administering Agency (SAA)" for PACE and is working with each potential PACE agency through the planning, policy and PACE application processes.

Other Efforts

Karin Mongeon and I have continued our discussions with Chip Thomas, Executive Director, North Dakota Healthcare Association (NDHA), to gauge interest from healthcare networks in partial- and full-risk Medicaid managed care arrangements. NDHA is coordinating the effort to form a committee to guide this issue.

We have also been approached by a healthcare network interested in developing a risk-based Medicaid Managed Care program and will work with this network to develop a program that meets mutual needs.

House Bill 1460

Medical Services has contracted with an actuarial vendor to complete the analysis of the Medicaid fee for service payment schedule. Fee schedule analysis will include comparison to other payors (Medicare, Workforce Safety and Insurance, and North Dakota Blue Cross Blue Shield) and surrounding states.

Some of the information requested in HB1460, is available within the Department. We are assembling this information and we continue to expect the final report to be available in mid-Summer.

Prescription Drug Monitoring Program (PDMP)

The Prescription Drug Monitoring Working Group submitted an application for an implementation grant in December. The Department of Justice reviews the grant applications. In the past, awards have been announced in July.

The working group is drafting rules and legislation for next session. The draft rules will allow for the operation of the PDMP under current legislation. The draft legislation will be for three primary purposes (1) Allow the PDMP to require medications other than controlled substances to be submitted, (2) Address North Dakota Medical Association concerns with liability issues, and (3) Ensure Health Insurance Portability and Accountability Act (HIPAA) compliance.

The working group agrees that a PDMP will be beneficial and address substance abuse problems in ND. Physicians in the working group have often stated that North Dakota has a serious prescription drug abuse problem that exceeds their experience from past places of employment (Ohio, California).

Brendan Joyce, Howard Anderson, and Harvey Hanel are here and available for questions.

Medicare Part D Implementation

On January 1, 2006 Medicare Part D went into affect. Local pharmacies and nursing home staff were faced with significant problems resulting from data integrity issues in the CMS files, and the lack of preparedness by the Prescription Drug Plans (PDPs).

Recognizing that it was not acceptable to allow dual eligibles to go without needed medications, Governor John Hoeven directed the Department to open up the Medicaid payment system. By the middle of January, most states had stepped in to assist the dual eligibles. By the end of January, the Centers for Medicare and Medicaid Services (CMS) notified states of the availability of a demonstration project to cover the cost of any prescription paid for on behalf of a dual eligible.

The Department submitted the demonstration project application and it has been approved. The demonstration authority ended yesterday. The Department has authorized 31 prescriptions since February 1, 2006, and none with a date of service after March 1, 2006. Through Monday's checkwrite, the Department paid $303,110 in Part D claims for 1,916 recipients.

CMS and the PDPs have made significant improvements to the enrollment data and technical assistance provided. The Department will continue to work with pharmacists and CMS to address issues, related to the dual eligibles, as they arise.

The clawback process has also experienced changes and implementation challenges. To date, the Department has not received an invoice to make payment. We expect the first billing to arrive some time in March; however, it is still unclear whether it will be for one, two, or three months.

In addition, in February, CMS reissued the clawback calculations for all states. This change was based on the actual inflation rate being lower than first anticipated. This change results in an estimated $1.7 million savings for the biennium.

2005 - 2007 Appropriation		**$ 15,851,709**
Initial Estimate	**$ 15,648,435**	
Current Estimate		**$ 14,135,727**
Difference between Appropriation and Current		**$ 1,715,982**

Medicaid Prescription Drug Expenditures – see Attachment C

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