

**TESTIMONY BEFORE THE BUDGET COMMITTEE ON HUMAN SERVICES**  
**MEDICAL SERVICES UPDATE**  
**JULY 11, 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 the development of management initiatives as provided in 2005 House Bill 1459, the development of the biennial medical assistance report as required by 2005 House Bill 1460, the status of activities of the Prescription Drug Monitoring program, the status of the MMIS project, the percentage of Medicaid payments to billed charges by provider type for fiscal year 2005, and a review of the information collected as a result of Section 11 of 2005 House Bill 1012.

**2005 House Bill 1459**

**Targeted Case Management / Disease Management Efforts**

On March 13, 2006, the Medical Services Division released a Request for Proposal (RFP) to identify a vendor to deliver health management services to Medicaid Recipients with select chronic conditions. Proposals were due May 3, 2006 and a team of Department staff evaluated the proposals and selected Specialty Disease Management Services, Inc. (SDM) from Jacksonville, Florida.

SDM was selected above other vendors because they were able to offer the most local staff to provide direct services to Medicaid Recipients and they proposed to establish significant partnerships with North Dakota entities to conduct the program. For example, SDM will subcontract with the University of North Dakota's (UND) Office of Continuing Medical Education and Outreach and the Library of Health Sciences for provider and recipient education. They also

**propose to partner with UND's College of Nursing to use graduate and student nurses for recipient assessment and program outreach. SDM will also have a North Dakota physician on staff to work part-time as a physician advisor to the program and to garner support for the program from local physicians.**

**The Department has announced its intent to contract with SDM and is now in the process of completing a State Plan Amendment (SPA) and a 1915(b) waiver application to obtain the appropriate authority from the Centers for Medicare and Medicaid (CMS) to operate the health management program. It is anticipated that the SPA and waiver will receive CMS approval some time this year. Once the State Plan Amendment and waiver are approved, the Department will enter into a contract with SDM and prepare for program roll-out.**

**SDM will be responsible for marketing the program to recipients and providers, enrolling and dis-enrolling recipients, training program staff, training local physicians on the use of clinical practice guidelines, developing and distributing recipient education materials, and providing evaluation data to meet State-defined criteria.**

**Program services will place significant emphasis on recipient education to improve recipient's self-management of their specific condition. All services will be based on clinically sound practice guidelines and overseen by the local physician on staff with SDM.**

**Having this health management program in place should avert more costly health care services like emergency room visits or unnecessary physician visits or hospitalizations.**

## **Risk Sharing Agreements / Managed Care**

### **Program for All-Inclusive Care of the Elderly (PACE)**

**As described in previous testimony, PACE is a full-risk, dual capitation (Medicaid/Medicare) program for those ages 55 and above that provides a comprehensive package of acute and long-term care services through an interdisciplinary team of professionals (social and health services). The intent of PACE is to provide necessary services to members in the PACE community to prevent them from moving to a more costly level of care such as a skilled nursing facility. However, if a PACE enrollee requires care in a skilled nursing facility, the PACE agency is responsible for those costs, within their capitated payment.**

**Medicaid will be the “State Administering Agency” for PACE and is working with each potential PACE agency through the planning and PACE application processes.**

**There are two potential PACE agencies. One agency is in the process of completing their PACE application and plans to submit the application sometime in August. This agency hopes to have a PACE program in place by the first quarter of 2007 and is writing a grant in response to CMS’s Rural PACE Provider Grant Program to obtain funds available through the grant program to support new, rural PACE programs.**

**The second potential PACE agency is still looking into the feasibility of PACE or PACE-like managed long-term care programs.**

### **Other Managed Care Efforts**

**The Medical Services Division continues discussions with Chip Thomas,**

**Executive Director, North Dakota Healthcare Association (NDHA), to gauge interest from health care networks in Medicaid managed care arrangements. There are several entities that are interested in further discussions about managed care arrangements and these opportunities will continue to be pursued.**

**There are other efforts underway within the Division that may ultimately expand Medicaid managed care for the purpose of improving the quality and cost of care received by Medicaid recipients.**

**1) The Division plans to develop a strategic plan for managed care expansion. The strategic plan will include analysis and recommendations related to the following questions:**

- a) Should the aged and disabled population be included in managed care? (Currently, only low-income families and pregnant women are required to participate.) If so, how should this be implemented?**
- b) Does the existing primary care case management (PCCM) program contribute to improved care management and cost savings?**
- c) Is pay-for-performance (P4P) a valid consideration? If so, how should P4P be incorporated into existing managed care programs?**
- d) Which managed care arrangements would be most beneficial to North Dakota Medicaid: full-risk, partial-risk, long-term care?**

**2) The Division will be placing greater emphasis on evaluation of delivery systems by establishing and tracking specified quality indicators for all programs. These include both clinical and non-clinical indicators (non-clinical would be specific to access and utilization). This will allow Medicaid to continually track and compare the quality of delivery systems to assure services are being provided to recipients through the best quality systems.**

## **2005 House Bill 1217 – Long Term Care Insurance/Partnership Program**

The Department of Human Services is working in conjunction with the Insurance Department to create and implement a long term care insurance partnership program. The partnership program will allow someone who purchases long term care insurance to protect assets equal to the amount the insurance has paid if they need to apply for Medicaid. The Insurance Department's role is to insure that partnership insurance policies meet the criteria required by the Deficit Reduction Act.

Basic policy principles and procedures have been identified, however, there are issues without answers relating to both the process and acceptable insurance policies. The Centers for Medicare and Medicaid Services (CMS) is working to resolve these issues and hopes to have a state plan template distributed within the next few weeks. CMS is also preparing a State Medicaid Director letter, which will provide guidance and have the force of regulations. We expect this letter in August or September.

A partnership program cannot begin until acceptable insurance policies are available in North Dakota, and a state plan amendment is approved. The Department is closely monitoring information from CMS in order to begin a partnership program in North Dakota at its earliest opportunity.

## **House Bill 1460**

Medical Services contracted with an actuarial vendor to complete an analysis of the Medicaid fee for service payment schedule. We expect to receive the analysis from the vendor this week. The analysis will include a comparison to other payers (Medicare, North Dakota Workforce Safety and Insurance and North Dakota Blue

Cross Blue Shield) and surrounding states (Montana, South Dakota and Minnesota).

We are in the process of preparing a report to meet the expectations of HB 1460 using the information from the actuarial analysis and other information available within the Department. We will have a final report for the September meeting of this Committee.

### **Prescription Drug Monitoring Program (PDMP)**

The 2005 legislature assigned a number of tasks to the Prescription Drug Monitoring Program (PDMP) Working Group. Following is a task-by-task summary of their progress.

- 1) **Identify problems relating to the abuse and diversion of controlled substances and how a prescription drug monitoring program may address these problems.** The diversity of the working group has allowed input from a variety of areas, and all are in agreement that North Dakota is not immune to abuse and diversion of controlled substances. The working group believes that the PDMP will allow timelier access to vital information to prevent and control these issues.
- 2) **Determine types of drugs to be monitored by the program.** The working group is recommending the Board of Pharmacy bring forth draft legislation clarifying program expansion to other drugs that are abused yet or are not controlled substances.
- 3) **Determine types of drug dispensers that will be required to participate in the program.** The working group has agreed that the vast majority of prescriptions dispensed are through outpatient pharmacies with a smaller amount coming from physicians, dentists, and other providers. Given this as well as the standardized billing systems used by outpatient pharmacies,

the working group recommends that outpatient pharmacies be required to submit information at the launch of the program, and other dispensers would be brought in gradually.

- 4) **Determination of data required to be reported.** The working group learned that the granting agency (Department of Justice) has standard data fields that must be followed. These standards contain all necessary information to identify patients, physicians, pharmacies, medications, and quantities as well as a number of other fields.
- 5) **Determination of what persons will be allowed to access data, what types of data will be accessible, and how to ensure appropriate protection of data.** The working group decided to follow the grant for these areas. Prescribers and dispensers, individuals requesting their own or their own minor child's profile, state boards and regulatory agencies, local, state, and federal law enforcement, the Department of Human Services, North Dakota Workforce Safety & Insurance, judicial authorities, and peer review committees will have access as outlined in the draft rules. Also, de-identified data will be available for public or private entities for statistical, research, or educational purposes.
- 6) **Determination of the entity that will implement and sustain the program.** The working group decided that the program should be housed at the Board of Pharmacy.
- 7) **Establish how the program will be implemented, the fiscal requirements for implementation, and the timelines for implementation.** The working group feels that the program would be able to be started before the end of 2006 provided the grant is awarded by the end of the summer. Continued funding options have not been agreed upon and will need further discussions.
- 8) **Consider possible performance measures the state may use to assess the impact of the program.** The working group believes that until a baseline is established, determining performance measures would be premature.

They wish to evaluate and determine performance measures after the program has started operating and data is available.

- 9) Provide the Department of Human Services a draft of proposed administrative rules to implement the proposed program. The Working Group finalized the draft at their meeting on June 29<sup>th</sup>. A copy is attached for your information. (Attachment A)

Grant announcements will be made near the end of the summer. Harvey Hanel and Howard Anderson are here and available for questions.

### Status of the MMIS project

At the March 8, 2006 meeting of the Budget Section, a motion passed that encouraged the Department of Human Services to begin preliminary work on the Medicaid Systems Project. The preliminary work was to include deliverables that would be required, regardless of the option selected during the 2007 Legislative Session.

In addition, the motion encouraged the Department to contract for an independent analysis of the following options:

- 1) Acceptance of the current ACS Bid
- 2) Re-bidding of the MMIS project
- 3) Joint development with another state
- 4) Use of a fiscal agent
- 5) Outsourcing the billing and payment components

In March, the Department submitted the proposed MMIS contract to the Centers for Medicare and Medicaid Services (CMS) for approval. CMS has approved the



contract and the contract was signed by ACS and the Department on June 23, 2006.

The Department requested competitive bids for an independent analysis and has selected a vendor to complete the independent analysis. The project team will explore joint development with nearby states, and has released a Request For Information (RFI) to solicit information regarding the outsourcing of the billing and payment components. The motion on March 8, 2006 requested the information be available to the Legislature by January 8, 2007. The Department anticipates no problems in meeting this deadline.

As we have reported previously, the state Information Technology Department (ITD) will assist with the development of the new MMIS. Based on the March 8, 2006 motion, ITD is also engaged in preliminary work to ensure the project moves forward. The Department has approved the ITD Project Plan and Schedule, which outlines all the major work components to be completed as part of the Phase I efforts.

Finally, the Department is developing the budget request for the 07-09 Biennium and once the budget is submitted to OMB, the expected MMIS project budget information would be available.

**Percentage of Medicaid payments to Billed Charges – See Attachment B**

#### **Section 11, 2005 House Bill 1012**

The Department is currently developing its 2007 – 2009 Budget Request. When considering the Federal Medical Assistance Percentage (FMAP) for the grant years during the next biennium, the additional general fund need is projected to

be \$21.7 million in order to maintain services at the current level (2005-2007 biennium). This estimate is based on the following FMAP amounts.

<b>Federal Fiscal Year 2007 64.72%</b>	<b>Actual</b>
<b>Federal Fiscal Year 2008 63.13%</b>	<b>Estimate released in March 2006 (Final to be released in the Fall 2006)</b>
<b>Federal Fiscal Year 2009 63.72%</b>	<b>Estimate based on Economy.com (Estimate to be released in Spring 2007)</b>

This increased general fund is the same amount of general fund needed to currently operate Northwest, North Central and Southeast Human Service Centers.

In addition to the FMAP, the Medicare Part D Clawback payment to the federal government next biennium is estimated to cost North Dakota an additional \$3.8 million beyond the current budget. This payment is 100% general funds. The primary reason for the increase is a change in the number of payments. During the current biennium North Dakota is making the Clawback payment for 18 months since January 2006 was the implementation date. Next biennium, the Clawback payment will be for the entire biennium or 24 months. In addition, the inflation factor used by the federal government in the calculation will continue to impact the growth of the payment. Even though, the payment is a “phased-down” contribution, the phase-down is one and two-thirds percent each year, while the inflation is estimated to be 8-9%.

Another area of significant increase is the estimated premium for the SCHIP program. Blue Cross Blue Shield has informed the Department that they estimate the monthly payment for the SCHIP premium to increase by as much as 20.33%. The current monthly payment is \$181.71. Based on the preliminary information from Blue Cross Blue Shield, this payment is estimated to increase to \$218.65.

**Considering these needs for additional general funds, and in an effort to work with the Legislature to address the long-term sustainability of the Medicaid program, we have prepared information on eligibility groups and services. This information, along with the input the Department has received from providers, can be the framework for the next steps:**

- **Eligibility Categories and Expenditures – Attachment C & D**
- **Mandatory and Optional Services – Attachment E**
- **Current Service Limits and Co-pays – Attachment F**
- **Input Received from Providers**

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