Testimony
Reengrossed House Bill 1194 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
March 6, 2019

Chairman Lee, members of the Senate Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here today in support of section 2 of Reengrossed House Bill 1194.

In February 2016, the Centers for Medicare and Medicaid Services (CMS) announced a re-interpretation of statute related to federal match available for services provided to Medicaid-eligible individuals receiving services "through" Indian Health Services (IHS)/Tribal 638. The re-interpretation was intended to help states increase access to care, strengthen continuity of care and improve population health, and made 100% federal financing available for services "received through" IHS/Tribal 638 facilities. Previous federal interpretation did not generally extend to services provided outside of IHS/Tribal 638 facilities.

In order to qualify for 100% federal financing, a request for services must be in accordance with a written care coordination agreement and there must be an established relationship between the American Indian Medicaid beneficiary and the IHS/Tribal 638 facility practitioner. There must be a written care coordination agreement between the IHS/Tribal 638 facility and the non-IHS/Tribal 638 provider. The IHS/Tribal 638 facility practitioner provides a request for specific services and provides relevant information about the beneficiary to the non-IHS/Tribal 638 provider. The non-IHS/Tribal provider sends information about the care provided back to the IHS/Tribal 638 facility practitioner. The IHS/Tribal 638 facility practitioner continues to assume responsibility for the beneficiary's care by assessing the information received from the non-IHS/Tribal 638 provider and taking appropriate action.

During the current biennium, the Medical Services Division has convened a work group to implement the care coordination agreements with Standing Rock Indian Health Services and the Bismarck Health Systems. The work group has identified many important pieces for care coordination and better patient outcomes and has continued to work on the electronic exchange of information rather than the historical, paper processes. The agreements have been signed and eligible services are being rendered.

Additional discussion regarding care coordination have occurred with the other North Dakota Tribal Nations and at the quarterly Tribal Consultation meetings hosted by Medical Services. It is clear the Tribal Nations are committed to the process; however, full implementation of care coordination is tied to assurance of "shared savings" with the Tribes.

The Department recognizes the extra effort that must be invested by Tribal Nations and cognizant of the health care disparities that Tribes could target, and we support the idea of shared savings. The percentage of savings will need to be negotiated between the Legislature and the Tribal Nations.

Section 3 of the original bill was removed by the House. The Department supports the Reengrossed version of the bill as the Department does not believe the care coordination efforts should be contingent upon the existence of Medicaid Expansion and payment of providers at commercial rates. The ultimate goal of the care coordination agreements is to improve health outcomes for Native Americans and the work on this effort should continue even if Medicaid Expansion ended or if the rates are not equal to commercial rates.

This concludes my testimony. I would be happy to address any questions that you may have.