TESTIMONY BEFORE THE BUDGET COMMITTEE ON HUMAN SERVICES

REGARDING THE MEDICAID REIMBURSEMENT SYSTEM

JULY 28, 2005

Chairman Dever, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding your study of the Medicaid reimbursement system, and to update you regarding several issues your committee will be monitoring during this interim.

As you are aware there has been much discussion regarding the payment rates paid by the Medicaid program. In general, these rates are much lower than both the insurance industry and the Medicare program. First I will provide you with some background regarding our payment policies.

Except for the managed care product available in three northeastern counties, Medicaid pays based on a fee for service concept. Payment is made based on the individual services provided by practitioners such as physicians, dentists, optometrists, nurse practitioners, and other similar providers. Payment for physicians and their allied providers are based on a relative value process. Each procedure is assigned a value based on the type of procedure being performed. For example, an office visit will have a much lower relative value than an open-heart surgery procedure. The relative value for each procedure is then multiplied by the conversion factor to arrive at the payment amount. Currently this rate after the 2.65% increase is $34.02 per unit. By way of contrast, the Medicare rate is $37.8975 per unit. As an example, a routine office visit for an established patient would pay $43.89 in the Medicaid program, and $48.83 in the Medicare program.

Dentists, ambulances, and other similar providers are also paid on the basis of established procedure codes. Fees were established decades ago and generally

increase only when the Department receives specific direction regarding inflation or other increases from the Legislature.

Inpatient hospital services are paid based on a Diagnosis Related Group that classifies each hospital stay based on the diagnosis and procedures that are performed. Currently, there are about 540 different groups. Each group has a particular value based on its complexity. That value is multiplied by the established rate to arrive at the payment for each hospital stay.

Outpatient hospital services are based on the established cost-to-charge ratio for each facility with no cost settlements. Also, outpatient surgery performed in a hospital setting that can be performed in an ambulatory surgical center is paid based on the same method used to pay those centers. These rates are grouped based on the complexity of the procedure with the more extensive procedures receiving a higher payment rate.

Currently pharmacies are paid on the basis of average wholesale price minus 10%, plus a dispensing fee of $5.60 for a generic drug, and $4.60 for a brand name drug. In addition, many (about 1,228) generic drugs are paid based on the maximum allowable cost process that estimates the actual cost of the drug. This pricing process has saved the State a substantial amount of dollars since it was implemented in 2002 of about $3.8 million per year.

Nursing facilities are paid based on the allowable costs that are submitted yearly. Those facilities that have costs below established limits will receive those costs plus inflation, operating margins, and incentives. Providers over the limits have only their costs up to the limit amount recognized for rate setting purposes. The limits will be recalculated based on costs submitted by providers for the cost reporting year ending June 30, 2004, and for the rate year beginning January 1, 2006.

For the most part, the process used to pay for services parallels the payment systems used by other third party payers. The issue is the differential between the amount paid by the Medicaid program and the amount paid by other third party payers.

OTHER ISSUES

The Department is in the process of writing the Request for Proposal (RFP) for actuarial services in order that we may provide you with the biennial report on historical and projected Medicaid statistics. We have contacted several of the provider organizations to obtain their input and comments regarding the document. We anticipate releasing the RFP no later than September 1, 2005. It would be helpful for planning purposes for the Legislative Council to indicate when they expect the Department to provide the report required in HB 1460.

There is much discussion in Washington regarding Medicaid reform. Congress has not yet taken any action to make any changes. The report from the newly formed Medicaid Commission is due to be completed by September 1, 2005. It is anticipated that Congress will then make several changes to the Medicaid program in anticipation of saving $10 billion in federal funds over a five-year period. We believe one of the actions they may take would be to allow additional states to disregard assets for persons who purchase long term care insurance. However, until Congress acts, we are unable to implement the process in North Dakota.

We are in the process of developing the proposal to obtain federal grant funding to implement the drug monitoring program. The first formal meeting of the planning group established in Legislation will be held on August 24, 2005, to assist the Department in the implementation of this new and important program. A request of information (RFI) will be released to determine what process has worked the best in other states that have implemented the drug monitoring

process. The grant application deadline is January 15, 2006. Implementation is contingent on federal approval of the program.

We have begun our review of the provisions contained in HB 1459 regarding suggested changes in the Medicaid program. We will have more specific information available at your next meeting.

The Department did contract with Muse and Associates to prepare an action plan for the implementation of the Medicare prescription drug program. Mr. Muse has been to North Dakota twice to meet with our staff, and has also spoken with members of the coalition working on the implementation in North Dakota. On July 25, 2005 we received the draft implementation plan from the contractor. We have scheduled training for county office staff so they will be prepared to respond to questions about the program, and will be able to provide assistance to those individuals who are interested in applying for the subsidy program, but are currently not on the Medicaid program.

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