Testimony
Senate Bill 2012 – Department of Human Services
House Appropriations – Human Resources Division
Representative Pollert, Chairman
February 21, 2007

Chairman Pollert, members of the House Appropriations - Human Resources Division, I am Maggie Anderson, Director of Medical Services, for the Department of Human Services. I am here today to provide you with an overview of the Traditional Medicaid and the State Children's Health Insurance Programs, as well as the administrative costs of the Medical Services Division. The Long-Term Care Continuum overview will be provided separately.

Programs

The Medical Services Division currently administers three programs, they are Medicaid, the State Children's Health Insurance Program (Healthy Steps), and Children's Special Health Services (CSHS). The 2007-2009 Budget proposes to fund the CSHS unit as part of the Department of Health. This area of the budget for Medicaid and Healthy Steps provides health care coverage for families and children, pregnant women, the elderly, and the disabled citizens of North Dakota. Attachment A shows the Medicaid Mandatory and Optional Services, and Attachment B shows the current services that have a co-payment.

Caseload

The Executive Budget for Traditional Medicaid was built on the April 2006 enrollment, which was 52,308. Attachment C shows the Medicaid

Enrollment (eligibles) and the unduplicated count of recipients for each month of the current biennium.

Healthy Steps was built on an average caseload of 3,958 children. Attachment D shows the number of children enrolled each month in Healthy Steps since the beginning of the current biennium. As of January 2007, Healthy Steps enrollment has increased by 1,135 children since the beginning of the biennium. This increase, which is greater than the current budget estimate, is attributable to several factors, including simplification and alignment of eligibility requirements, very effective outreach efforts through Dakota Medical Foundation (Covering Kids and Families Grant), and a streamlined application process.

Program Trends / Major Program Changes

The Federal Medical Assistance Percentage (FMAP) is calculated based on per capita income over a three-year period. The overall economy in North Dakota continues to see improvement a bit faster than other states; therefore, the FMAP for North Dakota has dropped over the past two years and will continue to fall through Federal Fiscal Year 2008. The current FMAP (through September 2007) is 64.72 percent. The percentage will drop to 63.75 percent for Federal Fiscal Year 2008 (October 1, 2007 - September 30, 2008) and is expected to be 64.08 percent for Federal Fiscal Year 2009 (October 1, 2008 – September 30, 2009). The impact to the Department's budget as a result of the FMAP reductions totals $9.1 million, of which $2.9 million is directly related to the services covered in this portion of my testimony.

Medicaid Payments	$2,694,040
Healthy Steps	$210,652
Total Impact	$2,904,692

As noted in my earlier comments, the 2007-2009 Budget proposes to fund Children's Special Health Services (CSHS) in the Department of Health. The question regarding the placement of CSHS has been raised in past Legislative Sessions; therefore, over the interim the Department held conversations with the Office of Management and Budget and with the Department of Health. It was determined, based on types of programs and the philosophical approach to those programs, that CSHS placement would be most appropriate in the Department of Health. Sections eleven through fourteen and Sections sixteen and seventeen of Senate Bill 2012 outline the changes necessary to facilitate this move. Both the Department of Human Services and Department of Health have and will continue to meet on "transition" issues that need to be considered as part of the move. This change would be effective July 1, 2007.

In January, Medicare Part D was implemented and the Medical Services Division assisted the nearly 10,000 dual-eligible individuals (those who qualify for both Medicare and Medicaid) manage issues that arose with the Medicare systems. Early on, Governor Hoeven directed the Department to ensure that no dual-eligible individual went without their needed medication. Medical Services processed 4,794 prescriptions for 1,724 dual-eligible individuals for a total of $292,412. To date, $266,498 has been reimbursed by the Centers for Medicare and Medicaid Services (CMS), and we await the final payment.

As of July 2006, individuals applying or recertifying for Medicaid enrollment are required to provide documentation of citizenship and identity. This is mandated by the Deficit Reduction Act, which passed in Congress in 2006. This new requirement and an improved economy has resulted in a decrease in enrollment over the past six months. The Department has implemented an interface with the Division of Vital Records of the North Dakota Department of Health, which should help ensure eligible individuals are not denied coverage, solely because of lack of citizenship documentation. It is too early to estimate the impact of this electronic match; however, the feedback from eligibility workers indicates this is a significant improvement.

In October, Altru Health Care Systems determined they were unable to accept the capitated payment rates, developed and certified by an actuary vendor that was under contract with the Department. Therefore, the managed care contract expired October 31, 2006 and the 750+ individuals enrolled in the managed care program were transitioned to the Medicaid fee-for-service program.

Medicaid is 42-years old and has become one of the fastest-growing state expenditures, nationwide. There are many ideas about how the program should be reformed and sustained. The Medical Services Division continues to review and analyze the provisions of the Deficit Reduction Act and has expanded the Medicaid Medical Advisory Committee to establish a long-term plan for Medicaid program operations.

Overview of Budget Changes

Description	2005 - 2007 Budget	Increase / Decrease	2007 - 2009 Budget	Senate Changes	To House
Salaries	5,686,710	1,238,284	6,924,994	75,046	7,000,040
Operating	20,787,543	2,188,334	22,975,877	453,000	23,428,877
Grants	383,542,215	21,072,698	404,614,913	20,822,037	425,436,950
Total	410,016,468	24,499,316	434,515,784	21,350,083	455,865,867
General	110,092,728	18,055,111	128,147,839	7,640,395	135,788,234
Federal	273,154,025	1,665,678	274,819,703	13,709,688	288,529,391
Other	26,769,715	4,778,527	31,548,242	-	31,548,242
FTEs	64.00	-	64.00	1.00	65.00

Budget Changes from Current Budget to Executive Budget

The Salaries line item increased by $1,238,284 and can be attributed to the following changes:

- $500,182 in total funds, of which $260,127 is general funds, is due to the Governor's salary package for state employees.
- $335,444 in total funds, of which $167,823 is general funds, is related to organizational changes within the Medical Services Division. Over the interim, responsibilities for the Medicaid Waivers and Home and Community-Based Services were moved into the Medical Services Division. With these increased budget and program-related responsibilities, the Assistant Director position has been split into three areas: The Division now has an Assistant Director for the Long Term Care Continuum, an Assistant Director for Budget and Operations, and an Assistant Director of Program

and Policy. The Assistant Director changes resulted in the increase of one Full-Time Equivalent and the reclassification of another position. A position has also been added in the Home and Community-Based Service staff to assist with program policy and provider review responsibilities and a Certified Coder position has also been added to assist with claims review and audits. Since the reorganization of FTE occurred during the current biennium, the actual increase is not reflected in the FTE numbers; however, the salary authority needs to be increased to fund the changes.

- $59,141 in total funds, of which $29,588 is general funds, is for an increase in temporary salaries. This increase is related to the need for additional claims processing staff to ensure continued timely payments to providers, and for periodic assistance on special projects such as waiver applications and renewals.
- $36,721 in total funds is to provide for the annual and sick leave lump-sum payouts for three FTE expected to retire.
- The remaining $306,796 is a combination of increases and decreases needed to sustain the salary of the 64 FTE in this area of the budget.

The Operating Expenses had a net increase of $2.2 million. The combination of increases and decreases are as follows:

- The Medicare Part D Clawback payment is the most significant portion of this budget area. The Clawback is estimated at $19.15 million for 2007-2009. This is an increase of $3.3 million over the current budget of $15.85 million. The increase is almost exclusively the result of having 24 months of payments in 2007-2009 vs. 18 months in 2005-2007. The Clawback payment is 100 percent general funds.

- Operating expenses also include contracts for services, such as: medical consultants; utilization review and prior authorization; drug pricing; Medicaid Identification cards; nursing facility screenings; actuary services; and third party liability identification. In reviewing contracts, it was determined that the overall need in this area was less than the current biennium. In addition, Disease Management was funded as an Operating Expense in 2005-2007; however, based on CMS requirements, it will be implemented as health care program. Therefore, it is now funded in the Medicaid Grants. These changes resulted in a decrease of $1.1 million in this area, of which $.7 million is general funds.

The Executive Budget for the Grants in this area reflects an increase of $21.1 million in total funds, of which $14.3 are general funds, and $4.8 are other funds. The federal increase is only $2 million, because of the Excess Authority from the 2005-2007 Budget, which Brenda Weisz mentioned in her overview testimony. Overall, this $21.1 million increase is the net result of utilization changes ($-64.4 million), cost changes ($72.5 million), the 3 percent/3 percent inflationary increase ($12.1 million), addition of Nurse Aide Registry ($.3 million), and an increase in the Nursing Facility Survey costs ($.6 million).

- Utilization of Inpatient Hospital Services has continued to trend up. The Executive Budget requests $97.5 million, of which $35.1 million are general funds. This is an increase over the current biennium budget of $16.5 million, of which $7.4 million are general funds.
- Outpatient Hospital Services has trended up for both cost and utilization. This area of the Executive Budget request is $6.1 million higher than the 2005-2007 Budget request, of which $2.5 million are general funds.

- Physician Services utilization has also trended up. The Executive Budget requests $56.4 million, of which $20.3 million are general funds. This represents an increase of only $.5 million, as the average cost per Physician service has trended down over the current Biennium.
- For Prescription Drugs, the Executive Budget requests $60.8 million, of which $2.3 million are general funds, and $19.6 million are retained funds. This is a $27.8 million decrease over the budget for last biennium. Once the Excess Authority (-$26.7 million) is removed, this is a decrease of $1.1 million, which is the net result of cost changes ($72.3 million) and utilization changes (-$73.4 million) (See Attachment E and Attachment E1). North Dakota Medicaid has seen tremendous growth in the average cost of brand name medications the last two years (11.6 percent and 13.6 percent - going from a low of $103.64 for a brand script in January 2005 to a high of $130.39 in August 2006). During this same time, we have experienced a tremendous shift in the brand/generic mix of drugs (54.3 percent generic in January 2005 to 68.4 percent generic in October 2006). The average cost of a generic is only $22. With the significant shifts resulting from Medicare Part D, it is very difficult to compare past growth rates with current growth since we are in a new era post Part D. The patient mix and medication mix is completely different since January 1, 2006. It will take a few years before any true trending can be based on actual post Part D populations. National estimates from a variety of sources allowed us to generate our expected growth of drug costs of 6.5 percent per year for each year of the 2007-2009 Biennium. This is also consistent with National Health Expenditure estimates.

- The Healthy Steps request is based on an average 3,958 premiums per month, at an average premium of $207.31 per child. This premium reflects an increase of 13.99 percent over the average premium paid for the current biennium. The total Healthy Steps request is $19.7 million of which $5 million are general funds. This represents an increase over the current budget of $7.6 million, of which $2 million are general funds.
- The Executive Budget requests $19.9 million for Psychiatric Residential Treatment Facilities (PRTF). This is an increase of $9.2 million over the budget for the current biennium. During the interim, the Centers for Medicare and Medicaid Services indicated that Medicaid payments could no longer be made for Residential Treatment Facilities, but rather, the facilities had to operate as PRTFs. This required significant work for the six facilities involved; however, all have successfully completed the steps necessary to operate as PRTFs. Therefore, this increase is primarily the result of shifting the room and board expenditure from Children and Family Services to Medicaid. This allows us to capture FMAP for the entire rate (room, board, and therapy services).
- The budget request for premium payments has increased significantly over the 2005-2007 Budget. We are requesting $23.7 million. This represents an increase of $8.1 million. The majority of the increase is due to both the number of individuals requesting assistance with premiums such as Qualified Medicare Beneficiary (QMB), Special Low Income Medicare Beneficiary (SLMB), and Qualified Individuals (QI-1) and to the federally established increase in the amount of the premiums. The "woodwork effect" of Medicare Part D implementation is at least partially responsible for

the increase in the number of individuals seeking premium assistance.

- The remaining $7 million change is the result of changes in the other services such as Durable Medical Equipment ($1.1 million increase), Dental ($1.3 million decrease), Workers with Disabilities ($2.9 million increase), Disease Management ($1.8 million increase), and Indian Health Services ($2.1 million decrease). Attachment F shows each Traditional Medicaid Service comparing the 2005-2007 Budget, 2005-2007 Projected Need, and the 2007-2009 Executive Budget request.

Senate Changes

Provider Inflation - $4.6 million in total funds, of which $1.5 are general funds were added to provide a 4% annual inflation increase.

Medically Needy Income Levels - $7.0 million in total funds, of which $2.5 million are general funds were added to increase the Medically Needy Income Levels from 61% of the federal poverty level to 83% of the federal poverty level.

Continuous Eligibility - $6.3 million in total funds, of which $2.3 million are general funds were added to implement 12-month continuous Medicaid eligibility for children under 19 years of age in the Categorically Needy and Optional Categorically Needy groups. The Senate amendments also added Section 5, which provides legislative intent surrounding the monitoring and reporting of expenditures and using these funds only if the change in policy warrants the expenditure.

House Bill 1463 - $1.5 million in total funds, of which $.8 million are general funds were added to fund the Medicaid and SCHIP changes proposed in House Bill 1463. House Bill 1463 would increase the Medicaid eligibility level to 133% of poverty for 6 to 19 year olds and would increase the SCHIP eligibility level to 150% of poverty.

SCHIP Policy Changes - $1.6 million in total funds, of which $.4 million are general funds were added to allow for certain income disregards for SCHIP applicants.

SCHIP Outreach - $.5 million in total funds, of which $.1 million are general funds was added for providing outreach services for SCHIP. The Senate amendments also added Section 9, which indicates legislative intent would be for the Department to contract with entity that focuses on statewide community health care initiatives and issues.

SCHIP Full-Time Equivalent - $75,046 in total funds, of which $18,919 are general funds, as well as authorization for the addition of an FTE was added.

Certified Nurse Registry - $300,257 in total funds, of which $75,081 in general funds was removed.

Rebasing Medicaid Inpatient Hospital Payment Rates – The Senate Amendments also added Section 6, which requires the Department to determine, during the 2007-08 Interim, the estimated cost of rebasing Medicaid inpatient hospital payment rates.

This concludes my testimony on the 2007-2009 budget request for Traditional Medicaid, the State's Children Health Insurance Program and the Administrative Expenses of Medical Services Division. I would be happy to address any questions that you may have.