**North Dakota Department of Human Services**
**Interim Health Care Reform Review Committee**
**Representative George Keiser, Chairman**
**September 7, 2016**

Chairman Keiser and members of the Health Care Reform Review Committee, I am Erik Elkins, Assistant Director, Medical Services Division for the Department of Human Services (DHS/Department). I appear before you to provide information on Medicaid Expansion cost sharing.

The information in my testimony is compiled from materials prepared by the Medicaid and Children's Health Insurance Program (CHIP) Learning Collaborative, the Centers for Medicare and Medicaid Services (CMS), from various reports and studies regarding Medicaid cost sharing, and from current North Dakota Medicaid cost-sharing policies.

## Current Medicaid Copayments *(For Both Traditional and Medicaid Expansion)*

| Service | Copayment |
|---|---|
| For office visit/consultation codes 99201-99215 and 99381-99429 that are performed by providers authorized within their scope of practice to perform these services | $2 for each office visit |
| Brand name prescription drugs | $3 for each prescription |
| Dental clinic appointment – oral examination | $2 for each appointment |
| Optometry appointment – visual examination | $2 for each appointment |
| Spinal manipulation received during a chiropractic appointment | $1 for each appointment |
| Outpatient speech therapy | $1 for each visit |
| Outpatient physical therapy | $2 for each visit |
| Outpatient occupational therapy | $2 for each visit |
| Outpatient psychological appointment | $2 for each appointment |
| Outpatient hearing test | $2 for each visit |
| Hearing aid dispensing service | $3 for each |
| Rural Health Clinic or Federally Qualified Health Center | $3 for each appointment |
| Podiatry office appointment | $3 for each appointment |
| Emergency room visit that is not an emergency | $3 for each visit |
| Inpatient hospital stay | $75 for each stay |

## Background and Requirements

- Cost sharing may include copayments and premiums.
- Cost sharing may be imposed on individuals in the following eligibility groups: single adults, parents, and aged, blind and disabled (some exceptions).
- Copayments can assist health care payers (such as Medicaid) in controlling utilization of services, thus hoping to control (reduce) overall costs. Premiums are assessed before someone is enrolled in coverage; therefore, they do not generally control utilization of services.

## Services Exempt from Cost Sharing

- Emergency Services
- Family Planning Services
- Preventative Services provided to children
- Pregnancy-related services
- Services resulting from provider preventable services

## Mandatory Exempt Populations

- Children under 18 (limited exceptions – premiums for the Medicaid Buy-in for Children) (***Optional*** *exemption for individuals 19 and 20*)
- Pregnant Women
- Individuals living in an institution who are required to contribute nearly all of their income toward the costs of their care
- Individuals receiving hospice
- American Indians/Alaskan Natives who are eligible to receive or have ever received a service from an Indian health care provider
- Women enrolled under the Breast and Cervical Cancer Treatment Program (Women's Way)

## What if beneficiaries do not pay cost sharing?

If the beneficiary is in a household whose income is at 100 percent of the Federal Poverty Level (FPL) or less, a provider may not refuse to provide a service if the beneficiary cannot pay their cost sharing.

If the beneficiary is in a household whose income is above 100 percent FPL, the provider may refuse to provide a service if the beneficiary cannot pay their cost sharing.

## Medicaid Cost Sharing Limits

Cost sharing for most services is limited to nominal or minimal amounts. Federal law limits the amounts states can charge Medicaid beneficiaries for premiums and cost sharing.

### Maximum Medicaid cost sharing by Federal Poverty Level (FPL)

| | < 100% FPL | 100% to 150% FPL | >150% FPL |
|---|---|---|---|
| Outpatient Services | $4 | 10% of the fee paid by the state | 20% of the fee paid by the state |
| Inpatient Services | $75 per stay | 10% of the amount paid by the state per stay | 20% of the amount paid by the state per stay |
| Prescription Drugs | Preferred: $4<br>Non-Preferred: $8 | Preferred: $4<br>Non-Preferred: $8 | Preferred: $4<br>Non-Preferred: 20% of the amount paid by the state |
| Non-Emergent ER | $8 | $8 | No limit (but subject to 5% cap) |
| PREMIUMS | Not Allowed* | Not Allowed* | Permitted, subject to 5% cap |
| Aggregate Cost Sharing Cap | 5% Household Income | 5% Household Income | 5% Household Income |

** May be allowed with a waiver from CMS*

## Aggregate Limits on Premiums and Cost Sharing

Medicaid premiums and copayments are limited to 5 percent of family (household) income.

States must track beneficiary premium and copayments. This system used for tracking must:

1. Be an effective mechanism that does not rely on beneficiary documentation,
2. Include a mechanism for notifying beneficiaries and providers when the aggregate limit has been reached,
3. Track the amount of cost sharing and premiums incurred, not paid, and
4. Determine whether each beneficiary's cost sharing and premiums exceed the aggregate limit on either a monthly or quarterly basis (state option).

## Tracking and Monitoring of Cost Sharing

The Medicaid agency must inform each beneficiary/household of their cumulative cost sharing maximum, and be able to track and monitor all cost sharing based on both individual and household income. This requires integration of the eligibility and claims payment systems. While both of the recently-implemented systems, the Medicaid Management Information System (MMIS) and of Phase I of the Eligibility System (SPACES), will support this integration, the current CMS requirements surrounding calculating and tracking cost sharing were not included in the original requirements for the systems. To provide a bit of perspective on the requirements, please see **Attachment A** for a subset of slides CMS prepared to provide training to State Medicaid agencies. The Department

is working with the vendors for both systems to determine a timeline for the necessary integration of the two systems.

## Waiver of Cost Sharing Limits

Cost sharing waivers may be granted under a demonstration project (1115 Waiver). A waiver under this authority is limited to a two-year period (or less) and requires that all 1115 Waiver requirements be followed. Examples of premiums waivers approved by CMS can be reviewed on **Attachment B**.

## Premiums

Without a waiver, the Medicaid agency may not impose premiums under the state plan for individuals with incomes below 150 percent FPL.

To provide perspective on premium efforts from one of our neighboring states, we spoke with staff from Montana about the premiums they have included in their recently-implemented Medicaid Expansion product. Please reference **Attachment C** for a summary of the Montana premium.

If premiums are considered for the Medicaid Expansion population, there will be impacts on existing county and state staff and information technology systems. There are also early results from Montana that premiums have resulted in the disenrollment of some individuals for failure to pay premiums.

## Reports and Studies on Medicaid Cost Sharing

Prior to providing similar information to the Interim Human Services Committee, the Department reviewed the information in this testimony with the Medicaid Medical Advisory Committee and sought their input on current copayments, the possibility of increasing copayments, and the

possibility of adding a premium for the Medicaid Expansion population. Their input is summarized in **Attachment D**.

If there would be cost sharing (premium) changes to the Medicaid Expansion product that would require additional tracking, the Department, Sanford Health Plan, and the actuaries would need to determine if there would be an impact on the per member per month payments, including the administrative component of the payment.

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