Testimony
House Bill 1041 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 12, 2015

Chairman Weisz, and members of the House Human Services Committee, I am Brendan Joyce, PharmD, Administrator of Pharmacy Services for the Medical Services Division of the Department of Human Services (Department). I am here today to provide information regarding House Bill 1041.

At the conclusion of the 2013 legislative session, the Department began work on implementation of the Medicaid Expansion. This involved significant time for Department staff and staff from the Centers for Medicare and Medicaid Services (CMS). It is important to note that CMS staff were organized into very efficient "topic specific" teams and were directed to ensure that states electing to expand would be able to successfully launch their Medicaid Expansion programs by January 1, 2014. With all of this effort on both the state and federal ends, as well as the efforts of the health plan vendor, the contract was approved by CMS and signed by the Department and the Sanford Health Plan on December 31, 2013 – one day before the launch of North Dakota Medicaid Expansion coverage.

According to procurement rules, Subsection 3 of Section 1 of HB 1041 is a significant scope change such that the Department would have to re-procure the health plan (re-bid the contract). CMS resources have returned to their pre-Medicaid Expansion work, which will impact the amount of time needed to finish a re-procurement and secure a new contract. Given this, if HB 1041 passes, the Department expects the

effective date for a new contract as a result of a re-procurement to be no sooner than January 1, 2017. The Department is requesting an effective date of January 1, 2017 be added HB 1041 to coincide with the changes proposed in this bill.

With regards to Subsection 3 of Section 1 of HB 1041, if the pharmacy benefits are provided by an entity unrelated to the entity that provides medical benefit, DHS will ensure the facilitation of data sharing in both directions to allow the vendors to have complete patient information so as to provide the best care coordination possible for their recipients. For instance, the pharmacy benefit manager needs to know a patient's diagnosis to ensure they provide coverage for the most appropriate medication for that patient, and the medical benefit provider needs to know the medication a patient is taking to ensure proper physician visits are taking place to monitor that medication.

Costs for the pharmacy portion of the managed care organization (MCO) product are blended into the overall monthly capitated (per member per month) rate; therefore, it is not possible to directly compare the fiscal effect of MCO to Traditional Medicaid Fee-for-Service (FFS). However, the MCO arrangement provides payment to the pharmacy dispensing the prescription, a payment to the Pharmacy Benefits Manager (PBM) authorizing payment to the pharmacy for the prescription, and payment to the health plan which contracted with the PBM to coordinate the pharmacy component. With a Traditional Medicaid FFS pharmacy payment approach, only one entity (the pharmacy) would be receiving a payment. Also, with Traditional ND Medicaid FFS, all prescriptions would be from manufacturers that participate in the Medicaid Drug Rebate program and the Drug Use Review Board's prior authorization program

would be followed. Therefore, it is expected that rebate collections would be greater than under the MCO model.

Subsection 3.b.4 of HB 1041 requires an annual audit of the pharmacy benefit manager if the pharmacy benefits are not managed by the Department. As reflected in the fiscal note for HB 1041, the estimated costs for that service are $100,000 per annual audit. If this section remains in the bill, the Department requests an appropriation be added to cover the expected costs of the audit.

This concludes my testimony. I would be happy to answer any questions the committee may have. Thank you.