

**Department of Human Services  
Human Services Committee  
Representative Karen Rohr, Chairman  
June 3, 2020**

Chairman Rohr, members of the Human Services Committee, I am Caprice Knapp, Director of the Medical Services Division for the Department of Human Services.

**MEDICAID EXPANSION PROVIDER REIMBURSEMENT RATES**

Senate Bill (SB) 2012 of the 66<sup>th</sup> Legislative Assembly (2019) continued the medical assistance expansion program through June 30, 2021. Sections 7 and 8 of SB 2012 indicate the contract between the Department and the insurance carrier must include a provision stipulating the Department have full access to provider reimbursement rates. The Department is also required to provide Legislative Management a report regarding provider reimbursement rates under the medical assistance expansion program. The report may include cumulative and trend data but may not disclose identifiable provider reimbursement rates.

In addition, SB 2012 Section 17 directed the Managed Care Organization (MCO) under contract with the Department to manage the medical assistance expansion program to comply with the following:

- Reimburse providers with the same provider type and specialty at consistent levels and with consistent methodology;
- Incentive, quality, or supplemental payments to providers may not be included unless part of a value-based program offered to all eligible providers and approved by the Department of Human Services;
- MCO may consider urban and rural providers as different provider type;

- Critical Access Hospitals (CAH) may not be paid less than one hundred percent of Medicare allowable costs; and
- Ensure payments to Indian or Tribal 638 health care providers, federally qualified health centers, and rural health clinics meet the federally required minimum levels of reimbursement.

Section 17 also indicates that expenditures for the medical assistance expansion program may not exceed appropriations except for increases in medical assistance expansion program caseload and for the addition of coverage consistent with traditional Medicaid 1915i state plan services. Thus, any proposed provider reimbursement methodology by the MCO must be considered budget neutral. With regard to the MCO's provider reimbursement methodology, the Department shall ensure providers within the same provider type and specialty are reimbursed at consistent levels and with consistent methodology and shall ensure the capitation rates under risk contracts are actuarially sound and are adequate to meet managed care organization contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

Furthermore, per Section 13 of Article IV of the Constitution of North Dakota and North Dakota Century Code Section 1-02-42, for an appropriation measure, unless an alternative date has been specified within a bill, the effective date is July 1 after its filing with the Secretary of State. Therefore, since no alternative effective date was indicated for Section 17 of Senate Bill 2012, July 1, 2019 was the effective date.

Since medical assistance expansion program enactment in 2014, the MCO has used its own negotiated contracts with providers to set provider payment reimbursement rates; however, SB 2012 provisions required moving away from the existing contracted rates, towards a consistent and

uniform provider reimbursement methodology. Immediately following the adjournment of 66<sup>th</sup> Legislative Assembly, the Department and the medical assistance expansion program MCO worked collaboratively and in conjunction with the Department's actuary and in consultation with the Centers for Medicare and Medicaid Services (CMS), to implement SB 2012.

Throughout the uniform provider reimbursement methodology development and implementation process, the MCO provided updated information to its providers. Following finalization of the reimbursement methodology in September 2019, the MCO sent letters to providers indicating the individual impact to each provider and explained the necessity to adjust claims to reflect the reimbursement methodology for claims that had already been processed for dates of services on July 1, 2019 or later. In addition, the MCO sent letters to members of the Legislative Assembly to provide information about the impact to providers and health care facilities that serve the medical assistance expansion program. The letters indicated that some providers and health care facilities will be paid more than they were under previously negotiated contracts and others will be paid less for services provided as a result of the provisions within SB 2012.

## **Report**

The following table details the actual payment rates under the Medicaid Expansion program compared to traditional Medicaid rates for calendar years 2017 and 2018:

Type of Service	Actual % of Medicaid*	
	CY17	CY18
Inpatient	158.7%	165.8%
Outpatient	209.8%	208.0%
Professional	168.2%	168.2%
Total	175.0%	177.8%

*\*Excludes pharmacy expenditures and FQHC/RHC/IHS expenditures*

This table will be updated once the actual data is captured under the new uniform payment methodology.<sup>1</sup> This information is provided solely for reference.

This concludes my testimony. I would be happy to answer any questions.

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<sup>1</sup> Percentages will be updated to reflect 2019 and 2020 rates