S.B. 2012: DHS Testimony - Vision & Strategy Overview

Jan 17, 2019

- **Walkthrough of changes from the 2017-19 biennium to 2019-21**
- Key strategic priorities driving budget changes

After accounting for baseline adjustments and one-time investments, this budget proposes a $137 million increase in state funding sources and a decrease of 91.5 FTEs

Budget Segment	Total Funds, $m	General Funds, $m	Special Funds, $m	Federal Funds, $m	FTEs
2017-2019 Total Budget	**3,973**	**1,351**	**350**	**2,272**	**2,162.2**
Remove carryover from prior biennium	(60)	(12)	(5)	(44)	-
2017-2019 Appropriation	**3,913**	**1,339**	**346**	**2,228**	**2,162.2**
Baseline Adjustments	(44)	31	(34)	(42)	-
One-time investments: state hospital	35	35	-	-	-
One-time investments: Special	6	-	6	-	-
Operational & Strategic Increases/ Decreases	21	116	21	(116)	(91.5)
2019-21 Executive Recommendation	**3,931**	**1,522**	**339**	**2,071**	**2070.7**

This budget proposes 137 million in additional [General funds + Special funds] to fund ongoing operations and make strategic changes

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- Walkthrough of changes from the 2017-19 biennium to 2019-21
- **Key strategic priorities driving budget changes**
  - **Medicaid Administrative Simplification**
  - Behavioral Health
  - Long-term Services & Supports
  - Social (Human) Services Redesign (SB 2124)

In-sourcing the administration of Medicaid Expansion has financial savings of about $20m annually, additional benefits

Subject	Detail
Total Financial Impact	▪ By in-sourcing Medicaid administration the state expects total federal and general fund savings of about $20 million annually, of which $2m are general funds, which totals to ~$3m over 18 months in savings
Detail of financial impact	▪ **By in-sourcing** Medicaid administration, **the state will reduce payments to contractors by ~$14m annually and save an expected ~$8m annually** that would be incurred **in taxes** due to outsourcing – The $14m contractor payments include **$11m for admin costs and $3m for built-in profit margin** annually – **Leveraging existing infrastructure of DHS reduces admin costs from $11m to $2m and eliminates the $3m annual payments of profit** to the contractor – **Moreover, the state avoids $8m annually in taxes on health insurers**, which would have been included in the cost-based premiums paid to continue outsourcing
Impact on cost & caseload	▪ **Beyond admin**, in-sourcing is not expected to change the utilization of services by enrollees, so **grant costs for services would stay consistent** with what they would be through outsourcing
Additional benefits	▪ By in-sourcing Medicaid administration and going from managed care to fee for service**, the state will only pay for services utilized**, and avoid today's scenarios in which DHS needs to collect premiums paid for people who had rolled off the Expansion program ▪ Additionally, **enrollees will gain access to covered services such as vision and dental**, which are not currently covered under the premium payments of the Expansion managed care plan; **the state also becomes nimbler to innovate in the coverage of other services** as well, such as peer support or those included in the 1915i state plan amendment proposal

Overview of considerations for Expansion fee schedule changes

A. Costs to continue Expansion at commercial rates

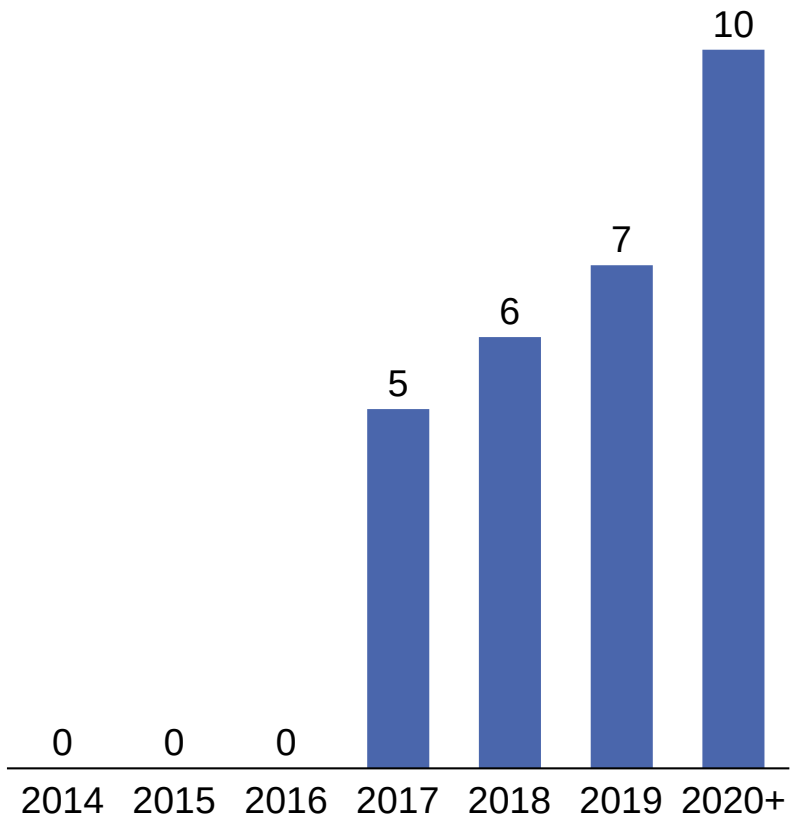
B. Expansion Rates relative to benchmarks

C. Total financial impact of rate changes

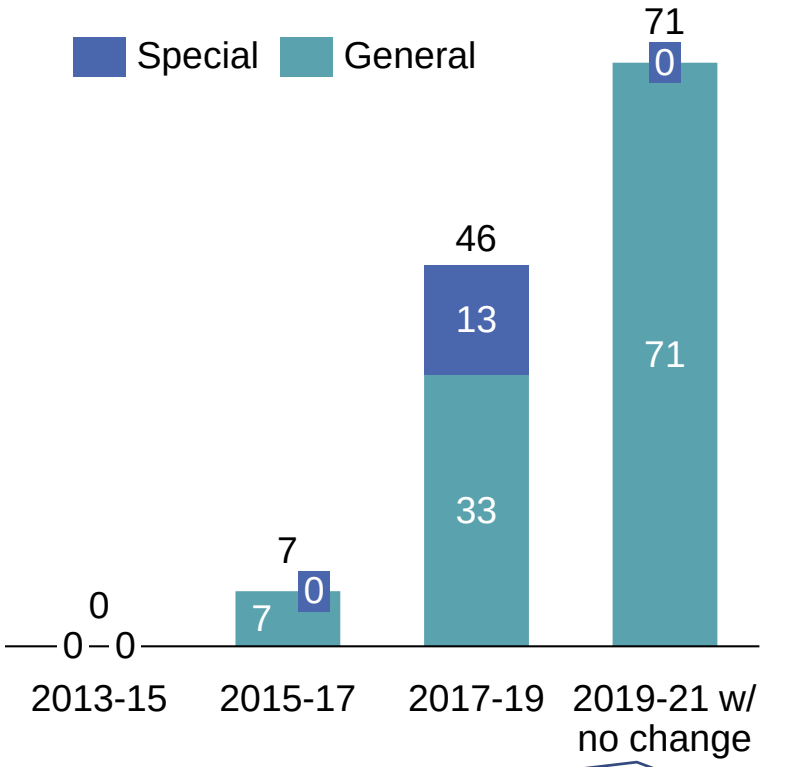
D. Impact on providers and healthcare market

A. While Medicaid Expansion started as fully federally funded, the FMAP shifts have required increasing state contributions

State Share of Medicaid Expansion Payments
Percent by Calendar Year

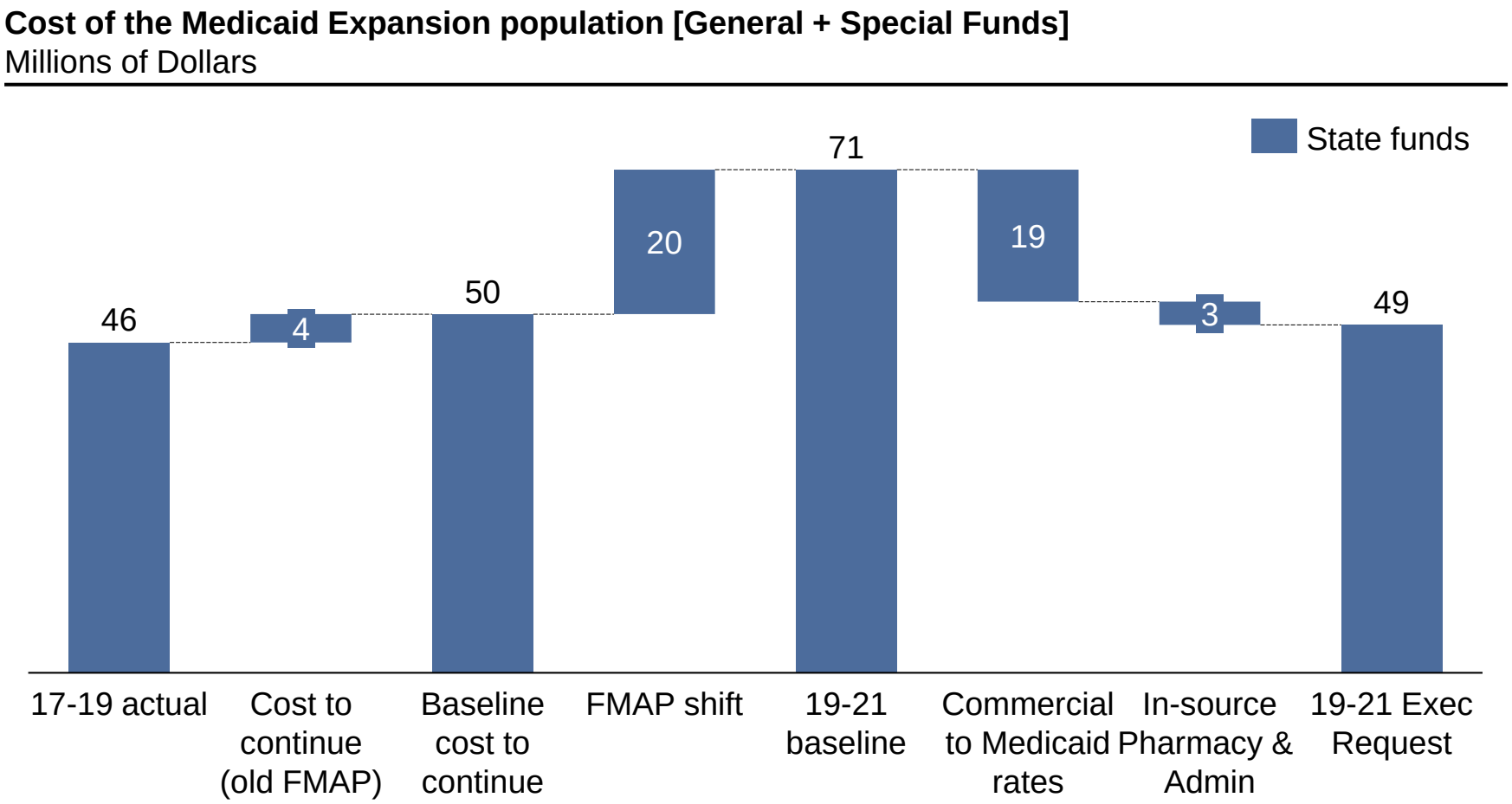


Appropriations for Expansion
Millions of Dollars

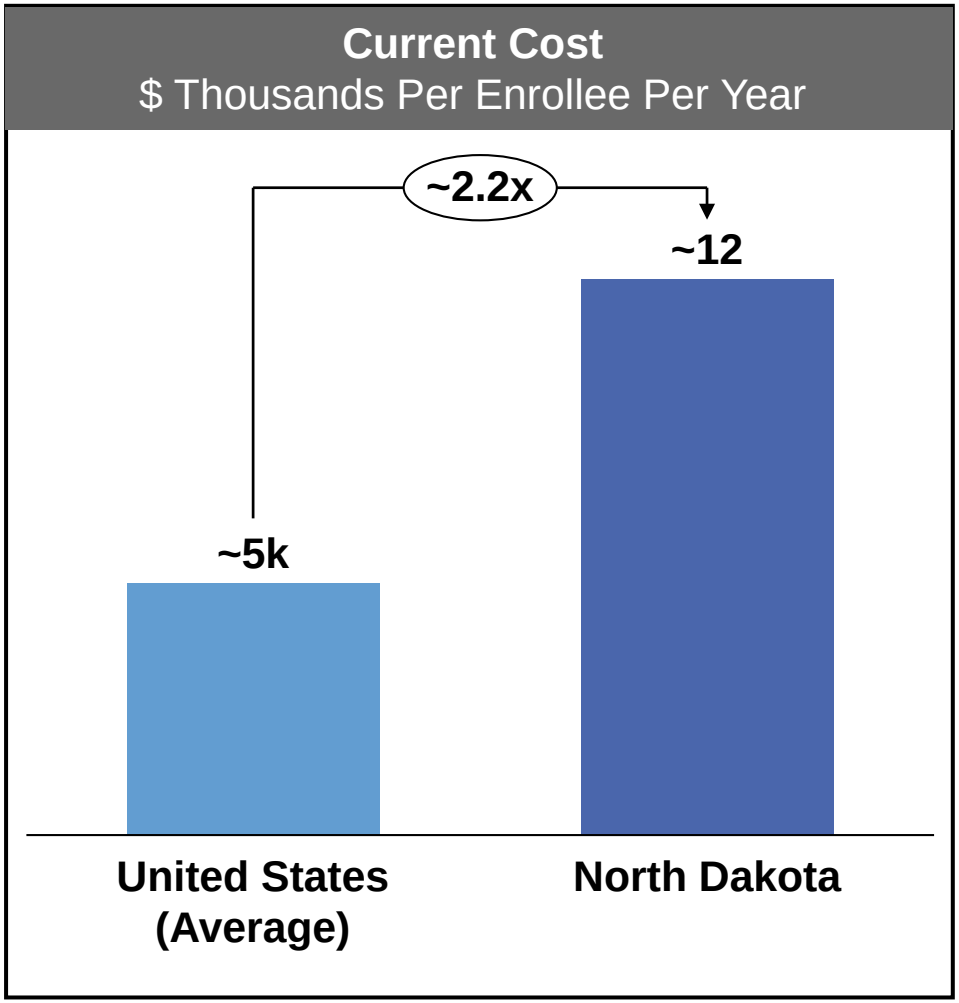


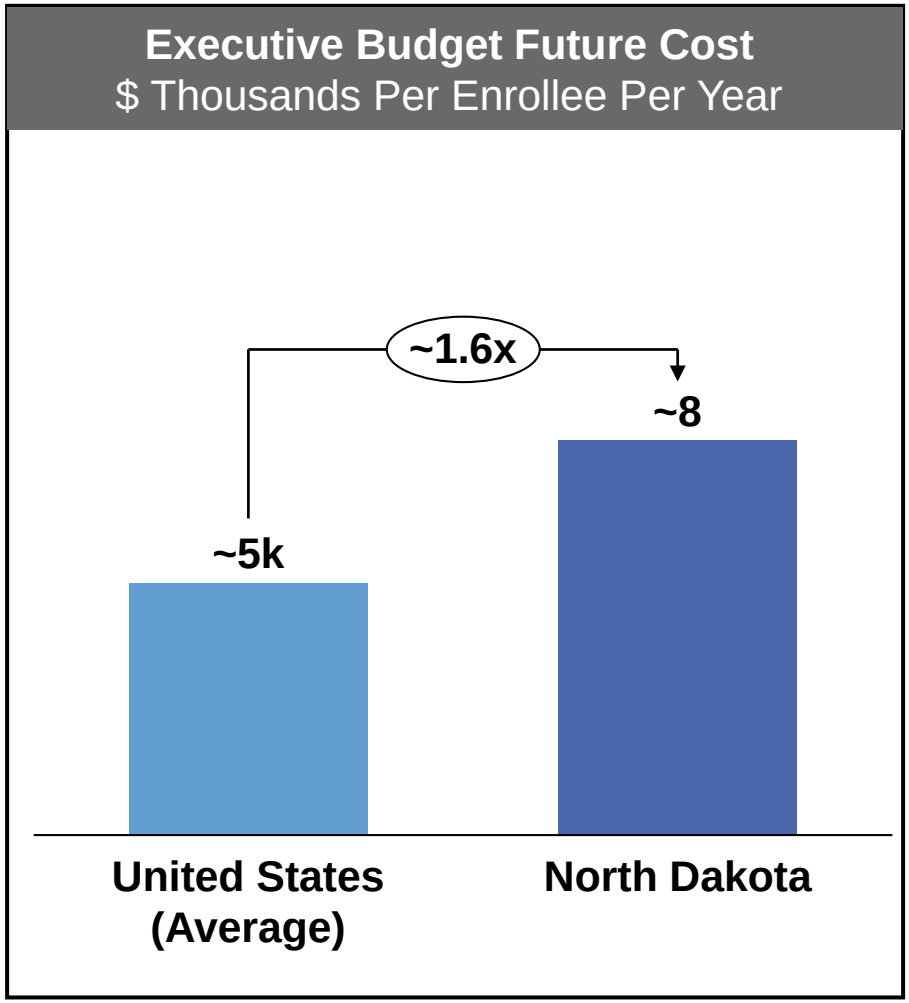
With no changes to the program, the General funds required to sustain the status quo would more than double from 2017-19 to 2019-21

A. The moves from commercial to Medicaid rates, coupled with in-sourcing & pharmacy changes, offset expected cost increases



B. Shifting from commercial to Medicaid rates takes rates from 2.2x the national average per enrollee to about 1.6x the average



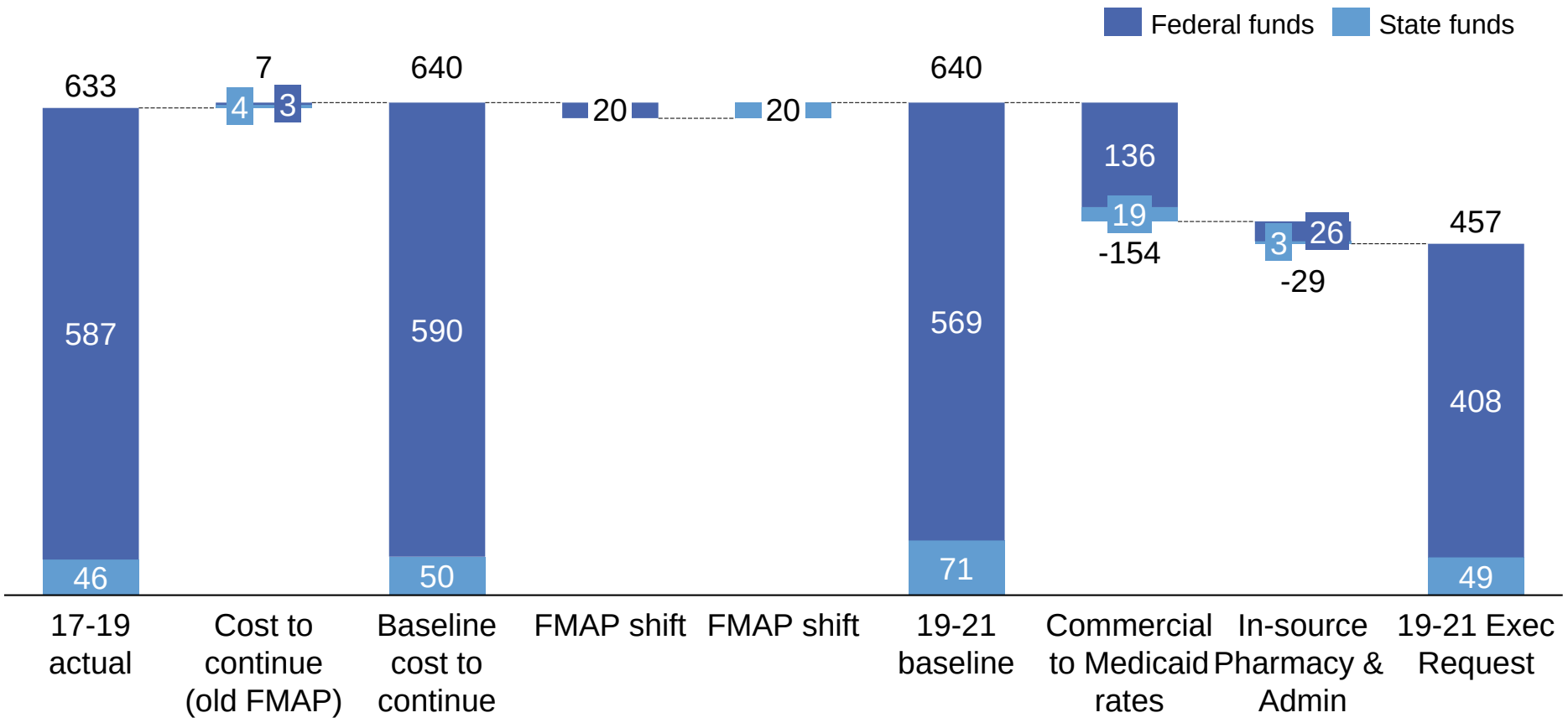


Note 1: ND est. includes both truly newly eligible and some individuals who previously received traditional Medicaid coverage in the state plan
Note 2: Per enrollee costs shown here include both full and partial benefits
Source: 2016 Actuarial Report on the Financial Outlook for Medicaid; DHS Medicaid Expansion Spenddown and Enrollee file

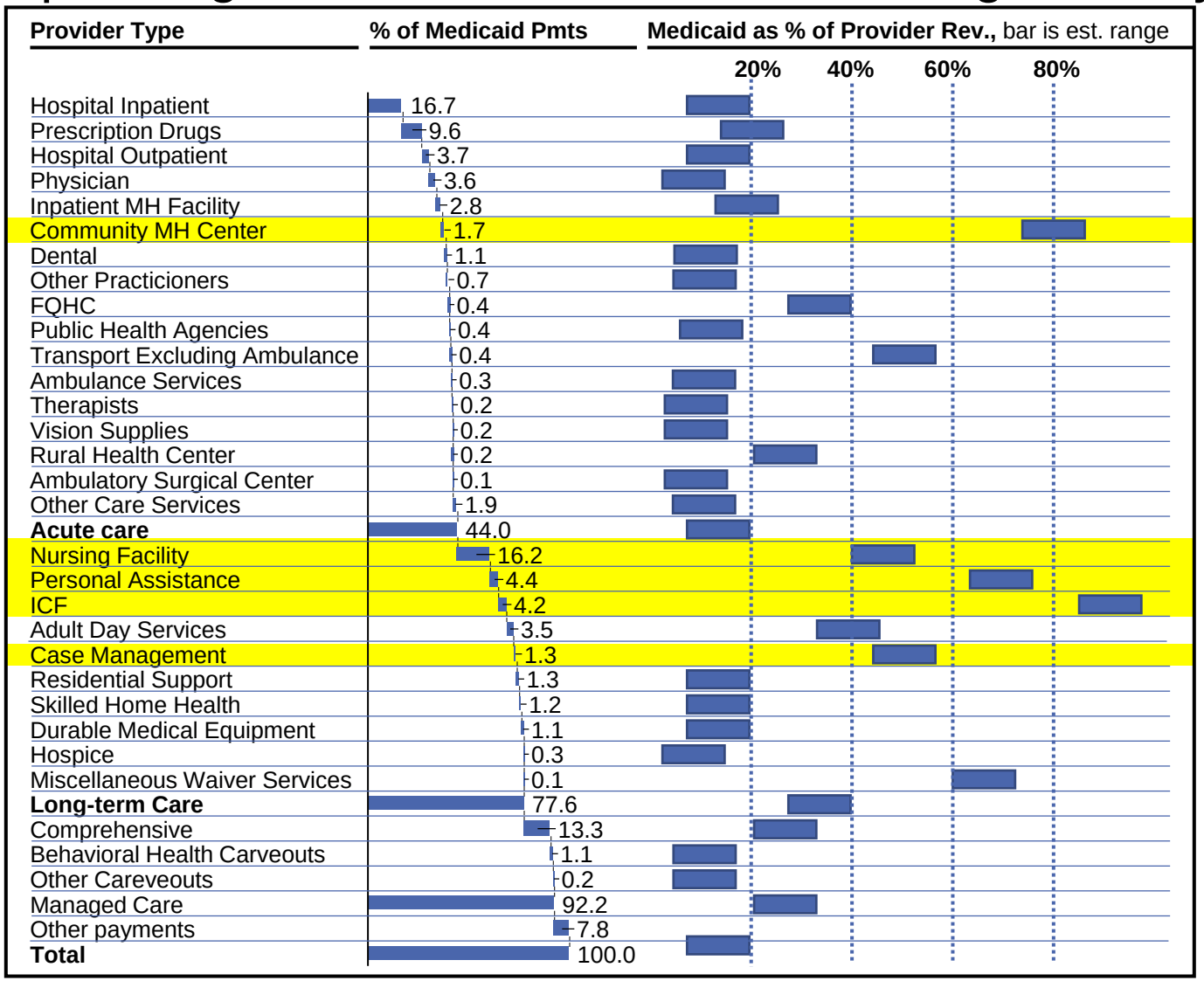
C. This would result in about $150m less total payment for providers over an 18 mo. period (or about $100m annually)

Cost of the Medicaid Expansion population

Millions of dollars for biennium; Note: impacts are captured over 18 mo of 24 mo period



D. While Medicaid overall represents ~12% of the healthcare spending in ND, market share varies significantly by segment



Spending >1% of Medicaid AND Medicaid share of market >40%

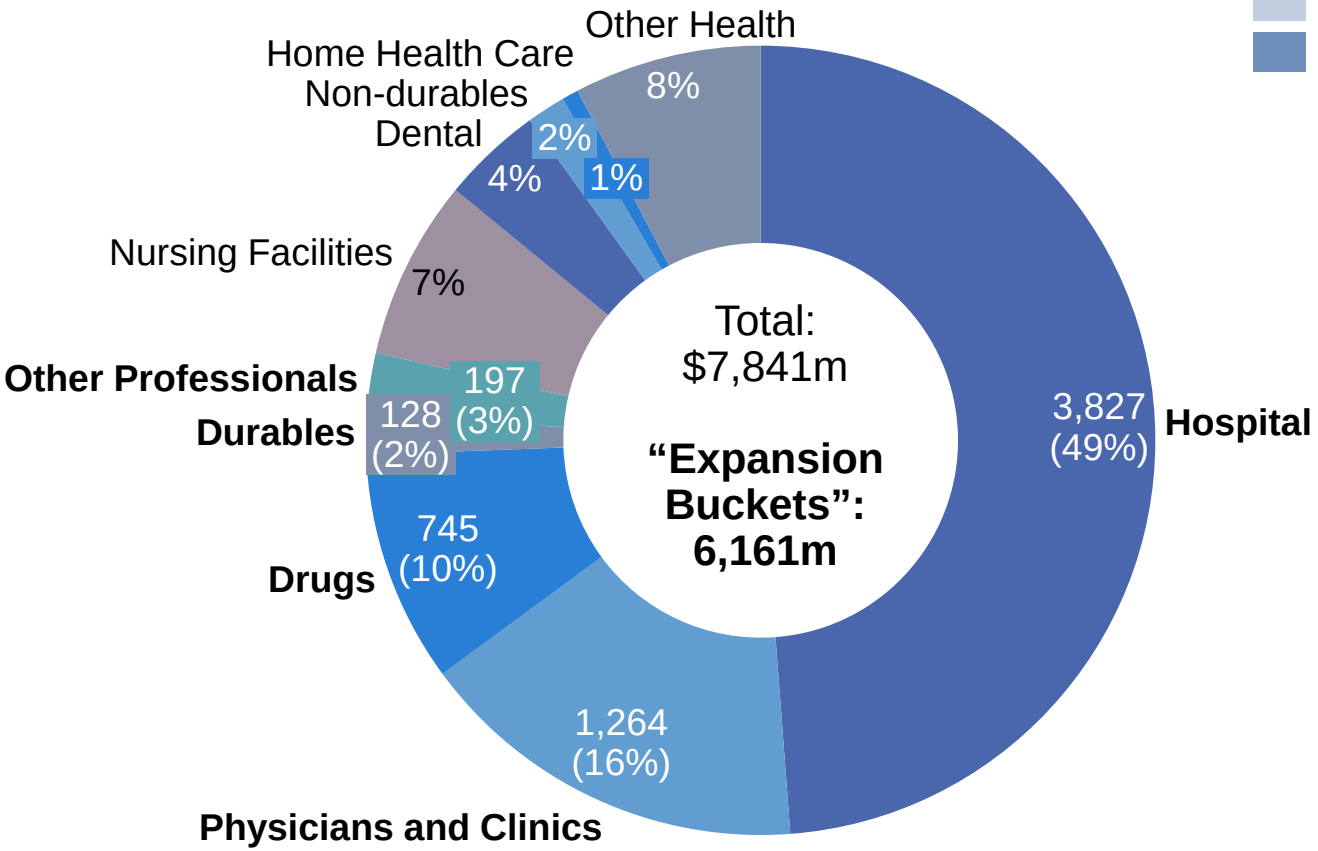
- The areas of significant Medicaid spending (>1%) on providers, where also Medicaid represents almost or more than half of the market (>40%), include primarily spend on services across 3 continuums of care:
  - Behavioral health[1]
  - Long-term services and supports (LTSS) for developmentally disabled (DD)
  - Long-term services and supports (LTSS) for aging and disabled (A&D)
- **Of payments across LTSS, payments to institutions** (i.e., Nursing Facility and ICF), as opposed to payments for home and community based services, **constitute the largest share** of payments in these continuums of care
- If payor share of payments represents market influence, then the **3 continuums of care across behavioral health and LTSS are where providers are most reliant on Medicaid funding**

Note: data shown here is for whole US from '07 study using FFY2003 data; small shifts are expected but data is assumed to be directionally accurate
1 Share of government spending on behavioral health is even higher when payments from other agencies are included
Source: Quinn, K., ACS Government Healthcare Solutions and Kitchener, M., University of California, San Francisco

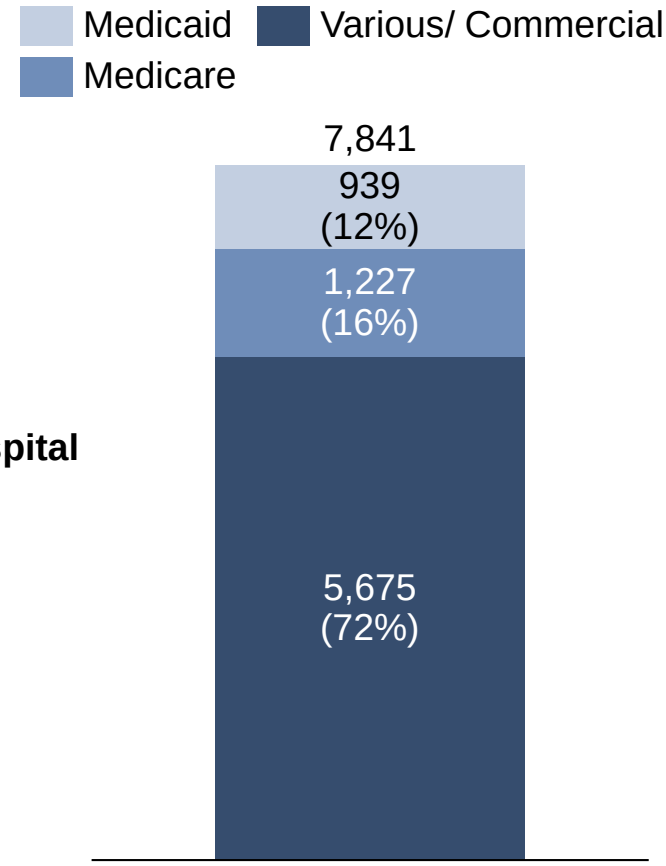
D. In 2014, markets with Expansion reimbursed goods, services received ~6Bn; Medicaid represented about 12% of payments

Expenditures by Type of Good, Services

In **BOLD** are goods & services reimbursable for Expansion enrollees



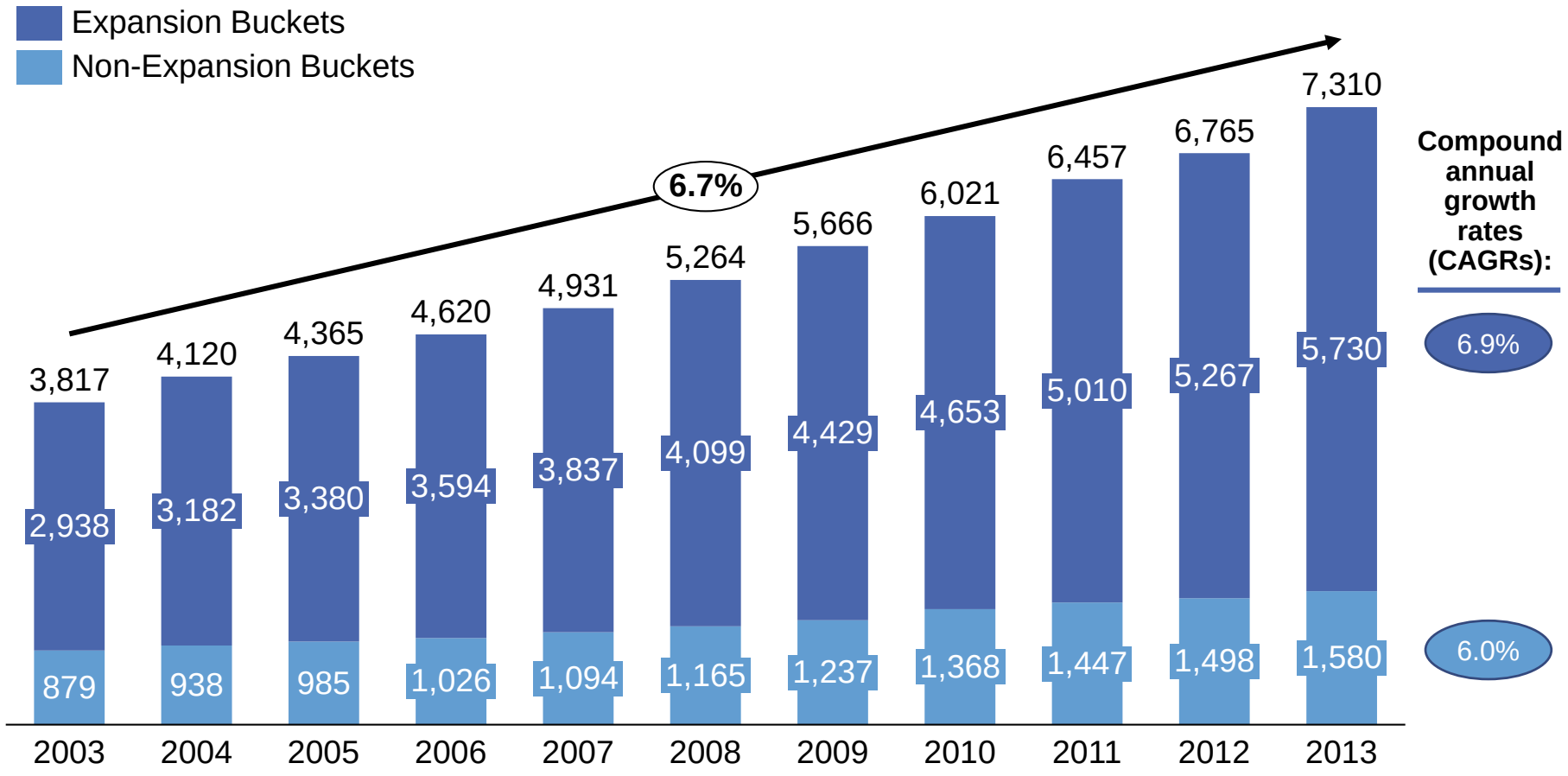
Expenditures by Payor Type



Source: Centers for Medicare & Medicaid Services (CMS), State Health Expenditures Accounts by State of Provider

D. For those goods & services Expansion reimburses, market size grew at 6.9% per year in the decade prior to Expansion

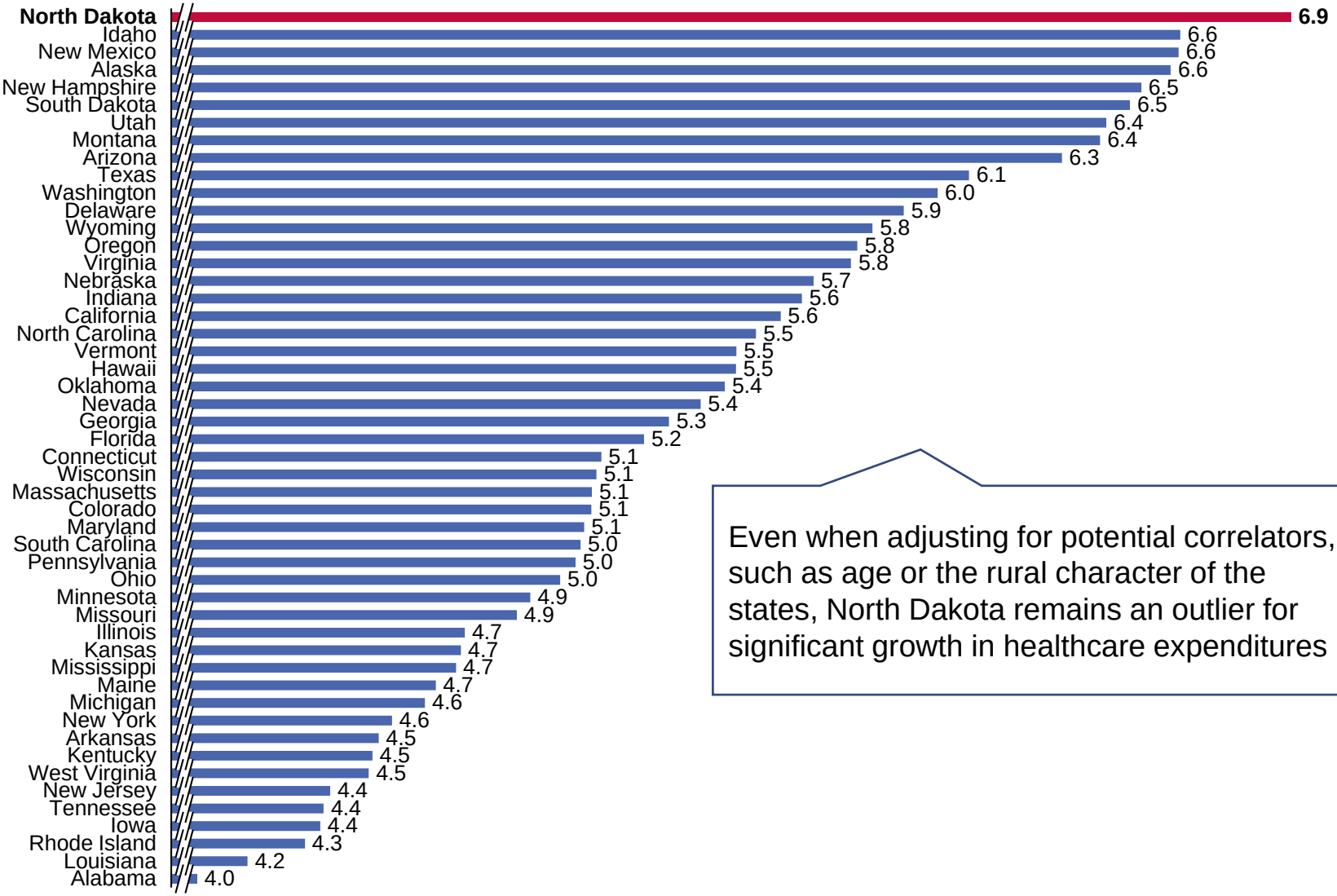
Growth in Healthcare Expenditures in the Pre-ACA decade (2003-2013)
Millions of dollars



Source: Centers for Medicare & Medicaid Services (CMS), State Health Expenditures Accounts by State of Provider

D. The growth of 6.9% per year for Expansion reimbursable goods & services is the highest in any state

Percent growth in goods & services over the Pre-ACA decade (2003-2013), % year over year growth

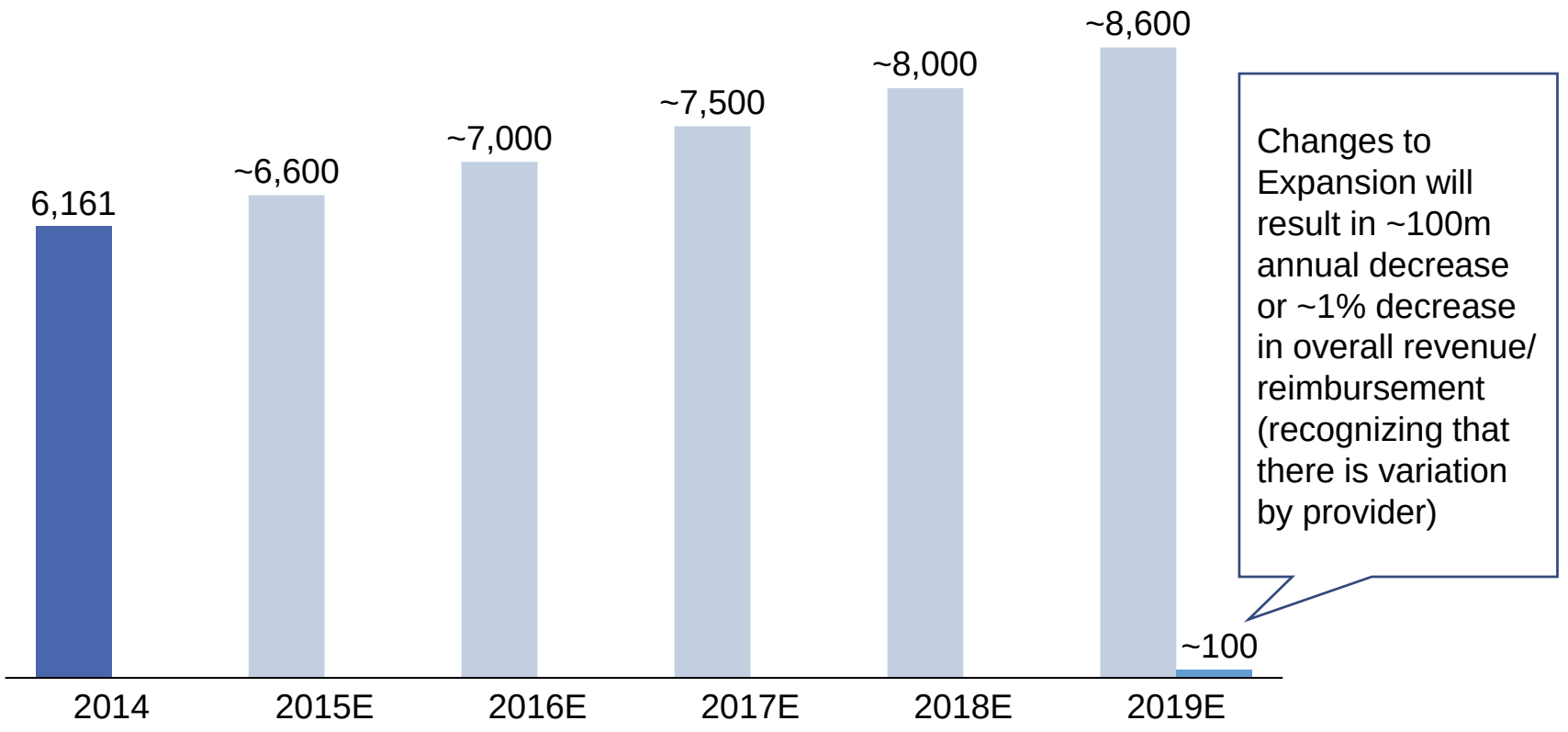


Even when adjusting for potential correlators, such as age or the rural character of the states, North Dakota remains an outlier for significant growth in healthcare expenditures

Source: Centers for Medicare & Medicaid Services (CMS), State Health Expenditures Accounts by State of Provider

D. After the proposed rate changes, the reduction in overall market revenue is just over 1% of total revenue (as a fraction of total estimated 2019 revenue)

Estimated Market Size for Expansion Reimbursed Goods & Services
Millions of dollars, Note: assumes continued 6.9% year over year growth



Review of Expansion changes and financial, provider impacts

Subject	Detail
A. Costs to continue	▪ **While Medicaid Expansion started at 100% FMAP** – meaning all federally funded – **the required state share has continued to increase**: in the absence of any changes, **the projected state contribution is expected to increase by 25 million,** due to the continued change in FMAP. ▪ **The proposed changes** to the Medicaid Expansion rates in this executive request **offset the expected cost increases to continue the program** in current form
B. Rates relative to benchmarks	▪ **Today ND pays** just under $12k per enrollee for expansion, **2.2x more than the national average** of $5.4k ▪ **Moving payment for expansion services to traditional Medicaid rates is ~30% decrease in payment**, bringing per enrollee costs down **to ~8.4k or 1.6x the national averages**
C. Total Financial Change	▪ **This reduction** in payment **amounts to approximately $100m annually,** or about $150 million over the course of the 18 month period over which these changes would be in effect
D. Impact on providers and enrollees	▪ **The budget changes translate to a reduction of ~1% of in revenue** across Expansion reimbursable goods & services ▪ **While payments are reduced,** rates would still be around 100% of the Medicare rates, which is the rate for the healthcare of ~115k Medicare enrollees across the state; thus, due to the reduction in payments **there is no expected change in access to services**

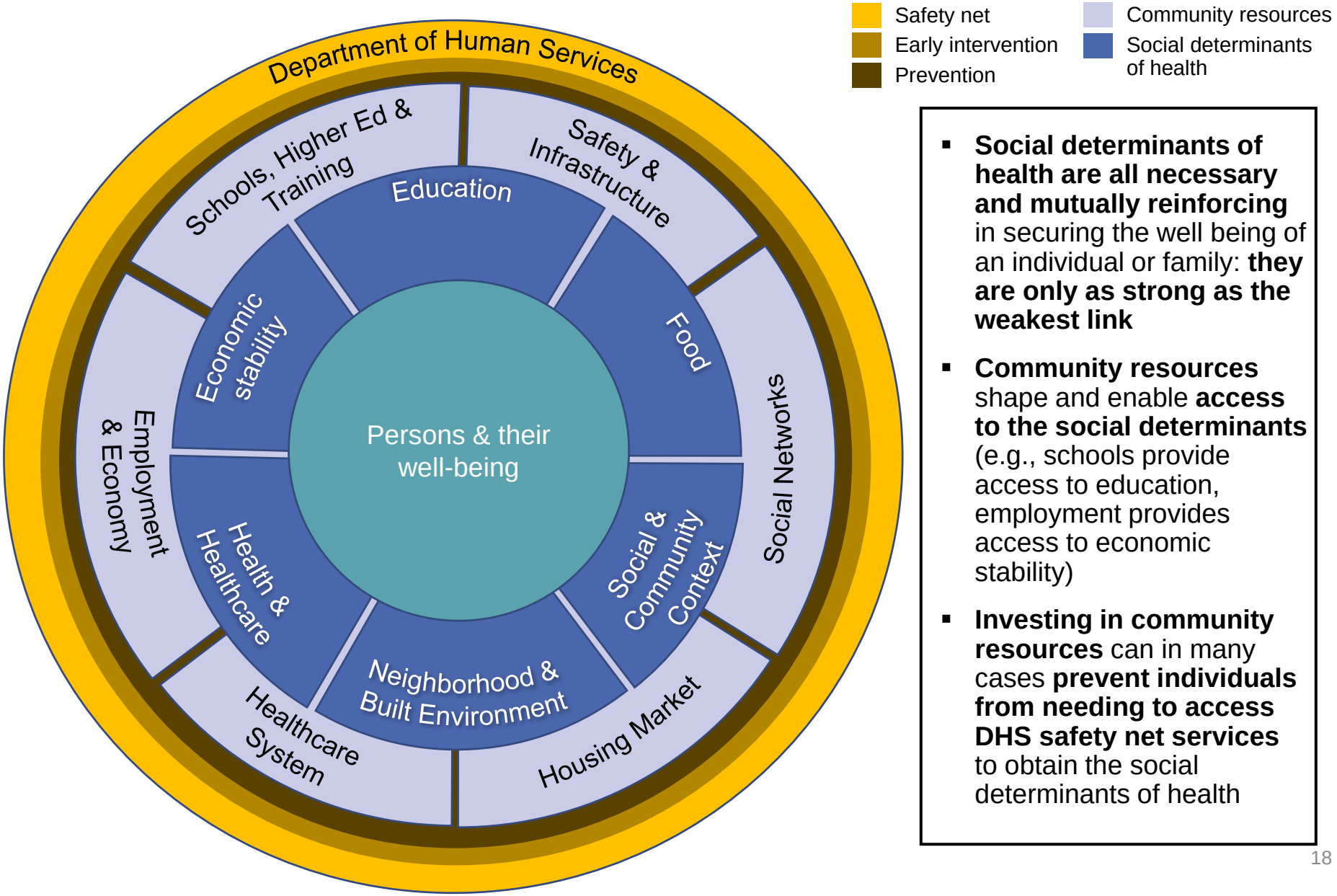
Medicaid Expansion changes do not occur in vacuum

Category	Budget Component	[General Funds + Special Funds] Increase/Decrease, $m	Detail ($m) / Notes / Comments Note: Increase shown x, Decrease as (x)
~ $96m Cost, Caseload, FMAP, and provider inflation	Medicaid Expansion	25	FMAP: 20.3; Caseload: 3.6; Cost: 0.8
	Traditional Medicaid	7	FMAP: 6.2; Cost & Caseload: 1.2
	Developmental Disabilities (DD)	24	Cost: 14.6; Caseload: 7.5; FMAP: 1.5
	Long-term Care (LTC)	23	Caseload: 13.5; Cost: 7.3; Other: 2.1
	Child & Family Services	4	Cost: 2.0; Caseload: 1.9
	Human Service Center	2	Cost: (0.9); Caseload: 2.5
	Behavioral Health Division	0	Caseload: 0.3
	Economic Assistance	-2	Cost: (1.2); Caseload: (0.9)
	Provider Inflation (1/1)	14	DD:4.7;Medical:3.9;NFs:1.8;Other: 3.2
~ $17m General Operations	**Sub-total**	96	
	IT Investments	14	MMIS: 9.8; SPACES: 3.2; Other: 1.5
	Shifts in Duties	1	Shift from DOH: 1.3; Other: (0.2)
	Other Costs to Continue	1	Increases: 10.7; Decreases: (9.3)
~ $12m Comp/staff	**Sub-total**	113	
	Governor's Comp Plan	23	DHS: 15.4; SB 2124 Fiscal Note: 7.8
	Staff Efficiencies	-11	Reduction of about 5% total FTE[1]
~ $38m Strategic Investments	**Sub-total**	125	FTR: 4.5; Crisis Services: 4.0; SUD
	Behavioral Health	16	Voucher: 3.1; Medicaid: 3.0; Other: 1.2
	Family First Implementation	10	Included in SB 2124 Fiscal Note
	Long-term Services & Supports	8	SPED:3.6;HCBS Waiver:3.4; CARES:0.5
	Tribal Partnerships	3	TANF kinship care for tribes: 2.9
~ ($30m) Key Savings	**Sub-total**	163	
	Medicaid Expansion Changes	-22	Rates: (18.6); In-source Admin:(3.1)
	Other Program Efficiencies	-8	FC FMAP:(3.2);CHIP:(1.9);Others:(2.7)
~ $4m Others	**Sub-total**	133	
	SB 2124 Fiscal Note - Remainder	4	Run-rate Adjust: (4.4); Other: 8.2
	Total	137	

1 These efficiencies depend crucially on investments in behavioral health supports

Acronyms: FMAP = Federal Medical Assistance Percentage; DD = Developmental Disabilities; NFs = Nursing Facilities; MMIS = Medicaid Management Information System; SPACES = Self-Service Portal and Consolidated Eligibility System; FTR = Free through recovery; SUD = Substance use disorder; SPED = Service payments for the elderly & disabled; CARES = Clinical Assistance, Resources, and Evaluation Services; TANF = Temporary Assistance for Needy Families; FC = Foster care; CHIP = Children Health Insurance Program

To improve lives, DHS enables access to social determinants of health when community resources are insufficient



- **Social determinants of health are all necessary and mutually reinforcing** in securing the well being of an individual or family: **they are only as strong as the weakest link**
- **Community resources** shape and enable **access to the social determinants** (e.g., schools provide access to education, employment provides access to economic stability)
- **Investing in community resources** can in many cases **prevent individuals from needing to access DHS safety net services** to obtain the social determinants of health

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  - Long-term Services & Supports
  - Social (Human) Services Redesign (SB 2124)

The executive budget request for DHS contains just over $16 million in additional general funds for behavioral health supports

Behavioral Health Supports in DHS Budget	
Medicaid Community-Based Supports (w/ Peer Support)	$3.0 M
Behavioral Health Crisis Services	$4.1 M
Free Through Recovery Expansion	$4.5 M
Substance Use Disorder Voucher Expansion	$3.1 M
Other Investments	$1.7 M
ADDITIONAL GENERAL FUND (in DHS)	**$16.3 M**

Note: numbers may not add due to rounding

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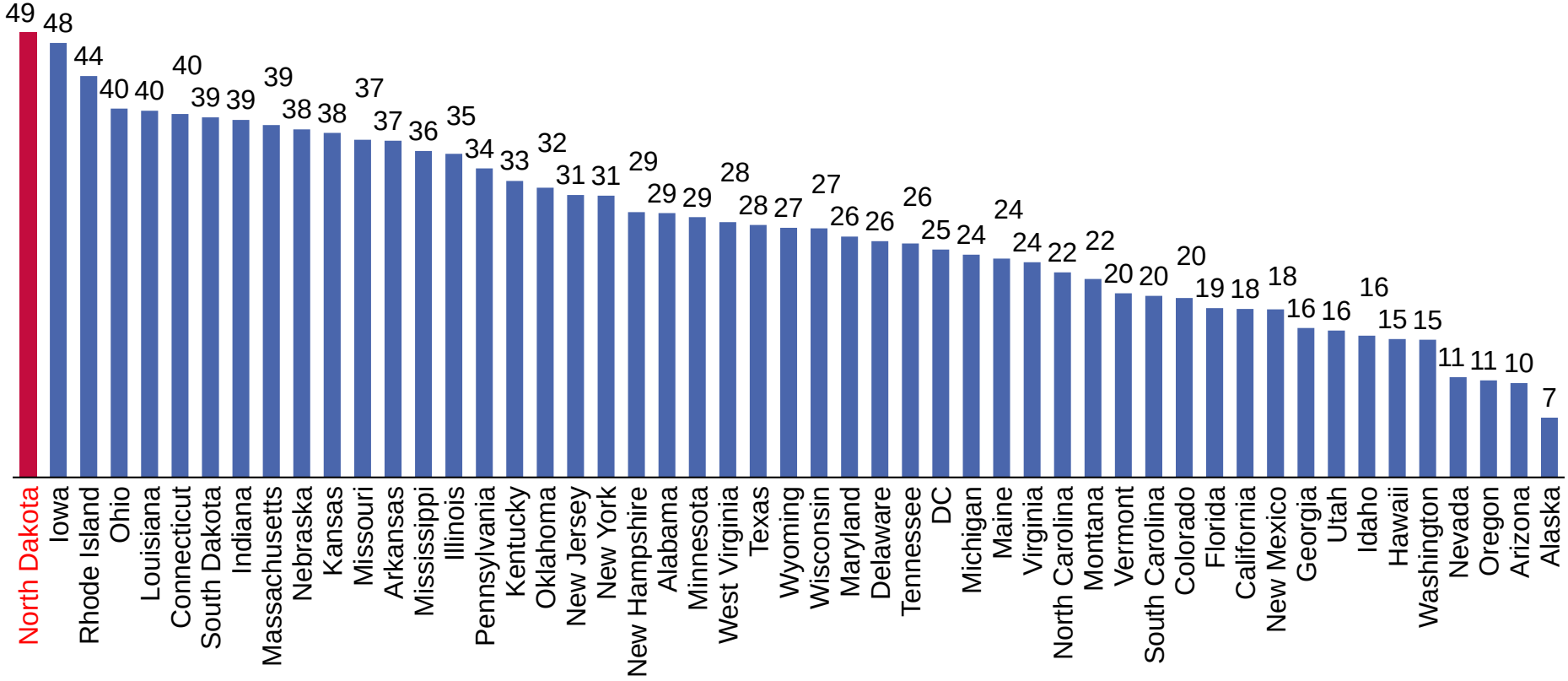
ND is highest in rate of citizens in nursing facility per 1k >65, suggesting need for home & community-based services (HCBS)

Rate of Citizens in Nursing Facilities

Number of people in nursing facilities divided by the number of people over 65[1] (shown as people per 1,000)



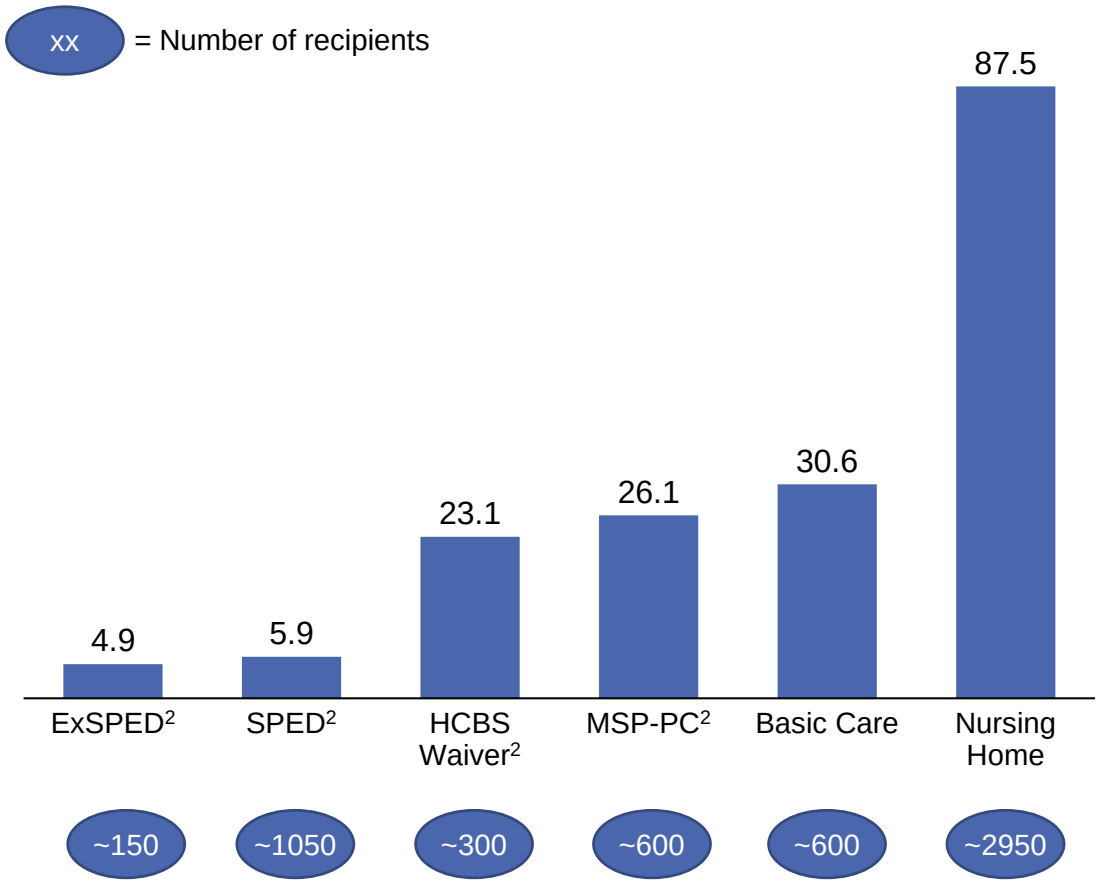
1 There are ~110-115k persons over 65 in North Dakota and about ~5.5k people in nursing facilities

Sources: Henry J Kaiser Foundation (# in certified nursing facilities by state, % over 65 by state), US Census (population by state)

When citizens are able to access HCBS services, these are typically less expensive than more institutional services

Cost Per Recipient Per Year

Cost paid by state by service in $ in State Fiscal Year 2017[1]



Program Descriptions / Detail

- **Expanded Service Payments for the Elderly and Disabled (ExSPED):** Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.
- **Service Payments for the Elderly and Disabled (SPED):** Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.
- **Home and community-based services (HCBS) waiver:** This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.
- **Medicaid State Plan personal care (MSP-PC):** Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.
- **Basic Care:** Room and board and personal care services for persons eligible for Medicaid.

1 Data is based on paid date; does not include recipient liability portion 2 Does not include room and board

Source: North Dakota Department of Human Services

We are also looking closely at nursing facility (NF) financial instability & revising NF payment methods to improve health

The Vision for the Payment System	The Defects of the Current System
Providers are stable and healthy. Providers receive stable and predictable revenue that ensures timely recognition of changing costs, particularly those targeted to improve care. There should also be compatibility with other payment models and models should be streamlined where possible to ensure holistic health.	**As of 3/31/18, two-thirds of providers are operating at a deficit.** This suggests that most providers are in an unstable and unhealthy position. Providers that are in a healthy position this year may not be able to sustain that position given the payment system methodology.
Residents receive consistently safe and high-quality care. Reimbursement is sufficient to promote safe and high-quality care in an economically run facility.	**The current quality measures for SNFs are incomplete, varied, imprecise, or lacking impact.** This suggests there is an opportunity to expand a holistic understanding of the quality of care in SNFs across the system.
There is choice for consumers in their setting of care.	**ND has one of the highest rates of people >65 in nursing facilities per capita.** This suggests there is a lack of awareness, supply, trust, or support for other settings of care.
The care received by residents is sustainable today and tomorrow. Growth in rates is reasonable and cost is managed as efficiently as possible.	**The rate increase per resident day has been ~5% per year over the last decade.** This rate of cost growth could be characterized as unsustainable for residents and taxpayers.
The reimbursement for services across providers is fair and equitable. Reimbursement rates are similar for like services provided in similar facilities, with recognition of the facility operating model or geography (which does not mean that every facility is paid the same).	**There is ~83% variation in payment to SNFs per resident day.** The variation in payment could be characterized as an unfair difference given the similarity in services provided.

Source: Prepared by appointed workgroup from the NF Payment Study Committee

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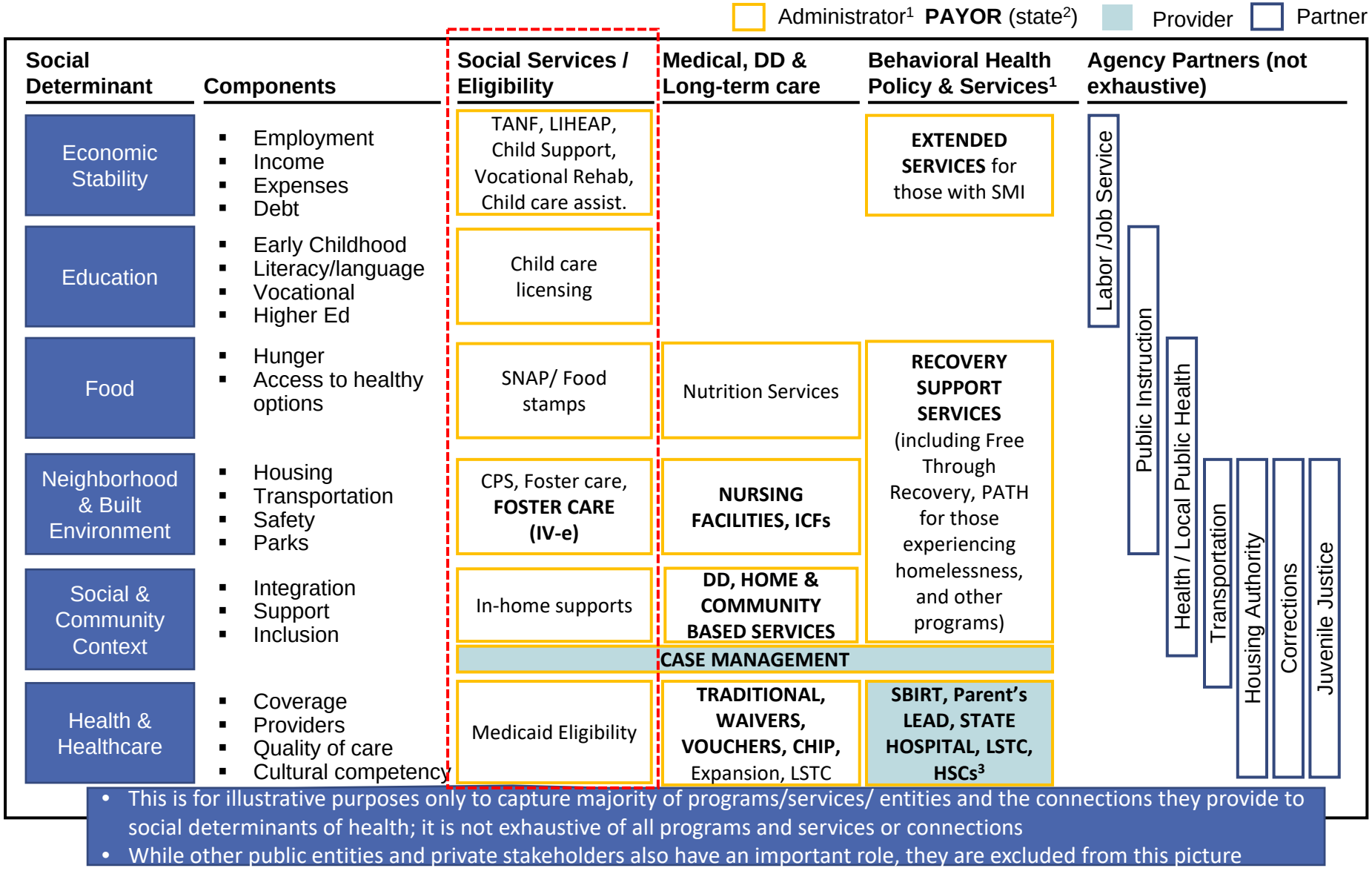
  - **Social (Human) Services Redesign (SB 2124)**

Social services is an essential link to connect citizens with a range of programs across social determinants of health



- This is for illustrative purposes only to capture majority of programs/services/ entities and the connections they provide to social determinants of health; it is not exhaustive of all programs and services or connections
- While other public entities and private stakeholders also have an important role, they are excluded from this picture

1 Administrative role also includes the function of licensing professionals 2 Those programs for which the state pays a large share
3 SBIRT = Screening Brief Intervention & Referral to Treatment, LSTC = Life skills & transition center, HSCs = Human Service Centers

Since the 1990s, social (human) services costs have been absorbed by the state incrementally

Timeline

Early 1990's: Social service delivery was one of largest single items in many county budgets, and one that was growing much faster than property values. So counties worked for legislation to shift that burden to statewide collected taxes.

1997: Counties were relieved of the local share of Medicaid payments to hospitals, doctors, and nursing homes, an area over which counties had no authority to approve, set rates, or change.

2007: The costs and employees of regional child support enforcement offices were shifted to the State.

2015: The county share of foster care maintenance payments was shifted to the state.

-> As a result of these transitions, **property tax payers were left with about $80 million per year in staff costs** with great variation**, as some taxpayers were paying 8 mills, others over 45 mills**

Source: North Dakota Association of Counties, SB 2206 Report to Legislative Management

In 2017-19, the state took over funding of social services in the 2017 S.B. 2206 pilot, keeping overall organizational structure intact

Subject	Details
Formulas	NDCC§53-34-04(4) Total Calendar Year Formula Payment = [Social Services (SS) Rate per case x SS Most Recently Available Calendar Year Case Month Data] + [Economic Assistance (EA) Rate per case x EA Most Recently Available Calendar Year Case Month Data)]
	NDCC§ 53-34-03(2) January 10th Payment = Total Calendar Year Formula Payment x 50%
	NDCC§ 53-34-03(3-4) June 15th Payment = (Totally Calendar Year Formula Payment x 50%) – 1st Payment +/- True Up or True Down – Amount Exceeding Fund Balance
Variable Definitions	NDCC§ 53-34-04(1) 2015 Net Expenditures = 2015 Gross Expenditures + 25% of Three-Year Average Eligible Federally Allowable Indirect Costs – 2015 Services Reimbursed by Medical Assistance
	NDCC§ 53-34-04(2-3) Rate per case = 2015 Net Expenditures / 2015 Case Month Data
	NDCC§ 53-34-03(3)(a) Recalculated Formula Payment = Rate per case x Most Recently Available Calendar Year Case Month Data
	NDCC§ 53-34-03(3)(b-d)) True Up/Down = If recalculated Formula is above or below 105% or 95% respectively of the Total Formula payment the county will receive or be reduced by the difference that is more or less than 105% or 95% respectively
Fund Balances	NDCC§ 53-34-06 Fund balance (Effective January 1, 2019): NDCC§ 53-34-05 Counties with $2,000K expenditures may not exceed a fund balance of $500k NDCC§ 53-34-05 Counties with less than $2,000k expenditures may not exceed a fund balance of $100k

- **Benefits of pilot formula:** shifted funding to the state under a more consistent reimbursement methodology, with some flexibility to adjust for workload changes as measured by caseload
- **Downsides to pilot formula:** caseload changes are only driver, locks in historical costs, locks in basket of services paid for in EA or SS rates, locks in current service levels even if variation

The following principles for zone budgeting are reflected in the fiscal note

Zone Budgeting Principles (in **BOLD** are principles driving prior formula)

1. **Reimburse historical costs of providing services across zone**
2. Adjust for differences in pay between zones and cost of living
3. Adjust for process change (enabling consolidation, sharing capacity)
4. Adjust for changes to the basket of services (enabling specialization)
5. **Adjust for caseload increases or decreases**
6. Adjust for equalizing service levels across the state, recognizing potential differences in delivery modes in different zones
7. Adjust for statewide changes in services or service levels
8. Adjust for contingencies or pressing situations

Ranked in order of priority

The fiscal note associated with S.B. 2124 of $182.3m will support transition to the new model of human service zones

Line Item	Estimated Amount[1], $	Rationale / Description of Calculation
Projection of CY18 and CY19 program-related costs	155,669,639	= [CY18 run-rate][2] + [CY19 projection][3]
Indirect Cost Obligation	5,351,022	The estimate for the indirect costs is 25% of the last available full 12 months of data (which is the state fiscal year 2018)
"Unallowable" Costs	683,734	The "unallowable" costs are those not submitted through accounting 119 forms and include additional activities (e.g., food pantries) that support individuals
Sub-total: Total Costs	**161,704,395**	Sum of program-related costs, indirect costs, unallowable costs
MMIS Revenue Estimate	5,445,672	Estimated as 2 times the amount distributed from MMIS in CY18. Monies distributed to the counties from the Medicaid Management Information system (MMIS) support costs for services like home & community-based services
Sub-total: Total Costs minus Revenues	**156,258,723**	
Inflationary Increases[4]	7,845,750	Inflationary increases are based on Governor's recommendation of 4% and 2%, enabling counties to give same comp increases for staff as state
Compensation Equity Adjustments	3,408,119	The same roles at various counties are paid very differently due to historical contingencies reinforced through the rate-per case formula; this amount would allow for bringing up compensation of lower-paid counties
Family First Legislation Implementation Investments	10,000,000	Funds to support preventative services and enhanced review of residential placements under Qualified Residential Treatment Provider (QRTP) provisions
IT/Transitional Costs	3,000,000	Investments to support pilot projects, training, or adjustments to SPACES
Contingency/ Emergency Fund	1,787,408	Calculated as about 20% of fund balances available for contingency use
Total	**182,300,000**	

1 Could adjust based on most recently available cost data from counties 2 [CY18 run-rate] is calculated as the actual costs reported on the 119 for the first 11 months, plus an estimate for December costs, which is projected to be the average of the costs for the first 11 months. 3 [CY19 projection] is calculated as 3% times the [CY18 run-rate] 4 Current accounting standards do not support splitting out costs based on Salaries and Wages from other operating costs; therefore, DHS here assumes that 100% of costs are salaries & wages, to which the 4/2 applies, recognizing that these costs are the majority but do not in fact constitute all costs included. It is the intent of the department to begin capturing Salaries & Wages separately in CY19 119 accounting forms.

FTE transfer authority is included in 2124 for functions where state can gain consistency/efficiency from specialization of work

Subject	Design Intent / Brief Description	SB 2124 Language	Rationale	SB 2124 Reference(s)
FTEs authorized as transfers from county	+ **From:** each county operates same basket of services + **To:** services are distributed to maximize efficiency and client outcomes	Up to two hundred twenty-eight full-time equivalent positions included in Senate Bill No. 2012, as approved by the sixty-sixth legislative assembly, may be adjusted or increased only if one or more human service zones transfers powers and duties…Any positions added to the department of human services under this section would be position transfers from the human service zones	+ The contingent authorization for these functions reflect 2206 study committee recommendations, as some functions were determined to be more efficiently performed in consolidated manner (which does not mean centralized) + These authorizations are contingent because not all may happen this biennium, or alternative strategies may be developed	**SECTION 124** p.109:3-9
FTEs transferred for specific functions	Broadly, those **functions targeted for potential transition to the state are those where work requires a greater specialization** and content knowledge**.** Through specialization of work, these transitions would ensure more consistent and efficient delivery.	[19 FTEs] to serve as human service zone directors	Number of zones not set, but DHS will need positions for directors	**SECTION 124** p.109:30-31
		[16 FTEs] if [DHS] assumes…duties associated with foster care training and the recruitment and licensing of family foster care homes [2 FTEs] if [DHS] assumes…duties associated with adoption assistance eligibility determination	CFS committee recommendations included: ▪ Establish statewide foster care recruitment strategy ▪ Regionalize foster care licensing ▪ Move sub-adopt negotiations to region or state	**SECTION 124** p.110:1-3 p.110:12-14
		[14 FTEs] if [DHS] assumes…duties associated with foster care assistance or IV-E eligibility determination	IV-E determinations are complicated/ error-prone, and a specialized team may perform better than generalists	**SECTION 124** p.110:4-6
		[27 FTEs] if [DHS] assumes…duties associated with child care licensing	Inconsistency or lack of critical mass in regional delivery motivates consolidating operations	**SECTION 124** p.110:7-8
		[16 FTEs] if [DHS] assumes…duties associated with [LIHEAP]	EA committee suggested to outsource; consolidation to state may be preferred	**SECTION 124** p.110:9-11
		[104 FTEs] if [DHS] assumes…determination of eligibility and other related activities [for various programs]	Some eligibility functions, such as long-term care eligibility, would be more efficiently performed at state level	**SECTION 124** p.110:15-19
		[30 FTEs] to relieve human service zones of miscellaneous duties [e.g., fraud investigations, estate collections, third party liability, etc.]	The state is better positioned to perform duties that would make human service zones less efficient by distracting them from core operations	**SECTION 124** p.110:20-22