Testimony
House Bill 1115 – Department of Human Services
House Human Services Committee
Robin Weisz, Chairman

January 8, 2019

Chairman Weisz, members of the House Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services (Department). I am here today in support of House Bill 1115, which was introduced at the request of the Department. This bill is a comprehensive review and update of North Dakota Century Code Chapter 50-24.1 ***Medical Assistance for Needy Persons***.

Section 1, Page 1, Lines 16 through 21 The Department is proposing to no longer process medical claims on behalf of county jail inmates. Considerable time and resources have been invested to support this effort, which takes resources away from focusing on our mission of serving vulnerable individuals. The jails would be able to access the Medicaid fee schedule; however, they would need to manage the processing and payment of those claims as they did prior to 2011 when Senate Bill 2024 was enacted. The proposed changes would then place the amended language in 12-44.1.

Section 2, Page 2, Lines 1 and 2 makes a necessary change to the list of individuals subject to a criminal history record check as "staff member of the applicant provider or provider" are not subject to such checks.

Section 3, Page 2, Lines 4 through 11 proposes to move 50-24.1-22 to a new section in Chapter 50-10.2, which is more germane to the information in the section. The Department of Health agrees with this change.

Section 4, Page 2, Lines 12 through 20 adds several definitions to ensure clarity and to streamline the use of these terms. With the addition of the definition for "Department", we have proposed to remove "of human services" throughout the chapter.

Section 5, Page 2, Line 21 through Page 3, Line 2 proposes to remove obsolete language and provide authority for the Department to publish dashboard reports about program utilization and provider care trends.

Section 6, Page 3, Lines 17 through 19 proposes clarity to how civil monetary penalty monies can be utilized. While the current language is technically correct; the Department proposes for the language to be broader, to allow other uses if the federal government broadens the use of civil monetary funds (e.g. to be used to enhance home and community-based services).

Section 7, Page 4, Lines 13 through15 and 18 and 19 proposes simplifying the use of the term "third party medical coverage".

Section 9, Page 5, Line 16 replaces the word "equal" with "up" to ensure that if there were significant increases in the community spouse resource allowance at the federal level, that the Legislature would have the opportunity to discuss an increase before it is automatically made by the Department.

Section 11, Page 7, Lines 3 and 4 are no longer necessary as this certification has already taken place.

Section 12, Page 7, Lines 10 and 19 simplify the reference to Medicaid "medically needy" coverage. The new, proposed language simply says North Dakota will have "medically needy" coverage and will have an income level no less than the level required by federal law.

Section 12, Page 7, Lines 23 and 24 requests authority for the Department to require, as a condition of eligibility, individuals eligible for Medicare Part A, B or D to apply for the coverage. The Department has encountered situations where clients refuse to apply for such coverage, which results in use of state funds for certain services (Citation: 42 Code of Federal Regulation (CFR) 431.625 (d) (3) *"No FFP is available in State Medicaid expenditures that could have been paid for under Medicare Part B but were not because the person was not enrolled in Part B."*).

Section 13, Page 8, Lines 3 through 6 proposes to replace reference to "family" with "household", which is consistent with Medicaid eligibility terms.

Section 14, Page 8, Line 14 through Page 12, Line 14 proposes to remove language based on a discussion in 2018 with the Centers for Medicare and Medicaid Services (CMS). CMS is the federal agency that funds the federal portion of Medicaid expenditures and has instructed the Department that changes to current statute are necessary to be consistent with federal law. The federal law regarding annuities was part of the Deficit Reduction Act of 2005, and provides that the purchase of an annuity after February 8, 2006, shall be treated as a disqualifying transfer unless certain requirements are met.

Section 50-24.1-02.8 currently includes provisions that are not included in federal law; specifically, provisions that relate to purchases prior to February 8, 2006, and provisions that relate to treating the annuity as an available asset. CMS has advised the Department that those additional provisions are problematic because they exceed the requirements in federal law. Additionally, the 8th Circuit Court of Appeals ruled against the Department in *Geston v. Anderson*, a case involving the purchase of an annuity that the Department treated as an available asset.

Subsections 2 through 5, located on page 8, line 21, through page 10, line 26, are provisions that relate to annuities purchased prior to February 8, 2006, and annuities under these provisions would be treated as either an available asset or a

disqualifying transfer if the requirements were not met. These provisions are proposed to be removed because CMS guidance states that an annuity cannot be an available asset unless it can be liquidated. Additionally, the five-year look-back rule ensures that no annuity purchased before February 8, 2006, would be a disqualifying transfer.

Subsection 7, located on page 11, line 17, through page 12, line 3, is also proposed to be removed because of CMS guidance and the *Geston* case. As it is currently written, this provision would treat an annuity that does not meet the requirements as an available asset. CMS has objected to this provision because it exceeds the requirements of the federal law. In the *Geston* case, the 8th Circuit Court of Appeals affirmed the federal district court holding that this provision is preempted by federal law.

The changes proposed for Subsection 8, located on page 12, lines 4 through 14, would amend the subsection to conform with federal law.

Section 15, Page 12, Line 20 proposes to include receipt of "home and community-based services" as a criteria for individuals to receive the deduction of real estate taxes from rental property from their countable gross income. Including home and community-based services was discussed in 2011 when HB 1320 enacted the change for individuals receiving "nursing care services"; however, it was not adopted. The Department is proposing this change to continue to ensure barriers to receipt of home and community-based services are removed.

Section 18, Page 14, Lines 3, 13, 22 and 27 makes a necessary change to the list of individuals subject to a criminal history record check as "staff member of the applicant provider or provider" are not subject to such checks.

Section 18, Page 14, Line 5 removes "a law enforcement agency" as they would already be "any agency authorized to take fingerprints".

Section 19, Page 15, Line 15 simplifies the words used to codify the authority of the Department to adopt rules.

Section 22, Page 17, Line 31 through Page 18, Line 2 removes language about negotiating rates. The Department does not believe the language is necessary, as each Legislative Assembly directs the annual amount of provider inflation (or other adjustments) to be granted.

Section 23, Page 18, Lines 14 through 25 updates language to ensure that coverage would be allowed for men who may be diagnosed with breast cancer and simplifies the reference to the poverty level to be consistent with other references in this chapter and in 50-29 (Senate Bill 2106).

Section 24, Page 18, Line 28 through Page 19, Line 2 proposes to remove unnecessary information and simply state the Department shall implement personal care services.

Section 25, Page 19, Lines 13 through 15 remove reference to examples of activities of daily living (ADLs), as the examples are unnecessary.

Section 26, Page 19, Lines 28 through 30 remove reference to applying for a waiver, since the waiver is “in force” and administered by the Department, and 50-24.1-01.1 provides the authority for the Department to submit state plans and seek waivers.

Section 27, Page 20, Lines 5 through 13 clarify definitions in this section. The proposed change to “Denial of payment” is necessary to ensure providers have appeal rights if a claim is recouped or adjusted as a result of an audit or review. In addition, the proposed change to “Provider” is necessary as some providers contract

with a third-party billing agency to manage certain claims processing functions on their behalf.

Section 27, Page 20, Lines 14 through 18 clarify the process around submitting a written request for review; and **Lines 20 through 22** clarify limitations of when a provider may not request a review.

Section 27, Page 21, Lines 1 and 2 propose the addition of “or as soon thereafter as possible” to recognize there are times when the seventy-five day window is not feasible. The Department strives to achieve the seventy-five day window, but cannot control unexpected staff absences or a high volume of appeals.

Section 28, Page 21, Lines 22 through 27 removes reference to “apply for” as this has already occurred and adds language to provide authority for an age range for the autism spectrum disorder waiver. Because the proposed changes expand this section to referencing more than the Children with Extraordinary Medical Needs waiver, it was necessary to modify the last sentence to make it clear that the “degree of need” is only applicable to the Children with Extraordinary Medical Needs waiver.

Section 29, Page 22, Lines 3 through 8 and 20 through 25 were relevant during the period of transition to Medicare Part D. These sections are no longer necessary.

Section 30, Page 23, Lines 7 and 8 are not needed as the definition has been added on page 2, Lines 17 and 18.

Section 31, Page 25, Lines 2 through 6 are not needed as the definition has been added on page 2, Lines 16, 19, and 20.

Section 32, Page 27, Lines 6 and 7 updates the reference to the poverty level to be consistent with other references in this chapter and in 50-29 (Senate Bill 2106).

Section 33, Page 27, Lines 15 through 21 removes outdated language and clarifies that receipt of services are based on the functional criteria established for the services.

Section 34, Page 27, Line 28 through Page 28, Line 2 removes the contingent effective date and clarifies Medicaid coverage for inpatient claims for inmates who are otherwise Medicaid eligible.

Section 35, Page 28, Line 10 is not needed as the definition has been added on page 2, Line 16.

Section 35, Page 29, Line 20 proposes the addition of "or as soon thereafter as possible" to recognize there are times when the seventy-five day window is not feasible. The Department strives to achieve the seventy-five day window, but at times has unexpected staff absences or priorities.

Section 37, Page 30, Section 37 proposes repeal of the following sections:

50-24.1-01.2. Department may establish and administer state unified dental insurance coverage plan.

This section was added in 1993 (Senate Bill 2408) and has not been amended since that time. Per legislative history, the bill was an effort to help make it easier for individuals to receive dental care on medical assistance. Prior to the bill, dentists felt their level of reimbursement was too low, and the bill concept was to allow the Department to create a plan to obtain federal waivers to allow establishment of a state dental insurance plan to be administered by a private entity with government oversight.

50-24.1-10. Joint Medicaid payment account - Educationally related services.
This language was created during the 1989 Legislative Session and has not been amended since that time. The Department's Fiscal Administration staff confirmed

there is no existing account for this purpose and the Department of Public Instruction supported repealing this section.

50-24.1-11. Joint Medicaid payment account - North Dakota vision services – school for the blind.

This section was initially established during the 1989 Legislative Session by SB 2538. The only time this language was amended was in 2001 by HB 1038, and in that instance the only change made was shortening the name of the institution to "school for the blind". The Department's Fiscal Administration staff confirmed there is no existing account for this purpose and Superintendent of the School for the Blind supported repealing this section.

50-24.1-13. Provider reimbursement rates.

This language was enacted by HB 1050 from 1995 Legislative Session. The Department does not believe the language is necessary, as each Legislative Assembly directs the annual amount of provider inflation (or other adjustments) to be granted.

50-24.1-19. Oral maxillofacial services - Medical necessity.

The section was the result of 2001 SB 2403, it has never been amended. The Department is proposing repeal as medically necessary services are required to be covered for children eligible for Medicaid and would be covered for adults if the impairment was impacting their ability to eat, drink, swallow or speak.

50-24.1-22. Long-term care facility information.

Section 3 of this bill proposes to move section 50-24.1-22 to chapter 50-10.2 of the North Dakota Century Code.

50-24.1-25. Operating costs for developmental disabilities service providers.

This language was adopted in 2005, by SB 2342. The Department does not believe the language is necessary, as each Legislative Assembly directs the annual amount of provider inflation (or other adjustments) to be granted.

50-24.1-27. Medical assistance program management.

This section was added during the 2005 Legislative Assembly. The Department prepared information and reports as a result of the 2005 legislation and is recommending removing the section as it is obsolete.

50-24.1-34. Processing of claims submitted on behalf of inmates.

As noted earlier, in Section 1 of this bill, the Department is proposing creating a new section in chapter 12-44.1 of the North Dakota Century Code to allow the county jails to access the Medicaid fee schedule; however, the Department would no longer process medical claims for the county jails.

50-24.1-38. Health-related services - Licensed community paramedics.

The Department is proposing removal of this section for several reasons: Due to the 2016 budget allotment, the Department had already proposed to limit the services to immunizations; no appropriation was received during the 2015 session for this purpose; and the Department has learned there are about ten of these individuals in the State and they are in the urban areas, which is not what was understood during the addition of this provider group during the 2015 Legislative Session.

This concludes my testimony. I would be happy to address any questions that you may have.