TESTIMONY BEFORE THE BUDGET COMMITTEE ON HUMAN SERVICES

DECEMBER 14, 2005

Chairman Dever, and members of the committee, I am Maggie Anderson, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding the Department's efforts on tasks assigned through House Bill 1459 and House Bill 1460.

2005 HOUSE BILL 1459

<u>Target Case Management/Disease Management</u>

After review of the top 2,000 high cost Medicaid recipients and their respective disease conditions, disease case management efforts will likely target recipients with: (1) asthma, (2) diabetes, (3) congestive heart failure (CHF), (4) chronic obstructive pulmonary disease (COPD), and (5) depression. Often, these diseases co-exist, meaning the majority of recipients have a dual diagnosis.

By supporting Medicaid recipients in managing their specific conditions, the Medicaid program will be instrumental in increasing the potential for the recipients to experience a healthier life. Disease case management could be monitored in several ways including face-to-face case management, telephone support, and pharmaceutical education, depending on the recipient's specific health care needs.

To facilitate development of an approach to disease case management, Department staff has involved representatives from the North Dakota Department of Health, Community Healthcare Association of the Dakotas (representing the

rural health clinics and federally qualified health centers), and the Home Health Care Association in the planning process.

The Department is currently procuring a consultant with specific expertise in implementing disease case management programs in other states. The consultant will be used to: (1) determine a model program for implementation, (2) draft a Request for Proposal (RFP) to identify service providers, and (3) work with the state to calculate a valid return on investment. It is expected that the RFP will be released this winter with program implementation by mid-year 2006.

Diagnosis and Reason Codes

We have reviewed our current policies and historical data to determine if we could improve the integrity of our operations by requiring providers who are not currently using ICD-9 (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis codes to submit claims with these codes. ICD-9 codes are a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan recipients.

The claims we do receive without diagnosis information are from providers where the type of service being provided does not require the use of a diagnosis code. Below is a list of providers that are not required to submit claims with ICD-9 diagnosis codes. In addition, we have provided the number of claims, by provider type, that were received in calendar year 2004.

Dental Providers

These claim types and services do not currently require a diagnosis. (Claims submitted in 2004: 54,151)

Pharmacy Providers

These claim types and services do not currently require a diagnosis. (Claims submitted in 2004: 1,496,499)

DD Providers

These claim types and services do not currently require a diagnosis. They are providing a non-medical service; therefore ICD-9 codes do not apply. (Claims submitted in 2004: 46,403)

Qualified Service Providers

These claim types and services do not require a diagnosis. They are providing a non-medical service; therefore ICD-9 codes do not apply. (Claims submitted in 2004: 56,734)

Basic Care Providers

These claim types and services do not require a diagnosis. They are providing a non-medical service; therefore ICD-9 codes do not apply. (Claims submitted in 2004: 16,856)

Nursing Homes

Before June 15, 2004, nursing home claims did not require a diagnosis. These claim types now require a diagnosis code. (Claims submitted in 2004: 42,219)

ICF/MRs (Intermediate Care Facilities)

Before June 15, 2004, ICF/MR claims did not require a diagnosis. These claim types now require a diagnosis code. (Claims submitted in 2004: 13,600)

Non-Emergency Transportation

These claim types and services do require a diagnosis to process through our system. However, since they are providing a non-medical service, the ICD-9 codes do not apply. Therefore, they must bill using an unspecified, dummy ICD-9 in order for the claim to process through the system.

Please advise if you would like additional information on this topic.

Mental Health Treatment

A preliminary meeting has been held with staff from the Medical Services and Mental Health and Substance Abuse Services Divisions. The members of this group are the same staff members who are concentrating on the implementation of Medicare Part D, which has been a priority at this time.

Because Medicaid is a physician driven program, three years ago, we initiated a contract with Comprehensive Neuro Sciences (CNS). Under the contract, CNS reviews pharmaceutical claims, based on 27 indicators, for appropriate use of medications. For example, if a child is prescribed five or more prescriptions for mental health drugs, the providers will receive educational letters from CNS.

Out of State Nursing Home Usage

North Dakota residents who enter a nursing facility in another state, with the exception of Minnesota, become a resident of the other state and must apply for Medicaid in that state. In some instances North Dakota may cover a North Dakota resident until the end of the month in which they are admitted if the individual would otherwise not be eligible in the receiving state.

Since 1993, North Dakota has had a reciprocity agreement with Minnesota for determining the state of residence for individuals entering nursing facilities in both states. If a North Dakota resident enters a Minnesota nursing facility, they are considered a North Dakota resident for two years from the date of admission and could be eligible for North Dakota Medicaid during that period. An exception to this is if the individual has a spouse in a North Dakota community. He or she

continues to be a North Dakota resident, as long as the spouse is a North Dakota resident.

Currently, there are approximately 55 North Dakota residents in Minnesota nursing facilities who are North Dakota Medicaid eligible, and receiving benefits. Minnesota has approximately 35 residents who are Minnesota Medicaid eligible and residing in North Dakota nursing facilities. Of the 55 North Dakota residents in Minnesota facilities, 70% reside in border towns, with the largest percentage residing in Breckenridge.

Currently, the average cost to North Dakota Medicaid for all Nursing Facility residents is $130 per day. The average cost to North Dakota Medicaid for residents in Minnesota facilities is $126 per day. On an annual basis, the total funds that North Dakota Medicaid pays Minnesota facilities is approximately $800,000 more than what Minnesota Medicaid pays North Dakota facilities.

Reasons to Continue:

- **Ease of access for residents living in border towns.**
- **Both states have rate equalization and honor each others' rate.**

Reasons to Discontinue:

- **Admission criteria are different in each state. After 24 months, if they were on the other state's Medicaid, they may not be eligible when they switch.**
- **Billing issues arise with different payment methodologies. Aside from rate equalization, North Dakota payments are different from Minnesota payments, with regard to items such as bed hold, oxygen, and therapies. Payment errors could occur, due to edit checks not applying to Minnesota claims. We essentially rely on Minnesota to bill correctly.**

If the committee would like additional information, we can provide the requested items at the next meeting of this committee.

Post Office or Street Addresses

The addresses reported by Medicaid clients are entered into the eligibility systems by eligibility staff at the time of enrollment, or upon notification of change from the client. If the client has a residence address (street address, it is entered. Mailing addresses are also entered, if they are different from the residence address. These could be post office boxes, or in care of someone else, in the case of a guardian. When addresses are entered into the system, a program (Finalist) runs to ensure the address is valid and that the correct abbreviations are used. When notices are printed, the system has another address correction program that further checks to ensure the address is valid, per the postal system.

Medicaid is required to send regular notices for various program purposes. If we want the recipients to receive their notices properly, we must use the mailing addresses provided by the clients. Some locations in North Dakota only have a post office box. Based on information the Department received from the United States Postal Service, there are 301 towns in North Dakota with mail delivery. Of those, 22 have city (street address) delivery and 279 have post office box delivery.

The Department is not aware of any problems encountered in the current system and recommends that no action be taken to require a certain type of address to be used.

Prior Authorization of High Cost Medical Procedures

Department staff members have reviewed the procedures to consider for prior authorization. The procedures that have surfaced at this time include Magnetic

Resonance Imaging (MRI), Positron Emission Tomography (PET) scans, and Computed Tomography (CT) scans. Estimates are being collected from entities that provide this type of prior authorization service to determine the average time per authorization and the potential savings from the prior authorization efforts. The Department will summarize these estimates in preparation for the 2007-2009 budget cycle. It will be necessary to release a Request for Proposal (RFP) for this service, as it would not be feasible for the Department's current utilization staff to absorb these efforts. If it is the committee's desire for the Department to consider procedures other than those noted (MRI, PET, and CT), please advise and these can also be included in the RFP.

<u>Photo Identification on Medicaid ID Card</u>

The Legislature asked the Department to consider the addition of a photo to the Medicaid ID cards; therefore the Department amended our RFP for this service to include a cost estimate from the vendors on adding a photo to each card. The proposals for this RFP were due September 30, 2005; however, no bids were received for the cards, or for the photo estimate. The Department extended the contract of our current ID card vendor. The current price per card is $.50, without a picture. Based on information we have gathered from potential vendors, we are estimating the cost of the card to increase $1.00 per card to add the picture. This does not include the costs to actually take the picture and send it to the ID Card vendor. Initially, all cards would have to be replaced, so it is estimated that the initial run would cost around $80,000.

The Department is still pursuing how the actual pictures would be made available. Since face-to-face eligibility applications are not required, we would need to develop a method to have pictures taken of every recipient. The Department of Transportation is a resource for those recipients with a valid Driver's License. However, this will not be for the majority of the children, disabled and elderly

recipients. Any input or guidance that this committee has in regard to how we would secure the pictures, would be most helpful and appreciated.

In addition, in order for us to refine and finalize this cost information, your input regarding how long the picture should be valid is also needed.

Tamper Resistant Prescription Pads

The Department supports the concept of tamper-resistant prescription pads; however, such a requirement, in order to be effective, would need to be implemented on a state-wide basis for all prescribers. Such a system would not be appropriate for the Department to direct rather, it would be best directed by the North Dakota Board of Pharmacy and the Board of Medical Examiners.

The Department recommends that, if the Legislature wants to pursue the use of Tamper Resistant Prescription Pads, that it consider assigning that responsibility to an entity with state-wide, all-prescriber capabilities.

Information Efforts – Medicare Part D

The Department has partnered with the North Dakota State Library to use two of their services: Talking Books and Dakota Radio Information Services (DRIS) to provide specific information regarding Medicare Part D. First, we submitted an article, which was included in their fall edition of the *Discovery* newsletter. This newsletter is sent to patrons who subscribe to Talking Books and DRIS, and in addition, is recorded and distributed to patrons who are not able to read the large-print version. Second, the Department submitted two fact sheets, which were broadcast for two weeks on the DRIS programs. The state library has received positive feedback on these efforts.

Risk-Sharing Agreements

Karin Mongeon, the Department's Managed Care Administrator and I met with Chip Thomas of the North Dakota Healthcare Association to begin conversations regarding the potential expansion of managed care. Mr. Thomas has drafted a framework for a discussion that we plan to expand to several interested entities. In addition, the Department has held meetings with two interested parties to discuss the possibility of implementing a Program for All-Inclusive Care of the Elderly (PACE) program in North Dakota.

Once an actuary contract is awarded and work ensues, we plan to move forward with these efforts to expand the managed care options within North Dakota.

I will cover the efforts of the Prescription Drug Monitoring Workgroup later on your agenda.

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On August 22, 2005, the Department released a Request for Proposal (RFP) for the purpose of securing a vendor to provide actuary rates for Managed Care, PACE, and Fee-for-Service. The draft of the RFP was sent to various stakeholders for review and input. The stakeholders included the North Dakota Healthcare Association, the North Dakota Medical Association, and Legislative Council. The input and recommendations were incorporated into the final RFP. Responses to the RFP were due September 16, 2005. The original proposals were cost prohibitive; therefore, the Department had to amend the RFP and request alternate proposals. The second proposals were received November 15, 2005 and were reviewed and scored. The Department is in the process of negotiating with two vendors, as one vendor has the lower bid for the managed care rate, and the other submitted the lowest bid for the PACE and Fee-for-Service rates. We expect to have a contract in place by January 1, 2006.

In addition, the Department has convened a working group to prepare the eventual report requested in House Bill 1460. Because it was necessary for the Department to amend the original RFP, we do not anticipate having the report finalized until mid-summer 2006.

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