

Testimony
Engrossed House Bill 1115 – Department of Human Services
Senate Human Services Committee
Judy Lee, Chairman

March 4, 2019

Chairman Lee, members of the Senate 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 Engrossed 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 18 and 19 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 2, Page 2, Lines 2 through 6 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 3 Page 2, Lines 10 through 15 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 4, Page 2, Lines 19 through 22 adds language that prohibits the Department from requiring additional documentation on certain claims when Medicare is the primary payer and Medicaid is secondary. This language was added by the House and the Department does not object to this addition.

Section 5, Page 2, Line 26 through Page 3, Line 3 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 19 through 21 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 16 through 18 and 21 and 22 proposes simplifying the use of the term “third party medical coverage”.

As introduced, **Section 9, Page 5, Line 21** replaced the word “equal” with “up”. The House Human Services committee intended to change this back to “equal” and the Department was not opposed to that; however, the change is not in Engrossed House Bill (EHB) 1115; therefore, Department is offering the attached amendment to remove the overstrike over “equal” and remove “up” on Line 21.

Section 11, Page 7, Lines 7 and 8 are no longer necessary as this certification has already taken place.

Section 12, Page 7, Lines 14 through 23 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 27 and 28 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 8 through 10 proposes to replace reference to “family” with “household”, which is consistent with Medicaid eligibility terms.

Section 14, Page 8, Line 25 through Page 12, Line 17 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 25, through page 10, line 29, 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 22, through page 12, line 6, 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 7 through 17, would amend the subsection to conform with federal law.

Section 15, Page 12, Line 23 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 5, 15, 24, 25 and 29 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 7 removes “a law enforcement agency” as they would already be “any agency authorized to take fingerprints”.

Section 19, Page 15, Line 17 simplifies the words used to codify the authority of the Department to adopt rules.

Section 22, Page 18, Line 2 ensures that expenditures under 50-24.1-34 relating to the Department processing county jail medical claims are not the responsibility of the federal government or the State of North Dakota, but rather are the responsibility of the applicable county jail.

Section 23, Page 18, Lines 8 through 10 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 24, Page 18, Line 25 through Page 19, Line 2 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 25, Page 19, Lines 5 through 9 proposes to remove unnecessary information and simply state the Department shall implement personal care services.

Section 26, Page 19, Lines 20 through 22 remove reference to examples of activities of daily living (ADLs), as the examples are unnecessary.

Section 27, Page 20, Lines 6 through 8 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 28, Page 20, Lines 13 through 21 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 28, Page 20, Lines 22 through 26 clarify the process around submitting a written request for review; and **Lines 28 through 30** clarify limitations of when a provider may not request a review.

As introduced, Section 27, Page 21, Lines 1 and 2 proposed to add “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. Through discussion with House Human Services, the Department drafted amendments to separate the time-frame for actions related to denied payment or reduction of the level of service payment from those actions related to recoupment or adjustment to a claim, or part of a claim following an audit. In review of EHB 1115, the Department noted a few edits we believe are needed and are included in the proposed, attached amendments.

Section 29, Page 22, Lines 4 through 9 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 30, Page 22, Lines 14 through 19 and Page 23 Lines 1 through 6 were relevant during the period of transition to Medicare Part D. These sections are no longer necessary.

Section 31, Page 23, Lines 19 and 20 are not needed as the definition has been added on page 2, Lines 12 and 13.

Section 32, Page 25, Lines 15 through 19 are not needed as the definition has been added on page 2, Lines 11, 14, and 15.

Section 33, Page 27, Lines 17 and 18 updates the reference to the poverty level to be consistent with other references in this chapter and in 50-29 (Senate Bill 2106).

Section 34, Page 27, Line 26 through Page 28, Line 3 removes outdated language and clarifies that receipt of services are based on the functional criteria established for the services.

Section 35, Page 28, Lines 10 through 19 provides clarifications and updates language in this section. As introduced, the Department, through House Bill 1115, proposed to repeal 50-24.1-34 and 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. Under the original proposal, 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 House did not concur with the Department's proposal regarding processing claims on behalf of county jail inmates and reinserted 50-24.1-34.

Section 36, Page 28, Lines 22 through 28 removes the contingent effective date and clarifies Medicaid coverage for inpatient claims for inmates who are otherwise Medicaid eligible.

Section 37, Page 29, Line 6 is not needed as the definition has been added on page 2, Line 11.

Section 39, Page 31 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.

Section 40, Page 31, Lines 21 and 22 propose an effective date of January 1, 2020 for Section 4 of EHB 1115.

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