

OTHER DUTIES OF THE HUMAN SERVICES COMMITTEE - BACKGROUND MEMORANDUM

In addition to the study responsibilities assigned to the Human Services Committee for the 2011-12 interim, the committee has also been assigned to:

- Receive annual report from the Department of Human Services describing enrollment statistics and costs associated with the children's health insurance program state plan (North Dakota Century Code Section 50-29-02 ([Appendix A](#))).
- Receive a report from the Health Information Technology Advisory Committee by June 30, 2012, regarding the outline on how best to standardize drug prior authorization request transactions between providers and payers, insurance companies, and pharmacy benefit managers (Section 2 of 2011 House Bill No. 1422 ([Appendix B](#))).
- Receive periodic reports from the Department of Human Services during the 2011-12 interim regarding the status of the dementia care services program (Section 6 of 2011 Senate Bill No. 2012 ([Appendix C](#))).
- Receive reports from the Department of Human Services and its steering committee beginning in June 2012 regarding the development of a new developmental disabilities reimbursement system (Section 1 of 2011 Senate Bill No. 2043 ([Appendix D](#))).
- Receive preliminary findings and any recommendation from the Department of Human Services before September 30, 2012, regarding the department's comprehensive review of the substance abuse services pilot voucher payment program (Section 2 of 2011 Senate Bill No. 2326 ([Appendix E](#))).

CHILDREN'S HEALTH INSURANCE PROGRAM

Section 50-29-02 provides that the Department of Human Services is to prepare, submit, and implement a children's health insurance program state plan and report annually to the Legislative Management and describe enrollment statistics and costs associated with the plan. The responsibility to receive the report has been assigned to the Human Services Committee.

Healthy Steps--North Dakota's children's health insurance plan--provides premium-free health coverage to uninsured children in qualifying families. It is intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage, but not enough to afford private insurance. To be eligible for the program, the family's net income may not exceed 160 percent of the federal poverty level.

Legislative Appropriations

The schedule below summarizes legislative appropriations for the Healthy Steps program:

	General Fund	Federal Funds	Total
2003-05	\$2,127,162	\$7,359,222	\$9,486,384
2005-07	\$2,895,233	\$9,180,309	\$12,075,542
2007-09	\$4,669,885	\$15,534,861	\$20,204,746
2009-11	\$5,598,799	\$16,033,737	\$21,632,536
2011-13	\$8,517,391	\$19,007,011	\$27,524,402

Federal Medical Assistance Percentage and North Dakota's Allocation

The schedule below summarizes the federal medical assistance percentage (FMAP) and North Dakota's allocation of federal funds for the Healthy Steps program:

Federal Fiscal Year Ending	FMAP ¹	North Dakota Allocation
September 30, 2003	77.85%	\$5,437,000
September 30, 2004	77.82%	\$5,437,000
September 30, 2005	77.24%	\$6,384,719
September 30, 2006	76.10%	\$6,346,156
September 30, 2007	75.30%	\$7,737,529
September 30, 2008	74.63%	\$11,017,680 ²
September 30, 2009	74.21%	\$15,821,554
September 30, 2010	74.11%	\$16,595,628
September 30, 2011	72.25%	\$15,257,665
September 30, 2012 (estimate)	68.78%	\$17,773,917
September 30, 2013 (estimate)	68.78%	\$17,773,917

¹The federal fiscal relief FMAP was in effect for five quarters--April 2003 through June 2004.

²This amount includes one-time additional federal funding of \$3,128,684.

Children Enrolled and Premium Rates

The schedule below summarizes the average annual recipients and premium rates in effect for the majority of the year for the majority of children covered:

State Fiscal Year Ending	Average Annual Recipients	Monthly Average Premium Rates
June 30, 2005	2,322	\$154.78
June 30, 2006	3,329	\$181.90
June 30, 2007	3,821	\$183.45
June 30, 2008	4,006	\$202.32
June 30, 2009	3,470	\$204.03
June 30, 2010	3,368	\$229.18
June 30, 2011	3,716 (estimate)	\$228.56 (estimate)
June 30, 2012	4,086 (estimate)	\$272.67 (estimate)
June 30, 2013	4,326 (estimate)	\$272.67 (estimate)

HEALTH INFORMATION TECHNOLOGY

Section 1 of House Bill No. 1422, codified as Section 23-01-38, provides that:

- Effective August 1, 2013, a drug prior authorization request must be accessible to a health care provider with the provider's electronic prescribing software system and must be accepted electronically, through a secure electronic transmission, by the payer, by the insurance company, or by the pharmacy benefit manager responsible for implementing or adjudicating or for implementing and adjudicating the authorization or denial of the prior authorization request.
- Effective August 1, 2013, electronic transmission devices used to communicate a prescription to a pharmacist may not use any means or permit any other person to use any means, including advertising, commercial messaging, and popup advertisements, to influence or attempt to influence, through economic incentives, the prescribing decision of a prescribing practitioner at the point of care. Such means may not be triggered by or be in specific response to the input, selection, or act of a prescribing practitioner or the prescribing practitioner's staff in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy. Any electronic communication sent to the prescriber, including advertising, commercial messaging, or popup advertisements, must be consistent with the product label, supported by scientific evidence, and meet the federal Food and Drug Administration requirements for advertising pharmaceutical products.
- Electronic prescribing software may show information regarding a payer's formulary if the software is not designed to preclude or make more difficult the act of a prescribing practitioner or patient selecting any particular pharmacy or pharmaceutical.

Section 2 of House Bill No. 1422 provides that during the 2011-12 interim, the Health Information Technology Advisory Committee is to establish an outline on how best to standardize drug prior authorization request transactions between providers and the payers, insurance companies, and pharmacy benefit managers responsible for adjudicating the authorization or denial of the prescription request. The outline must be designed with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions and alignment with standards that are or will potentially be used nationally. By June 30, 2012, the Health Information Technology Advisory Committee is to provide a report to the Legislative Management regarding the outline on how best to standardize drug prior authorization request transactions. This

responsibility has been assigned to the Human Services Committee.

DEMENTIA CARE SERVICES PROGRAM

The 2007-08 interim Long-Term Care Committee studied the availability of and future need for dementia-related services and funding for programs for individuals with dementias. The committee learned the following services are available for individuals with dementia:

- Skilled nursing facilities.
- Assisted living/basic care facilities.
- In-home care providers.
- Adult day care programs.
- Adult foster care.
- Medical professionals.
- Support groups.
- Care consultation/geriatric case managers.

The committee recommended House Bill No. 1043, which was approved by the Legislative Assembly in 2009. The bill:

- Directed the Department of Human Services to contract with a private provider for a dementia care services program in each area of the state served by a regional human service center. The dementia care services must include:

Identifying available services within the region.

Providing information to medical professionals, law enforcement, and the public regarding the symptoms of dementia, the benefits of early detection and treatment, and the services available to individuals with dementia and their caregivers.

Assessing the needs of individuals with dementia and their caregivers.

Training care providers to manage and provide for the care of individuals with dementia.

Providing consultation services to individuals with dementia and their caregivers.

Facilitating the referral of individuals with dementia and their caregivers to appropriate care and support services.

- Provided for a report to the Legislative Management regarding the outcomes of the program.
- Provided a \$1.2 million general fund appropriation for the program.

The 2009-10 interim Long-Term Care Committee received reports from the Department of Human Services regarding the dementia care services program and learned that the department entered a contract with the Alzheimer's Association of

Minnesota-North Dakota Chapter for provision of a dementia care services program in each area of the state served by a regional human service center. The association hired five regional care consultants to provide services in the state. The consultants have been fully trained and are networking with other agencies and organizations to coordinate efforts, develop referral processes, and assure that services are not duplicated. Preliminary outcomes include:

- The number of citizens completing intake into the program continues to grow each month.
- Services are being provided in all eight human service regions.
- An estimated 56 percent of those living with Alzheimer's disease remain in their own home.
- Families caring for the family member in their own home are those needing the greatest assistance.

The Legislative Assembly in 2011 provided a \$1.2 million general fund appropriation to the Department of Human Services for continuing the dementia care services program for the 2011-13 biennium.

Section 6 of Senate Bill No. 2012 provides that the Department of Human Services is to report periodically to the Legislative Management regarding the status of the dementia care services program. The reports must include information on budgeted and actual program expenditures, program services, and program outcomes. The responsibility to receive the reports has been assigned to the Human Services Committee.

DEVELOPMENTAL DISABILITIES REIMBURSEMENT SYSTEM

House Bill No. 1556 (2009) provided that during the 2009-10 interim the Department of Human Services contract with an independent contractor to study the methodology and calculation for the ratesetting structure used by the department to reimburse all developmental disabilities service providers, including public and private, licensed developmental disabilities ICF/MR facilities, such as the Anne Carlsen Center, and home and community-based service providers serving ICF/MR medically fragile and behaviorally challenged individuals. The study was to address reimbursement adequacy and equitability and fairness of reimbursement rates among providers; the level of medical and supportive services required by providers to adequately serve individuals in those categories; the varying levels of medical and behavioral complexity of individuals requiring services by the providers; and any other analytical comparisons bearing upon issues of reimbursement adequacy, fairness, and equitability to providers. The bill provided a \$200,000 appropriation, of which \$100,000 was from the general fund, to the department for conducting the study.

The 2009-11 interim Long-Term Care Committee received information from the Department of Human Services regarding the state's developmental disabilities ratesetting process. The committee learned the current ratesetting process for the developmental disabilities program is a mix of a cost-based, retrospective ratesetting system with additional compensation provided for individuals who are medically fragile or behaviorally challenged. The following is a summary of the ratesetting and reimbursement process:

1. Submission of a provider budget - Each developmental disabilities service provider submits an annual budget based on allowable, reasonable, and client-rated costs to the department's Developmental Disabilities Division, and an interim rate is established.
2. Establishment of a provider budget limitation - Provider budget limitations are used to implement available appropriations and apply appropriation increases or decreases. Payments are made in the current year based on this interim rate.
3. Application of targeted appropriations - After the budget limitation and interim rate are set, targeted appropriations tied to six specific categories of adults and children who are medically fragile or behaviorally challenged are applied. These targeted appropriations are based on two assessment tools. Payments for these targeted groups are totaled by provider, and each provider is paid that provider's allotment on a quarterly basis.
4. Submission of cost reports - At the end of the provider's fiscal year, a cost report is submitted to the department's Developmental Disabilities Division. Providers are allowed three months with a potential of a one-month extension to submit their cost reports.
5. Audits and cost settlement - The department conducts an annual compliance audit of reported costs for each provider, and the audited, allowable costs are compared to the reimbursements received through the interim rate. Final payments are cost-settled after completion of an audit. Actual revenue received by a provider is limited to the lesser of the budget limitation or costs, whichever is less. The audit and cost settlement is a lengthy process. Some audits and cost settlements are completed approximately 20 months after the end of the fiscal year.

The committee learned that the Department of Human Services contracted with Burns & Associates, Inc., to complete the study. The following is a summary of findings and recommendations by Burns & Associates, Inc.:

Assessment findings and recommendations	<p>Discontinue use of the Oregon behavioral assessment for both children and adults</p> <p>The Oregon medical assessment does not have predictive value for children, but it is no better than the currently used progress assessment review to predict costs for adults.</p> <p>The progress assessment review is a powerful tool and predicts 43.1 percent of the current developmental disabilities expenditures.</p>
Reimbursement systems findings	<p>North Dakota's current system is seen by providers to adequately pay in total for services and supports, but the dollars are not always distributed to the individuals who are medically fragile or behaviorally challenged.</p> <p>Other states that base payment on the needs of individuals do not use cost-based reimbursement systems.</p> <p>North Dakota's reimbursement system is slow and very resource-intensive.</p>

The committee learned Burns & Associates, Inc., offered four options for consideration by the state--two options for adults and two options for children. The following is a summary of the four options:

Adults	<p>Option A - Revise and shorten the progress assessment review and continue the cost-based, retrospective reimbursement process</p> <p>Option B - Adopt a new assessment tool--supports intensity scale--and move to a prospective reimbursement process</p>
Children	<p>Option C - Pilot the child supports intensity scale and move to a prospective reimbursement process</p> <p>Option D - Continue the Oregon medical tool and add the child and adolescent level of care utilization system or other similar tools and continue the cost-based, retrospective reimbursement process</p>

The committee learned replacing the progress assessment review with the supports intensity scale would result in high administrative costs initially because it requires new assessments to be performed on all consumers and the results of those assessments to subsequently be used to develop a resource allocation model and prospective rates. However, administrative costs would decrease in future years. The following is a five-year summary of estimated state administrative costs for the four options:

	Options A and D		Options B and C	
	Low	High	Low	High
Year 1	\$1,422,000	\$1,665,000	\$2,459,000	\$2,879,000
Year 2	1,252,000	1,297,000	2,582,000	3,023,000
Year 3	1,314,000	1,362,000	1,586,000	1,586,000
Year 4	1,380,000	1,430,000	1,666,000	1,666,000
Year 5	1,449,000	1,501,000	818,000	818,000
Total	\$6,817,000	\$7,255,000	\$9,111,000	\$9,972,000

The committee learned the department agrees with the recommendation to move to a prospective reimbursement process using an independent ratesetting and resource allocation model for the entire developmental disabilities client base. The department recommends hiring a consultant to guide the ratesetting and assessment implementation process and to begin implementation with a pilot project.

The committee recommended Senate Bill No. 2043, which was approved by the Legislative Assembly. The bill provides that:

- The Department of Human Services, in conjunction with developmental disabilities service providers, develop a prospective or related payment system with an independent rate model utilizing the supports intensity scale.
- The department established a steering committee consisting of representatives from all interested providers and department representatives. The steering committee is to guide the development of the new payment system, including assisting a consultant to conceptualize, develop, design, implement, and evaluate a new payment system.
- The department contract with a consultant by September 1, 2011, to develop, in collaboration with the steering committee, the payment system and the resource allocation model tying funding to supports intensity scale assessed needs of clients.
- After the prospective or related payment system rates are developed, the new rates must be tested on a sampling of clients and providers, the sample to be determined by the steering committee, allowing sufficient time to capture provider cost, client-realized need, and service provision data. The consultant is to provide the appropriate sampling number to sufficiently test the rates, types of services, and needs of clients with the intent to include as many providers as fiscally feasible.
- The department contract with a team of supports intensity scale assessors by September 1, 2011. The team is to begin assessing immediately the client pilot group identified by the consultant.
- Once testing is complete, the data must be analyzed by the consultant, and the consultant is to make any needed rate adjustments, resource allocation modifications, or process assumptions.
- Implementation of any system developed may not occur before the implementation of the department's new Medicaid management information system.
- Beginning in June 2012, the department and the steering committee report development activities and status information to an interim

legislative committee. The responsibility to receive the reports has been assigned to the Human Services Committee.

SUBSTANCE ABUSE SERVICES PILOT VOUCHER PAYMENT PROGRAM

Senate Bill No. 2326 provides that the Department of Human Services is to establish and administer a pilot voucher payment program to provide substance abuse services for the 2011-13 biennium. The program must consist of voucher use and private choice as a method of providing substance abuse services to beneficiaries, and must allow a voucher to be submitted to the beneficiary's provider of choice for payment of substance abuse services. The department is to develop service agreements with substance abuse service providers licensed and accredited by the state to offer services in exchange for vouchers, which may be presented to the department for payment as provided for in the agreement. The payment amount may not exceed the cost of the same service provided by the state. The program must be developed to improve access to substance abuse services. The department is to apply for funding available through a federal access to recovery grant program available from the federal

substance abuse and mental health services administration center for substance abuse treatment. All money received by the department through the federal access to recovery grant for the pilot program is appropriated to the department for costs associated with the program. If the federal access to recovery grant funding is not available to the department, the department is not required to implement the pilot voucher payment program.

The department is to perform a comprehensive review of the substance abuse services pilot voucher payment program for the 2011-13 biennium. The review must include information regarding the cost of substance abuse services provided through the pilot voucher payment program compared to the cost of similar substance abuse services provided during the 2011-13 biennium. The review must also analyze the effect of the substance abuse services pilot voucher payment program on access to care and outcomes. The department is to report the preliminary findings of the comprehensive review and any recommendations for continuation or expansion of the pilot voucher payment program to the Human Services Committee prior to September 30, 2012.

ATTACH:5