19.8087.03000

FISCAL NOTE

Requested by Legislative Council
02/07/2019

Amendment to: HB 1115

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$500,000		$1,500,000
Expenditures				$500,000		$1,500,000
Appropriations				$500,000		$1,500,000

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1115 is a complete review of NDCC 50-24.1 - Medical Assistance for Needy Persons.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

As introduced, HB 1115 proposed to eliminate the requirement for the Department of Human Services (Department) to process claims on behalf of the county jails. Engrossed HB 1115 will continue to require the Department to process county jail claims. For the 2019-21 biennium, the Department of Human Services would need additional appropriation of $500,000, all of which is other funds, added to their base level budget in SB 2012.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Engrossed HB 1115 requires the Department to continue to process county jail claims. The Department charges the county jails for both a claims processing fee and for the actual amount paid on the claim. The additional $500,000 is estimated due to expected increases in the volume of claims. The additional revenue is other funds, which will come from the county jails to cover the cost of the claims processed by the Department.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Engrossed HB 1115 will continue to require the Department to process county jail claims. For the 2019-21 biennium, Department of Human Services would need an additional appropriation of $500,000, all of which is other funds, added to their base level budget in SB 2012.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Engrossed HB 1115 will continue to require the Department to process county jail claims. For the 2019-21 biennium, Department of Human Services would need an additional appropriation of $500,000, all of which is other funds, added to their base level budget in SB 2012.

Name: Heide Delorme

Agency: Human Services

Telephone: 701-328-4068

Date Prepared: 02/11/2019

19.8087.02000

FISCAL NOTE

Requested by Legislative Council
02/07/2019

Amendment to: HB 1115

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$500,000		$1,500,000
Expenditures				$500,000		$1,500,000
Appropriations				$500,000		$1,500,000

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1115 is a complete review of NDCC 50-24.1 - Medical Assistance for Needy Persons.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

As introduced, HB 1115 proposed to eliminate the requirement for the Department of Human Services (Department) to process claims on behalf of the county jails. Engrossed HB 1115 will continue to require the Department to process county jail claims. For the 2019-21 biennium, the Department of Human Services would need additional appropriation of $500,000, all of which is other funds, added to their base level budget in SB 2012.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Engrossed HB 1115 requires the Department to continue to process county jail claims. The Department charges the county jails for both a claims processing fee and for the actual amount paid on the claim. The additional $500,000 is estimated due to expected increases in the volume of claims. The additional revenue is other funds, which will come from the county jails to cover the cost of the claims processed by the Department.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Engrossed HB 1115 will continue to require the Department to process county jail claims. For the 2019-21 biennium, Department of Human Services would need an additional appropriation of $500,000, all of which is other funds, added to their base level budget in SB 2012.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Engrossed HB 1115 will continue to require the Department to process county jail claims. For the 2019-21 biennium, Department of Human Services would need an additional appropriation of $500,000, all of which is other funds, added to their base level budget in SB 2012.

Name: Heide Delorme

Agency: Human Services

Telephone: 701-328-4068

Date Prepared: 02/11/2019

19.8087.01000

FISCAL NOTE

Requested by Legislative Council
12/31/2018

Bill/Resolution No.: HB 1115

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$(1,500,000)		
Expenditures				$(1,500,000)		
Appropriations				$(1,500,000)		

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1115 provides for the Department of Human Services to no longer be the processor of county jail claims and for the county jail and health care providers to be responsible for the billing and payment processes of county jail claims.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Assuming the cost to continue adjustments included in the executive budget recommendation, $500,000, all of which are other funds, are adopted for SB 2012, the net reduction in expenditures for the 2019-21 biennium would be $1,500,000 all of which is other funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

Assuming the cost to continue adjustments included in the executive budget recommendation are adopted for SB 2012, the net reduction in revenue received from county jails for the 2019-21 biennium would be $1,500,000 all of which is other funds.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

Assuming the cost to continue adjustments included in the executive budget recommendation, $500,000 all of which are other funds, are adopted for SB 2012, the net reduction in expenditures for the 2019-21 biennium would be $1,500,000 all of which is other funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Assuming the cost to continue adjustments included in the executive budget recommendation are adopted for SB 2012, the net reduction in appropriation for the 2019-21 biennium would be $1,500,000 all of which is other funds.

Name: Heide Delorme

Agency: Human Services

Telephone: 701-328-4068

Date Prepared: 01/07/2019

2019 HOUSE HUMAN SERVICES

HB 1115

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1115
1/8/2019
30562

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Elaine Stromme by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:

Relating to criminal history record checks on Medicaid services applicants,

Minutes: A,B,C,D,E

Vice Chairman Rohr: Opened the hearing on HB1115.

Maggie Anderson, Director of Medical Services Division for the Department of Human Services: (See attachment A & B)

Representative Porter: The feds are saying part B which comes with a payment, is that payment then income scaled because that is optional coverage?

Ms. Anderson: Individuals who would qualify for Medicaid, as a dual eligible, we would pay their part B premium. But even though we are willing to pay for that premium, we still have people who are not willing to enroll in Medicaid.

Representative Porter: So, the feds say Part B, you're saying A, B, and D? So were going to exceed what the minimum required is?

Ms. Anderson: Correct. The feds are saying that they will not provide FFP for services that could be covered by part B. We're also trying to use the resources wisely. If they are services that could have been paid for under part A or D, then the individuals should enroll under that coverage.

Representative Porter: Inside of that application, especial on the Part D, it can take months to years to get coverage, what happens in the mean time?

Ms. Anderson: I'm not familiar with individuals having to wait that long for coverage. I know it can take a while for disability to go through sometimes, but as Part D, I understood was a fairly straight forward process. There is existing language where we don't pay for drugs under Part D of the Century Code.

Ms. Anderson: (continued attachment A)

Representative Porter: Inside of section 14, there are going to be a bunch of people who already completed their estate planning, and something of this nature is already in place. How are these people going to update inside of their estate planning, because what they have doesn't qualify anymore?

Beth Steffen Attorney in the Legal Advisory Unit for the Department of Human Services: Anyone who has an annuity already, will most likely already comply with subsection 6. It will not affect anyone negatively. There will be changes that are actually better for applicant than the current law.

Representative Porter: We'll have to look at that closer.

Representative Schneider: Did we have any retroactive liability to folks we denied because they did not meet the previous CMS deleted language?

Ms. Steffen: I'm not aware of anyone who has been denied recently. Most people do follow the law and the requirements in Federal law and in subsection 6. Because everyone complies with that, we think that the rest isn't going to hurt anyone by taking it out. If there was anyone who was denied with subsection 7, as long as they comply with subsection 6, they would then be eligible.

Representative Schneider: Does the Gaston case change that? Did it require any look back for those that may have been denied?

Ms. Steffen: The Gaston Case invalidated subsection 7 and it did require us to make the Gaston's eligible and anyone else that was in the same boat as the Gaston's were.

Ms. Anderson: (continued attachment A)

(46.39) Representative Schneider: On the dental provision, you referenced some of the things you worked on with the dental association, is there anything going on in the department to expand dental care to poor children and adults?

Ms. Anderson: We have a staff person who focuses on dental access, and she remains in contact with the dental association to make sure that we keep the same number of dentists enrolled in the program. In addition to that we keep an updated list of providers who accept patients who use Medicaid. Another thing that she is working on is the take 5 program, where we ask dentists who are already taking patients covered by Medicaid, if they can take 5 more patients under it. Another thing we are working on is that the coverage for Medicaid expansion would mirror the coverage under traditional Medicaid, so then they would be covered under Medicaid.

Representative Schneider: Is there an increase in unmet need for that, despite that activity and the expansion?

Ms. Anderson: I think that it would be hard for me to say that there is not unmet need. I think that the programs in place speak more about are helping to cut down on the unmet need, as I have not heard many calls about patients complaining about their unmet needs.

Representative Fegley: Did I hear you that you no longer file for the counties, so they'll have to have their own educated person file for their claims?

Ms. Anderson: We are proposing that the department no longer processes the claims. We started processing those claims in 2011, but today the clinic sees a Medicaid patient and they bill us for that patient. If someone in jail needed to see a clinic and they were under Medicaid, the clinic would bill us too. Today, however, the provider would send a bill to a county jail, and then they would send it to us. Prior to that they were paying the bill charges that were coming from the provider. We are still proposing that they can have access to the Medicaid fee schedule and pay the provider based on those rates there.

(54.59) Roxane Romanick, Executive Director of Designer Genes of ND: (see attachment C & D)

Representative Westlind: What's the poverty rate right now?

Ms. Romanick: It's at 200%

Terry Trainer, Association of Counties: I would like to address sections 34 and 1. Section 34 makes some grammatical corrections to the provision that allows for the coverage of inpatient, otherwise eligible Medicaid services, for inmates in jails and the penitentiary, and clarifying that and I want to thank the Legislature for keeping that in there. Section 1, however, it does shift the responsibility for tracking the billing of inmate medical for those non-Medicaid things. It has been challenging for counties to keep up with the process, and I don't think that we have been doing the best job of that. I would like to ask the committee to possibly consider changing a few words and moving one. I would like to delete the first 4 words, and have it start out as "Healthcare providers for services received by inmates [shall] bill each county." The way that the bill is written now, it seems to put coding responsibility on the jails.

Vice Chairman Rohr: Anyone here to testify in opposition of HB1115?

(1.03.09) Melissa Hauer, General Counsel of the ND Hospital Association: (see attachment E)

(1.06.20) Vice Chairman Rohr: Do you have any suggestions as to what a reasonable timeline may be?

Ms. Hauer: We didn't want to com here with a deadline to suggest. We think that it would be more so in the departments hands for a deadline.

NO FURTHER MEETINGS, MEETING CLOSED.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1115
1/22/2019
31235

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Elaine Stromme by Risa Bergquist

Explanation or reason for introduction of bill/resolution:

Relating to criminal history record checks on Medicaid services applicants,

Minutes: Attachment 1

Chairman Owens: Opened the hearing on HB1115.

1:00 Maggie Anderson, Director of Medical Services Division of the Department of Human Services: Went through the proposed amendment **(see attachment 1)** We had visited with Representative Porter, he requested some changes and there's a couple of other things we will have to talk about. On page 1 of the bill we are proposing in these amendments to remove the new section that would have moved the authority related to the county jail claims. We were proposing to no longer process the county jail claims but the counties could get the Medicaid fee schedule. This is actually going back to the existing code and is removing the new section 1 of the bill.

2:30 Chairman Owens: The reason for taking the part out and going back to how we used to do it yes?

Representative Porter: When we put this in it was in the middle of the MMIS system discussion and the department was doing the claims for the state penitentiary, we found that the counties where being charged full fair by the health care industry so we put into place that said no you can't do that you're going to get reimbursed the Medicare fee schedule. They don't have a way to do the fee schedule so the department put it into place. Their biggest claims are related to pharmaceuticals and there was a question on whether or not they were becoming bad debtors to the state. It was negotiated to the point that they can recouple their actual costs of processing the claims. If the jail wants to do something different they can. We discussed the possibility of changing the language so that they could get the cost of doing the business back.

Ms. Anderson: Then on page 2 after line 20 of the bill there is a new section. Basically it's saying if Medicare has prior authorized a piece of durable medical equipment the Medicaid can't also authorize that for individuals that are dueling eligible.

Page 17 after line 26, we had not included this section in the original bill because we were repealing the count jail claim information, but as we updated it we realized it was worded that it was the responsibility of the state and federal government and it should be the county.

8:25 (page 2 of attachment 1) Page 21 have to do with the provider appeal section. The 75 days would apply to audits because that was the point of concern. Page 27 after line 23; this is now bringing back in the section referencing the processing of claims submitted on behalf of inmates. This section also added in the words "for the amount and also the processing fee", we've had situations when we billed county jails for the claim and processing fee they would tell us that it was the states responsibility. We just wanted to clear that up. The next section is to get rid of the $30 maximum for processing, with IT systems we never know and if it were to cost more than $30 it would have to get covered by the state general fund, so we wanted to make sure that we had the full amount covered. Changed the word "annual to actual" cost and then the last few lines are no longer needed because that time has come and gone.

13:40 Chairman Weise: Further questions?

Representative Devlin: You know how much we like an open ended processing fee of any kind. I would rather you come up with some kind of fee that you think would last for this time period.

Ms. Anderson: We open up 750202 every biennium coming out of session and we know we will have to again this time with rule making, would you see it being there where we would identify what that would be? The concern I have with $30 dollars that that the new MMIS system is more expensive to operate and we have no control over those expenditures because we have a n outside vendor and it they walked away tomorrow we wouldn't have a backup plan where ITD could administer that system. So if we exceed that $30 we are using general funds to cover those costs.

Representative Devlin: I would prefer that you did here rather than in the rules.

Representative Weise: Would you be satisfied with it saying not to exceed actual costs? Is there a number you would be comfortable with?

Ms. Anderson: Knowing we have to reset it before you come back, $50?

Representative Devlin: I would be fine with 50 I just would like some kind of an amount in there.

Representative Skroch: Do you have past history that you can make a pretty good guess as to where you think it could go?

Ms. Anderson: It's the uncertainty, the contract with our current MMIS vendor runs out of renewal options under state parturient law Oct. of 2020, and we are going through certification the week of cross over. We have no idea what the new contract will look like but we'll have to agree to something before we get back for the next session.

Representative Chairman Wiese: Do we have a motion of some kind?

Representative Porter: I would like to make a motion to adopt the amendment with the change to page 2 inside of section 34 directly related to 50-24.1-34 that the overstrike is removed and the amount if changed $50.

Representative Ruby: I'll second that motion.

Representative Chairman Weise: Any further discussion? Seeing none we will do a voice vote.

All in favor, any opposed? Motion carries.

Representative Chairman Weise: Are there any other issues or problems with this bill?

24:35 Representative Porter: We've have before us in section 9-14 and 15 with the community spouse and the splitting of assets. It really took exception to a previous department's administrated rules on whether we are a maximum or a minimum state. We also check with the other attorney who was here to testify at the time. They responded back that section 15 was a good change but they thought that section 9 and 14 need to be reworked.

Section 9 we used to be a maximum state and now we're not, and section 14 would be better dealt with if we done away with the whole section. I do need time for the department to review those suggestions so we can come up with a correct amendment.

Representative Schneider: I did contact William Guy and he felt that this was an area that he doesn't work in and feel comfortable with it.

Representative Chairman Weise: We know the areas of concern; we will stop at this point.

Ms. Anderson: To clarify, on page 5 section 9 of the bill, where we're just replacing the word "equal" with "up to" In my written testimony it says "we replaced that to ensure that if there were significant increase in the community spouse resource allows at the federal level that the legislature would have the opportunity to weigh in before the change was automatically made by the department". Our intention was not to go to a minimum state, our intention was to give the legislature the opportunity. The annuity things, we need to visit with a lawyer first in our shop, we just haven't had time.

Representative Chairman Weise: Ok with that we will close this hearing until we get those final amendments.

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1115
1/30/2019
31867

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Nicole Klaman by Donna Whetham

Explanation or reason for introduction of bill/resolution:
Relating to payment of claims received on behalf of inmates, furnishing financial information to a facility, and definitions for medical assistance for needy persons; criminal history record checks on Medicaid services applicants and relating to medical assistance for needy persons.

Minutes:

Chairman Owens: Opened the hearing on HB 1115.

Rep. Porter: I would move we would further amend HB 1115 on page 5 Section 9, Line 16 we remove the word "up" and we remove the overstrike on "equal". That was the bill that Rep. Keiser had brought in and it puts it back to the way that it currently is in the law. The changes in section 14 do put us as close to on par with the Federal government as we can be.

Rep. Rohr: Seconded.

Chairman Owens: Does everyone understand the amendment? Any discussion? Seeing none.

Voice Vote taken: Motion Carries to further amend HB 1115.

Rep. Porter: I would move a Do Pass as amended on HB 1115 and rerefer to Appropriations.

Rep. Rohr: Seconded.

Chairman Owens: Any discussion? Seeing none. The clerk will call the roll on a Do Pass as amended on HB 1115.

Roll call vote taken: Yes 13 No 0 Absent 1. Motion carried for Do Pass as amended with rerefer to Appropriations.

Rep. Porter: Will carry the bill.

HB 1115 reconsidered on 2-5-2019

2019 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

HB 1115
2/5/2019
32210
☐ Subcommittee
☐ Conference Committee

Committee Clerk: Nicole Klaman by Donna Whetham

Explanation or reason for introduction of bill/resolution:
Relating to payment of claims received on behalf of inmates, furnishing financial information to a facility, and definitions for medical assistance for needy persons; criminal history record checks on Medicaid services applicants and relating to medical assistance for needy persons.

Minutes:

Chairman Weisz: Opened the hearing on HB 1115. We need to reconsider HB 1115 because appropriations will have to deal with it because it is basically transferring money from one individual budget to another.

Vice Chairman Rohr: I move to reconsider our actions on HB 1115 for further action.

Rep. Devlin: Seconded.

Voice Vote taken: Motion carries.

Rep. Devlin: I will make a motion for a Do Pass as amended and rerefer to Appropriations.

Rep. Rohr: Seconded.

Chairman Weisz: Any further discussion? Seeing none. The clerk will call the roll on HB 1115 for a Do Pass as amended and rerefer to Appropriations.

Roll Call Vote taken: Yes 12 No 0 Absent 2. Motion carries.

Rep. Porter: will carry the bill.

Hearing closed.

19.8087.01001
Title.02000

Adopted by the Human Services Committee

January 30, 2019

1/30/19
1 of 2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1115

Page 1, line 1, remove "a new section to chapter 12-44.1,"

Page 1, line 2, remove the first comma

Page 1, line 2, replace "a" with "two"

Page 1, line 2, replace "section" insert "sections"

Page 1, line 3, remove "payment of claims received on behalf of inmates,"

Page 1, line 4, remove "and"

Page 1, line 4, after "persons" insert ", and medical assistance claims processing"

Page 1, line 7, after "50-24.1-12" insert ", 50-24.1-14"

Page 1, line 9, after "50-24.1-33" insert ", 50-24.1-34"

Page 1, line 12, remove "and"

Page 1, line 13, after the second comma insert "and"

Page 1, line 13, remove ", 50-24.1-34, and 50-24.1-38"

Page 1, line 14, after "persons" insert "; and to provide an effective date"

Page 1, remove lines 16 through 21

Page 2, after line 20, insert:

"**SECTION 4.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medicaid and Medicare eligible individuals.

The department may not require prior authorization, additional documentation not required by Medicare, or additional prescription requirements of durable medical equipment and supplies in order to process a claim for Medicaid-eligible individuals who are also eligible for Medicare if an item has been paid by Medicare, unless the item is not covered by Medicaid."

Page 17, after line 26, insert:

"**SECTION 22. AMENDMENT.** Section 50-24.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-14. Responsibility for expenditures.

~~Expenditures~~Notwithstanding section 50-24.1-34, expenditures required under this chapter are the responsibility of the federal government or the state of North Dakota."

Page 21, line 1, after "days" insert "of receipt of the notice for review, if the department has denied payment for a medical assistance claim or reduced the level of service payment for a service and within seventy-five days"

Page 21, line 2, after "review" insert ", if the department has recouped or adjusted claim, or part of a claim, following an audit"

Page 27, after line 23, insert:

"**SECTION 35. AMENDMENT.** Section 50-24.1-34 of the North Dakota Century Code is amended and reenacted as follows:

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

The department of human services shall process claims submitted by enrolled medical providers on behalf of inmates at county jails. Each county shall pay the department for the paid amount for the claims processed and also a processing fee for each claim submission. The department ~~shall~~may establish a processing fee that may not exceed ~~thirty~~fifty dollars and shall update the fee annually on July first. The processing fee must be based on the ~~annual~~actual costs to the department of the claims processing operations divided by the annual volume of claims submitted. The department shall invoice each county for payment of the processing fee. ~~Beginning July 1, 2011, the department of human services shall increase the claims processing fee to recover the cost of the Medicaid claims system changes. The department shall deposit the portion of the fee associated with recovering the costs of the Medicaid claims system changes in the general fund.~~"

Page 29, line 20, remove ", or as soon thereafter as possible"

Page 30, line 23, after the third comma insert "and"

Page 30, line 23, remove ", 50-24.1-34, and 50-24.1-38"

Page 30, after line 24, insert:

"**SECTION 40. EFFECTIVE DATE.** Section 4 of this Act becomes effective on January 1, 2020."

Renumber accordingly

Date: 1/22/2019
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Changing the amount for processing fees from $30 to $50

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Representative Porter Seconded By Representative Ruby

Representatives	Yes	No	Representatives	Yes	No
Voice Vote					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Motion Carries

Date: 1-30-19
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO HB 1115

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: Pg. 5 Sec. 9 Line 16 remove the word "up" and the overstrike on "equal."

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep Rohr

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Motion carries

Date: 1-30-19
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.8087.01001

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Porter Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman	X		Gretchen Dobervich	X	
Karen M. Rohr – Vice Chairman	X		Mary Schneider	X	
Dick Anderson	—				
Chuck Damschen	X				
Bill Devlin	X				
Clayton Fegley	X				
Dwight Kiefert	X				
Todd Porter	X				
Matthew Ruby	X				
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 13 No 0

Absent 1

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

Do Pass As Amended

Date: 2-5-2019
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☒ Reconsider ☐ _____

Motion Made By Rep. Rohr Seconded By Rep. Devlin

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman			Gretchen Dobervich		
Karen M. Rohr – Vice Chairman			Mary Schneider		
Dick Anderson					
Chuck Damschen					
Bill Devlin					
Clayton Fegley					
Dwight Kiefert					
Todd Porter					
Matthew Ruby					
Bill Tveit					
Greg Westlind					
Kathy Skroch					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Voice Vote: Motion carried.

Date: 2-5-2019
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Rep. Devlin Seconded By Rep. Rohr

Representatives	Yes	No	Representatives	Yes	No
Robin Weisz - Chairman	X		Gretchen Dobervich	X	
Karen M. Rohr – Vice Chairman	X		Mary Schneider	X	
Dick Anderson	X				
Chuck Damschen	X				
Bill Devlin	X				
Clayton Fegley	X				
Dwight Kiefert	A				
Todd Porter	A				
Matthew Ruby	X				
Bill Tveit	X				
Greg Westlind	X				
Kathy Skroch	X				

Total (Yes) 12 No 0

Absent 2

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1115: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (12 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). HB 1115 was placed on the Sixth order on the calendar.

Page 1, line 1, remove "a new section to chapter 12-44.1,"

Page 1, line 2, remove the first comma

Page 1, line 2, replace "a" with "two"

Page 1, line 2, replace "section" insert "sections"

Page 1, line 3, remove "payment of claims received on behalf of inmates,"

Page 1, line 4, remove "and"

Page 1, line 4, after "persons" insert ", and medical assistance claims processing"

Page 1, line 7, after "50-24.1-12" insert ", 50-24.1-14"

Page 1, line 9, after "50-24.1-33" insert ", 50-24.1-34"

Page 1, line 12, remove "and"

Page 1, line 13, after the second comma insert "and"

Page 1, line 13, remove ", 50-24.1-34, and 50-24.1-38"

Page 1, line 14, after "persons" insert "; and to provide an effective date"

Page 1, remove lines 16 through 21

Page 2, after line 20, insert:

"**SECTION 4.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medicaid and Medicare eligible individuals.

The department may not require prior authorization, additional documentation not required by Medicare, or additional prescription requirements of durable medical equipment and supplies in order to process a claim for Medicaid-eligible individuals who are also eligible for Medicare if an item has been paid by Medicare, unless the item is not covered by Medicaid."

Page 17, after line 26, insert:

"**SECTION 22. AMENDMENT.** Section 50-24.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-14. Responsibility for expenditures.

~~Expenditures~~Notwithstanding section 50-24.1-34, expenditures required under this chapter are the responsibility of the federal government or the state of North Dakota."

Page 21, line 1, after "days" insert "of receipt of the notice for review, if the department has denied payment for a medical assistance claim or reduced the level of service payment for a service and within seventy-five days"

Page 21, line 2, after "review" insert ", if the department has recouped or adjusted claim, or part of a claim, following an audit"

Page 27, after line 23, insert:

"**SECTION 35. AMENDMENT.** Section 50-24.1-34 of the North Dakota Century Code is amended and reenacted as follows:

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

The department of human services shall process claims submitted by enrolled medical providers on behalf of inmates at county jails. Each county shall pay the department for the paid amount for the claims processed and also a processing fee for each claim submission. The department ~~shall~~may establish a processing fee that may not exceed ~~thirty~~fifty dollars and shall update the fee annually on July first. The processing fee must be based on the ~~annual~~actual costs to the department of the claims processing operations divided by the annual volume of claims submitted. The department shall invoice each county for payment of the processing fee. ~~Beginning July 1, 2011, the department of human services shall increase the claims processing fee to recover the cost of the Medicaid claims system changes. The department shall deposit the portion of the fee associated with recovering the costs of the Medicaid claims system changes in the general fund.~~"

Page 29, line 20, remove ", or as soon thereafter as possible"

Page 30, line 23, after the third comma insert "and"

Page 30, line 23, remove ", 50-24.1-34, and 50-24.1-38"

Page 30, after line 24, insert:

"**SECTION 40. EFFECTIVE DATE.** Section 4 of this Act becomes effective on January 1, 2020."

Renumber accordingly

2019 HOUSE APPROPRIATIONS

HB 1115

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1115
2/14/2019
32764

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:
A Bill for an Act to create and enact a new section to chapter 50-10.2 and two new sections to chapter 50-24.0 of the North Dakota Century Code, and relating to furnishing financial information to facility.

Minutes:

Chairman Delzer: Opened hearing.

Representative Weisz: This is a long bill but the only thing that is relevant to this committee is page one section one. That has to do with processing and paying claims to inmates in county jails. This is just the transfer. Currently what is happening is that the department is processing the claims for the inmates that are coming to jail. What this is doing is saying that the department doesn't have to be in the claims process, and it moves it back onto the counties. It would give savings to the state.

2:10 Chairman Delzer: What is section 35 on page 28?

Representative Weisz: I don't know. That would then be the new way that claims would be handled without the help of the department.

Chairman Delzer: You've increased the fee there, and you said that the department isn't going to be a part of that, then why did you increase the fee?

Representative Weisz: If it's an enrolled Medicaid provider, they increase the processing fee from 30 to 50 dollars.

Chairman Delzer: Is that in the fiscal note?

Representative Weisz: No, it said that that cost is pretty minimal.

Representative Bellew: Does this represent a property tax increase?

Representative Weisz: No, because the county would pay for it either way regardless who does it. They pay it to the state now and this will change it to pay it to the provider.

Representative J. Nelson: In the case of a Medicaid eligible inmate, do you think the counties have the means to follow and access the Medicaid third party payment?

Chairman Delzer: The counties do the eligibility to start with.

Representative J. Nelson: Some of the county inmates are there longer or shorter, and they may not be vetted through there.

Chairman Delzer: If it would cost the county in their eligibility you would think that they would do that.

Representative Weisz: The county is still going to process through, just like they would with any other Medicaid claims. The county has to determine if the inmate is Medicaid eligible. They aren't having to try to process what is covered or not.

Representative J. Nelson: So you can say that that should not change as all.

Representative Weisz: I would say it shouldn't change and after the amendments the department was comfortable with the bill.

Representative Bellew: It says they can update the fee annually in the amendment, why?

Representative Weisz: The testimony was such that their cost would change based on different things, and they would want to cover their costs.

Chairman Delzer: It does say the cost annual, so whatever their fee is, it will cover the cost.

No further questions, hearing closed.

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1115
2/14/2019
32812

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:
A BILL for an Act to create and enact a new section to chapter 50-10.2 and two sections to chapter 50-24.1 of the North Dakota Century Code.

Minutes:

Chairman Delzer: This will remain revenue neutral, but the fees go up to whatever they are needing to cover the costs.

Representative Meier: Move for a do pass.

Representative Beadle: Second.

Roll Call Vote: 18 Yes, 1 No, 2 Absent.

Motion carries.

Chairman Delzer: We will have to find out who the carrier is from human services, and that will be the carrier.

Floor Assignment: **Representative Porter**

Meeting closed.

Date: 2/14/2019
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By **Representative Meier** Seconded By **Representative Beadle**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X				
Representative Kempenich	X				
Representative Anderson	X		Representative Schobinger	X	
Representative Beadle	X		Representative Vigesaa	X	
Representative Bellew		X			
Representative Brandenburg	A				
Representative Howe	X		Representative Boe	X	
Representative Kreidt	X		Representative Holman	X	
Representative Martinson	X		Representative Mock	A	
Representative Meier	X				
Representative Monson	X				
Representative Nathe	X				
Representative J. Nelson	X				
Representative Sanford	X				
Representative Schatz					
Representative Schmidt					

Total (Yes) 18 No 1

Absent 2

Floor Assignment **Representative Porter**

Motion Carries

REPORT OF STANDING COMMITTEE

HB 1115, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO PASS** (18 YEAS, 1 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1115 was placed on the Eleventh order on the calendar.

2019 SENATE HUMAN SERVICES

HB 1115

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1115
3/4/2019
Job #33086

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez and Alicia Larsgaard

Explanation or reason for introduction of bill/resolution:

Relating to criminal history record checks on Medicaid services applicants, providers, and staff members and medical assistance for needy persons; relating to medical assistance for needy persons; and to provide an effective date.

Minutes: Attachments: 2

Madam Chair Lee opens the hearing on HB 1115

(01:08-9:) Maggie Anderson, Director, Medical Services Division, Department of Human Services: Testifying in support of HB 1115. Please see Attachment #1 for testimony.

(09:55) Senator Hogan: Do most states do that?

Maggie Anderson: To my knowledge, yes, most states do.

Maggie Anderson continues with her testimony talking about Section 11, Page 7, Lines 7 and 8 and so on.

(15:00) Senator Hogan: This is one of the areas that I get a lot of complaints from people applying for Medicaid with annuities. Will this make it more simple for the consumer in any way?

Maggie Anderson: Are the complaints you received the time it takes to process the application?

Senator Hogan: Both the time and confusion about what is covered and how to report it. It is also the detail of this in terms of processing a long term care Medicaid application. This annuity issue has often been brought up as one of them. Will this simplify it in any way?

Maggie Anderson: My gut tells me no. We have already been operating under what we are proposing because of the Gustan case and the deficit reduction act. It is simply to clean up the code because state law conflicts with federal law so we always have to defer to the feds if it conflicts. Some of that long term care processing and the timelines will hopefully be

streamlined as we move forward with some of the 21-24 efforts and centralizing some of that work as well as allowing the staff who do it on a regular basis to focus on it. Sometimes, in smaller counties, they are not as in tuned to all the requirements. IF there are any specific concerns about timeliness, we want to address them. I know that Beth and John in the legal advisor unit try to move those things as quickly as they can if they are reviewing trust or if there are specific annuity questions.

(16:51) Maggie Anderson continues her testimony regarding Section 15, Page 12, Line 23 and so on.

(20:15) Senator Anderson: Since the feds don't want to pay, what service are we providing by doing this? What is the purpose?

Maggie Anderson: By processing the county jail claims, they are using our system. For years, we have been processing the claims for the Department of Corrections. In 2011, the legislature adopted a bill that said they wanted the department to process the county jail claims as well. There were a few benefits to the counties. One was our fee schedule. Prior to that, if an individual in the county jail had medical issues in the process of the arrest and they needed care, then the medical provider would bill the county jail for their usual charges. Now, they are going to bill us but we will pay it off of the Medicaid fee schedule. The other benefit to the county and the provider was none of this back and forth of bill writing and paying. It was simply that they could bill us like everyone else. There is nothing Medicaid related in this. It was an administrative decision to simplify the work for the counties.

Senator Anderson: Are there third party payers other than Medicaid that would pay these claims?

Maggie Anderson: I'm not aware that there are. We do not have any of our third party edits built around these claims because in this role we are not the payer of last resort. We are the payer. We bill the county for the cost of the claim. We are also allowed to set a processing fee. This is what the whole fiscal note is about. There is nothing of Medicaid on the fiscal note. It is all about the county jail piece. The change is just the revenue. It is basically money in and money out. It is a wash for us. The reason why, in the original version, we proposed to remove it, is because it is not our core service and it is not a mission of the department to be the claims processing entity. There were some issues with the processing of these claims when we implemented MMIS. It wasn't our priority. Ours was our Medicaid providers and our Medicaid federal reports. This took a back burner.
Madam Chair Lee: If we are going to be doing this, should this be someplace else? Should we even be processing these claims? If we are going to be doing this, is there another place in statute that is more appropriately such as the sections that are dealing with county jails rather than being in this section that is really supposed to be dedicated to Medicaid.

Maggie Anderson: I think if the claims processing remains within the department of Human Services, it makes sense for the sections of code to remain of 50-24.1. Our point in putting it here is that we would never want a situation where the county could come back and use existing code against us.

Senator Hogan: How many jails are currently using this? It is a huge issue with the county level.

Maggie Anderson: I'm not sure. In large communities it has been used since the beginning. There are those who haven't participated, have to appropriately notify us when someone comes to the county and when they leave because if they do not notify us when they leave the county jail, we are continuing to bill them for those claims because our system doesn't know any better that that person has now left the jail. It is not without its bumps. We are on a good path now.

Madam Chair Lee: Do they have the option of doing what you just described?

Maggie Anderson: Yes. This has been voluntary for the county jails to participate in and they still can.

(27:25) Maggie Anderson continues her testimony regarding Section 23, Page 18, Lines 8 through 10.

(42:05) Senator Anderson: The language says that you have to update the fee annually on July 1st. Is that language that causes you work that you do not need to do?

Maggie Anderson: We would want to update it every July 1st and notify the county. Most of these costs are the contract that we pay to our vendor who runs MMIS, the cost that we pay to ITD to help support the cost of MMIS, and our claims processing staff. If the legislature grants salary increases or if there is a change in the cost of health insurance, we would want that to be reflected.

Senator Hogan: Do you know what the current processing fee is that we are using?

Maggie Anderson: I am not sure of the exact number; I can have Eric check on that for us.

(43:17) Maggie Anderson continues her testimony regarding Section 36, Page 28, Lines 22 through 28.

(44:34) Senator Hogan: This is in place right now?

Maggie Anderson: Yes, we implemented this with Go Live of MMIS in 2015.

(44:45) Maggie Anderson continues her testimony regarding Section 37, Page 29 Line 6.

(49:53) Senator O. Larsen: On page 28 when you are in the section around the Medicaid coverage and the new part, does that correlate with page 8 on line 8; the 250% of poverty? What Medicaid level are we covering?

Maggie Anderson: I can tell you it wouldn't have to do with anything on page 8, that is specifically for the Workers with Disabilities Program. It is essentially if they would be otherwise eligible for Medicaid coverage. Prior to implementing the Medicaid expansion

through the affordable care act, this group of individuals who are incarcerated would have been quite small. With the implementation of Medicaid expansion, this group is going to be much larger. It will include the expansion population which is the group up to 138. It could also include a parent caretaker and a pregnant woman.

Madam Chair Lee: Are there any other questions for Maggie Anderson?

(52:34-55:37) Melissa Hauer, North Dakota Hospital Association. Testifying in opposition for HB 1115. Please see Attachment #2 for testimony. We have a problem with the part that deals with the provider appeal. It is in section 28 of the bill on page 20. When a provider makes a claim to Medicaid and it is denied or paid at a lower level, the provider can appeal. Current law says the provider has 30 days to file that appeal and the department has 75 days to decide it. I understand there were changes made in the House to carve out audit appeals. If you are talking about an audit that resulted in this appeal, the current bill says you have an unlimited amount of time if you are the department, to make a decision. The concern is that audits are the area where you have those largest dollar amounts that issue. My testimony cites a couple of cases that went up to our Supreme Court where the dollar amounts in question after audits, were six figures. It took over 200 days for a decision to be made. Sometimes the provider has the money, but sometimes they do not if the payment was denied or if the level was reduced. If the provider has the money and they have to pay it back, they have to book that as a liability. That can have an effect on that hospitals operations. We are asking that there be deadlines for both parties. The other option is that under current law, the department can always go to the court and ask for additional time. If they have a difficult situation, they could ask the court for more time. That gives both parties the opportunity to go in front of the court and make their case and let them decide.

Madam Chair Lee: Do you have a recommendation for the time limit?

Melissa Hauer: We do not. We just feel there should be some deadline proposed on the department.

Madam Chair Lee: Maggie Anderson, would you have a response to what Melissa Hauer's issue is?

Maggie Anderson: We would stand behind the way it is worded. When those cases that Mrs. Hauer mentioned went to the supreme court, they indicated in their ruling that the 75 days was not really 75 days. It is a guideline but there are times where it needs to be exceeded. Whether it says 75 or 90 and we are not able to meet that, they ruled that that happens and we are not held to that 75 days. We are just trying to clean up code to say as soon as possible.

Madam Chair Lee: Are there further questions on the issue for Mrs. Anderson or Mrs. Hauer?

Senator Larsen: Would you be opposed to a 90-day window? Who brought up the 75 days.

Maggie Anderson: That came from the original 2005 legislation that created the provider appeals. It is your decision to make regarding the days but I just wanted to add the supreme court decision.

Madam Chair Lee closed the hearing on HB 1115.

2019 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

HB 1115
3/4/2019
Job #33112

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Justin Velez and Alicia Larsgaard

Explanation or reason for introduction of bill/resolution:

Relating to criminal history record checks on Medicaid services applicants, providers, and staff members and medical assistance for needy persons; relating to medical assistance for needy persons; and to provide an effective date.

Minutes:

Attachments: 0

Madam Chair Lee: Called the committee to order on HB 1115.

Senator Anderson: I did talk with Melissa a little bit and I think they are concerned with having a limit. Melissa disagrees with Maggie's interpretation of what the court said. She did not really have a specific suggestion. She just wanted the department to have a hard limit. She mentioned that you can just ask the court but not all cases go to court. That would cost both parties more money if they had to go to court. Maggie's character of it was that the hospital always has the money. Obviously that isn't always true if the claim was denied and they didn't get paid yet.

Senator Roers: In this case, these 75 days would apply to the denial. This is the audit where they caught is after the fact. The 75 days is already in effects for the denial ones. This is just for the audit ones where they would already have the money. Do we say 150 days or 125 where there is still that expectation where this is going to get done as soon as possible? That gives enough flexibility to the department while knowing these are far more complicated cases but it still gives the provider the ability to see the end.

Madam Chair Lee: I do not want it to be 90 days. I am not even uncomfortable with the way it came to us.

Senator Hogan: There are so many other good things in this bill. I was surprised there was not a recommendation not just for an amended but for a Do Not Pass which was a little extreme from my perspective. Maybe 120 or 150 days is what we want to look at.

Senator Anderson: It doesn't sound like extending the number of days in here is going to make much of a difference if the department still continues to say that it has to be more than

that. Melissa thinks the court said the legislature should fix it. I am comfortable with the 75 days. If it doesn't work over a period of time, we can fix it later.

Madam Chair Lee: Good point.

Senator Anderson: Moved to adopt amendment 19.8087.02001.

Senator Hogan: Seconded.

Madam Chair Lee: Any Discussion?

A Roll Call Vote Was Taken: 6 yeas, 0 nays, 0 absent.

Motion Carried.

Senator Anderson: Moved a Do Pass as Amended and Rerefer to Appropriations.

Senator Larsen: Seconded.

Madan Chair Lee: Any Discussion?

A Roll Call Vote Was Taken: 6 yeas, 0 nays, 0 absent.

Motion Carried.

Madam Chair Lee will carry the bill.

Adopted by the Senate Human Services Committee

March 4, 2019

3/5/19

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1115

Page 5, line 21, remove the overstrike over "~~equal~~"

Page 5, line 21, remove "up"

Page 21, line 10, overstrike "its" and insert immediately thereafter "a"

Page 21, line 12, replace "and within" with ". The department shall make and issue a decision within"

Page 21, line 14, after "adjusted" insert "a"

Renumber accordingly

Date: 3/4/19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 19.8087.02001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Anderson Seconded By Hogan

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen	X				
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3/4/19
Roll Call Vote #: 2

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1115

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Anderson Seconded By Larsen

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee	X		Sen. Kathy Hogan	X	
Sen. Oley Larsen	X				
Sen. Howard C. Anderson	X				
Sen. David Clemens	X				
Sen. Kristin Roers	X				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen. J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1115, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1115 was placed on the Sixth order on the calendar.

Page 5, line 21, remove the overstrike over "~~equal~~"

Page 5, line 21, remove "up"

Page 21, line 10, overstrike "its" and insert immediately thereafter "a"

Page 21, line 12, replace "and within" with ". The department shall make and issue a decision within"

Page 21, line 14, after "adjusted" insert "a"

Renumber accordingly

2019 SENATE APPROPRIATIONS

HB 1115

2019 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1115
3/21/2019
JOB # 34115

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Alice Delzer and Alicia Larsgaard

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact a new section to chapter 50-10.2 and two new sections to chapter 50-24.1 of NDCC, relating furnishing financial information to a facility, definitions for medical assistance for needy persons, to amend and reenact NDCC for medical assistance claims process, relating to criminal history record checks on Medicaid services applicants, providers, and staff members and medical assistance for needy persons, and to provide an effective date. (DO PASS)

Minutes: No testimony submitted

Chairman Holmberg: Called the Committee to order on HB 1115 at 11:00 AM in the Harvest Room. All committee members were present. Renae Bloms, OMB and Levi Kinnischtzke, Legislative Council were also present.

Maggie Anderson, DHS: This bill was introduced at the request of the department. It is a complete review and update to chapter 50-24.1. The only section of the bill that pertains to the fiscal note and why we are here and not already on the floor with HB 1115. You have the re-engrossed bill in front of you. In 50-24.1-37, I am sorry, it's 34 not 37, so 50-24.1-34 has to do with the processing of claims submitted on behalf of inmates. In the 2011 session, there was a larger bill going through that addressed various things with county jails, funding, and services. As part of that, there was an amendment added. Those amendments did two things. One of them was where the Department of Human Services (DHS) would process medical claims on behalf of county jails, which we had been doing for years for the department of corrections. It was consistent with that process. That was one piece and the other piece had to do with the inpatient prisoner component of Medicaid, because individuals who are prisoners and have an inpatient stay that lasts more than 24 hours and are otherwise Medicaid eligible, we can capture Medicaid funding for that. That piece was not able to be implemented until the implementation of our Medicaid Management Information System (MMIS) in October of 2015 because there were system changes that needed to go along with that. The piece that is captured in -34, which is the processing of the county jail claims, we did implement that in Legacy MMIS. It is now functioning within Enterprise MMIS. If you look at 50-24.1-34 and the changes that are in there; we clarified that it is the amount, the county shall pay the department the amount paid on the claims processed and the processing fee. The reason why we are proposing that language change is because there have been times

where we will bill the county for the processing fee and then we would also bill for this charge. They would come back and say they were just supposed to pay the charge to process the claim. No. These are not Medicaid claims. These are claims for individuals who are in jail and are not Medicaid eligible. The counties have to pay that because we cannot use Medicaid dollars for that. We thought that was important to clarify. And then it says the department may establish a processing fee. We just changed the shall to may. That is legislative council and some bill drafting guidance there. The language said $30, we had proposed to remove the $30 completely and just update that annually to correspond with our costs. Those costs are going to be the ones we pay to our vendor to maintain MMIS, the cost we pay to our staff to process claims, and any contracted cost in between. **(0.03.57)**

The House Human Services Committee wanted a dollar amount in there, and so we landed on $50 instead of $30 so the department will just need to keep their eye on that and should the processing fee near that $50 now, then we will have to come back and ask you to update code. We need to stay on top and in front of what the cost is. These costs cannot be subsidized by Medicaid dollars. If we don't make sure we capture the cost from the counties, then we are subsidizing it with 100% general funds when it should be a county expenditure. So that's the importance of that number.

The other piece we crossed out beginning July 1, 2011, that language was no longer applicable because when we did update Legacy MMIS as part of the legislation, you allowed us to build, in the rate, the amount per claim to recapture those costs. They can't be funded with Medicaid dollars. That is the section of the bill that the fiscal note applies to. The reason we have the fiscal note, is because processing county jail claims is not a core mission to the DHS and specifically to the MMIS system. Our core mission is to process Medicaid claims. To process Medicaid claims and ensure that we are filing the correct federal report. The other claims we do process, such as the department of corrections or the county jails are other things that we do and we recognize we have a system that can accommodate those. But when we go live with something as large as MMIS, the county jail claims were not our priority. They were put on the back burner for quite a long period of time. Now we are processing those again. That is fully functional. We have notified all the county jails of the back processing charges and things that need to happen. Our fiscal staff is working through that with the county jails. As we know, the processing fee will go up each year. We know that as you authorize inflationary increases for providers through Medicaid, the county jail claims use that same fee schedule. Because we are fully functioning, we have done this outreach to the counties and we are expecting there could be more claims and those claims could be at a higher rate. So really, the fiscal note is just a reflection of increased money in and out. There are no general funds involved here. It is solely that we are going to pay the claims, bill the counties, and we need the authority to bring that in as revenue and offset the expenditures we have made. That is the extent of the fiscal note. There is nothing else in HB 1115 that has a fiscal impact. I would be happy to talk about any of the other provisions of the bill because we have worked for over a year to bring it to session and we are happy to keep it moving.

Senator Robinson: What type of dollars are you looking at in terms of the money you are handling like the billing and so on with county jails?

Maggie Anderson: I do not know off the top od of corrections. Typically, these individuals are there fewer days then the department of corrections. typically these individuals are there fewer days than department of corrections. We were processing department of correction claims before I started in the department. That is a very long standing relationship.

Senator Mathern: Those counties that don't use DHS claims processing must use another system. Do you know what that system is? Is there anyone here to testify for the counties in that regard?

Maggie Anderson: I can't speak for what they use. What I can tell you is prior to 2011, and why some of this happened. An individual is arrested, they are in jail, and let us just say they are diabetic. They need insulin. The jail calls their pharmacy and asks for the insulin and how long they expect that person to be there. The pharmacy would provide that and then they would bill the county jail for those expenses. They billed them at whatever the pharmacies usual charges were. The benefit of us doing that, is that the county jail benefited because they were able to receive those services at the Medicaid fee schedule. Also, the billing would come from the provider to us and we would then pay the provider and bill the county jail back. It's not that the county jail is without touch points in this process because they have to notify us that that person is in jail and when they are no longer in jail. Sometimes,when they fail to do that, and that person is otherwise eligible for Medicaid, or maybe not, and we continue to receive bills from that provider for that person but they are now at their house, the county jail is still getting bills for their care if the forget to dis-enroll them. There are administrative tasks the county jail has to do for this process to work. Prior to this process, they would have had to get out their checkbook, write a check to the provider and pay them. I suspect the county jails that are not participating are still doing something like that where perhaps their volume is so small that it has not been advantageous to them to use this or they just don't want that process where they have to enroll and dis-enroll that person in order to get the bills paid.

Senator Bekkedahl: On page 2 of the bill, section 6, lines 5 and 6, is that a whole new section that is being amended?

Maggie Anderson: One through 6 is actually currently in 50-24.1 but it does not pertain to Medicaid. So it was added during a session in the past. We worked with the department of health because it is something that belongs in 50-10.2. We are simply moving it from 50-24.1 to 50-10.2. At the end where you have the repealed sections, it is repealing it. It is in 50-24.1-22.

Senator Bekkedahl: I was not familiar with the language on line 5 and 6. It says a facility may deny admission to an applicant for admission who is unable to verify a viable payment source. Are we denying a lot of people access to facilities under that provision that might need facilities?

Maggie Anderson: Because that piece is not Medicaid specific, Medicaid would be one of many payers that could potentially look at that. What I can tell you from being in the Medicaid program is our staff do have contact with providers who are seeking to accelerate a Medicaid application or to find another placement for someone. Maybe someone is in the hospital, and they have not received their long term care Medicaid approval yet and the nursing facility wants to have that before admission. I do not want to speak for anyone and say they are

denying but sometimes people might end up staying in the hospital for a longer period of time because they are waiting for some of that payment piece to come through.

Senator Grabinger: You talk in your testimony that the House put in that $50 limit. I am reading on page 28 of section 35. It opens it up because it says it is up to $50 and it has to be based on the actual cost of the department and it has to be updated every July 1st and it gives you the leeway to do that. What is your conflict there?

Maggie Anderson: We don't necessarily have a conflict now. We do believe that if we reach that $50, we would need to re-evaluate that. We are far from that at this time. We have the ability. It says it may not exceed $50 and it shall be updated and it must be based on the actual costs. First of all, it cannot exceed $50. In order to determine what the cost is, we have to do it annually and it has to be based on actual cost. I think we are still restricted by the $50.

(0.14.03) Senator Dever: Do I understand correctly that the fiscal note would go away if we restored the bill the way it was introduced? How would the service be different?

Maggie Anderson: If the bill was restored as introduced which would be that we would be out of the business of processing county jail claims, then we would not expect the expenditures and the revenues to be going back and forth and the fiscal note should no longer be needed. The only portion that would be needed is if we would be able to effectuate that change by July 1st.

Senator Dever: You would continue to process the Medicaid claims?

Maggie Anderson: Absolutely. We would continue to process the Medicaid claims and we would continue to process what we call the in-patient prisoner Medicaid claims but we would not process the county jail claims.

Senator Dever: So, the dollars are really associated with non-Medicaid claims.

Maggie Anderson: That is correct.

Senator Dever: Why is the fiscal note for the next biennium triple of what it is for this biennium?
(There is a pause as Ms. Anderson consulted with her colleagues before answering the question)
(0.15.52) Maggie Anderson: The $500,000 gets us to the $1.5M that we expect to have this next biennium and then the $1.5M is carrying that forward. The $500,000 is the increase over what we are currently at. We are expecting more claims and then to be higher dollars because of inflation and the cost of services. Then we would sustain that going into the next. I suppose you could argue that next biennium should have been $500,000 as well.

Senator Dever: If the department does not handle those non-Medicaid claims then how are they handled?

Maggie Anderson: If the Department were not processing the county jail claims, what we proposed in HB 1115 as introduced, is that it would go back to the way it was before 2011 which was that the provider would bill the county jail and the county jail would use their checkbook to pay the provider. The piece that we did include in 1115, because again, the bill from 2011 was about 2 things. One was about us processing the claims and the other was about access to the Medicaid fees. The county jails did not have to pay billed charges. In the introduced version of 1115, we proposed that the providers would use the traditional Medicaid fee schedule to bill the county jails. They would still benefit from the Medicaid fee schedule but we would no longer be processing the claims.

Chairman Holmberg: Is there someone from the counties here that is going to visit with us today?

(0.17.40) Senator Mathern: It seems we would also have the alternative of the state actually paying for this. Not the claim, but we would pay for the cost of claims processing versus billing each county per claim to do that. It would seem to be efficient and it would seem to get all of the counties a little more astute to using the Medicaid rate and the fee schedule. I am wondering, did the policy committee consider that option that we would appropriate the amount of money that is needed to process these claims as a function of your department.

(0.18:48) Maggie Anderson: House Human Services was interested in restoring it back to where the department processed the claims. We worked with them on the language changes that you see in section 35. That was the extent of the conversation. In Senate Human Services, we talked about the version that was introduced. There was no discussion about changing from the House amendments to that section. Up to this point, no one has raised that as an option. To your point, it is an option that the legislature could appropriate state funds to process those claims. We are already billing the county jail. From an administrative standpoint on our part, we have to bill them for both items for the cost of the claim and the administrative function. Those go out on the same billing.

Chairman Holmberg: Is anyone else testifying? We will close the hearing. Do the committee members have a sense of what we should do with this? Or should we just sit on it along with 40 other bills. A number of you have been working with human services.

Senator Mathern: I would hope we would hear from the counties on this.

Chairman Holmberg: The hearing has been scheduled.

Senator Mathern: It appears that the policy committee has been doing the work of the appropriations committee. They are trying to figure out how to raise the money to do something. I don't know if they thought there was an option. It seems to me that this would assist every county to get on this system to use the Medicaid fee schedule. I think it would be sad to know that some counties are not using the system because they do not want a $50 bill when they could save $5,000 on using the Medicaid fee schedule and not really knowing about it. They had an opportunity to be here.

Chairman Holmberg: It isn't from General Fund; it is coming from the counties to pay for the services as I understood it. Other folks on Human services, what do you think? Will this get better if we sleep on it? Or should we act today?

Senator Dever: It seems to me that it is an obligation of the counties. They are just paying for a service they will receive from the department. The counties are not in the business of health care, but the department is. There may be some wisdom in that. I could support the bill as it is.

Chairman Holmberg: With 34 in there, the expense is being covered by money they receive for services from the county.

Senator Dever: It seems to me if the counties recognize they are paying for that service and choose not to, they probably have that ability to.

Chairman Holmberg: Are you making a motion?

Senator Dever: Moved a Do Pass on HB 1115 as it came to us. 2nd by V. Chairman Wanzek.

Chairman Holmberg: Would you call the roll on a Do Pass on HB 1115?

A Roll Call vote was taken. Yea: 14; Nay: 0; Absent: 0.

This goes back to Human Services. Senator Judy Lee will carry the bill.

Chairman Holmberg: Closed the hearing on HB 1115.

Date: 3-21-2019
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1115

Senate Appropriations Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By Dever Seconded By Wanzek

Senators	Yes	No	Senators	Yes	No
Senator Holmberg	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator Grabinger	✓	
Senator Wanzek	✓		Senator Robinson	✓	
Senator Erbele	✓				
Senator Poolman	✓				
Senator Bekkedahl	✓				
Senator G. Lee	✓				
Senator Dever	✓				
Senator Sorvaag	✓				
Senator Oehlke	✓				
Senator Hogue	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Sen Judy Lee Back to Human Services

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1115, as engrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1115, as amended, was placed on the Fourteenth order on the calendar.

2019 TESTIMONY

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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.

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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.

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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).

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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:

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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.

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North Dakota Department of Human Services

ACA MEDICAID INCOME ELIGIBILTY LEVELS Effective April 1, 2018

Family Size	(MAGI Equivalent of Approximately 54% of PL) Parents and Caretakers		Adults age 19 and 20 and Medically Needy for Pregnant Women (90% of PL)		Medically Needy Individuals up to age 21 (92% PL)		Medically Needy Parents, Caretakers and their Spouses (93% PL)		Adult Expansion Group (age 19 to 65) & Children (Ages 6 to 19) 138% of the PL		Pregnant Women & Children (Ages 0 to 6) 152% of the PL		Healthy Steps – Children up to age 19 175% of the PL	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$517	$6,204	$ 911	$10,926	$ 931	$ 11,169	$ 941	$ 11,290	$ 1397	$ 16,753	$ 1538	$ 18,453	$ 1771	$ 21,245
2	694	$8,328	1235	14,814	1262	15,143	1276	15,308	1893	22,715	2085	25,019	2401	28,805
3	871	$10,452	1559	18,702	1594	19,118	1611	19,325	2390	28,676	2633	31,586	3031	36,365
4	1048	$12,576	1883	22,590	1925	23,092	1946	23,343	2887	34,638	3180	38,152	3661	43,925
5	1226	$14,712	2207	26,478	2256	27,066	2281	27,361	3384	40,600	3727	44,718	4291	51,485
6	1403	$16,836	2531	30,366	2587	31,041	2615	31,378	3881	46,561	4274	51,285	4921	59,045
7	1580	$18,960	2855	34,254	2918	35,015	2950	35,396	4377	52,523	4821	57,851	5551	66,605
8	1757	$21,084	3179	38,142	3250	38,990	3285	39,413	4874	58,484	5369	64,418	6181	74,165
9	1934	$23,208	3503	42,030	3581	42,964	3620	43,431	5371	64,446	5916	70,984	6811	81,725
10	2111	$25,332	3827	45,918	3912	46,938	3955	47,449	5868	70,408	6463	77,550	7441	89,285
+1	178	$2,136	$ 324	$ 3,888	$ 332	$ 3,974	335	$ 4,018	$ 497	$ 5,962	$ 548	$ 6,566	$ 630	$ 7,560

Maintenance of Effort – Medicaid

Family Size	111% of Federal Poverty Level		133% of Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly
1	$ 1,123	$ 13,475	$ 1,346	$ 16,146
2	1,523	18,271	1,825	21,892
3	1,923	23,066	2,304	27,637
4	2,322	27,861	2,782	33,383
5	2,722	32,656	3,261	39,129
6	3,121	37,451	3,740	44,874
7	3,521	42,247	4,219	50,620
8	3,921	47,042	4,698	56,365
9	4,320	51,837	5,176	62,111
10	4,720	56,632	5,655	67,857
+1	$ 400	$ 4,795	$ 479	$ 5,746

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North Dakota Department of Human Services

NON-ACA MEDICAID INCOME ELIGIBILTY LEVELS Effective April 1, 2018

Family Size	SSI Effective 01-01-2017	Medically Needy 83% of Poverty	QMB 100% of Poverty	SLMB 120% of Poverty	QI-1 135% of Poverty	Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$ 750	$ 840	$ 1,012	$ 1,214	$ 1,366	$ 2,024	$ 2,277
2	1,125	1,139	1,372	1,646	1,852	2,744	3,087
3	[redacted]	1,438	1,732	2,078	2,338	3,464	3,897
4		1,737	2,092	2510	2,824	4,184	4,707
5		2,035	2,452	2,942	3,310	4,904	5,517
6		2,334	2,812	3,374	3,796	5,624	6,327
7		2,633	3,172	3,806	4,282	6,344	7,137
8		2,932	3,532	4,238	4,768	7,064	7,947
9		3,231	3,892	4,670	5,254	7,784	8,757
10		3,529	4,252	5,102	5,740	8,504	9,567
+1		$ 299	$ 360	$ 432	$ 486	$ 720	$ 810

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (Effective 01/01/18)	Community Spouse Maximum Asset Allowance (Effective 01/01/18)	Community Spouse Income Level (Effective 01/01/16)	Income Level for each Additional Individual (Effective 07-01-17)
$24,720	$123,600	$2,550	$677

Average Cost of Nursing Care

Average Monthly Cost of Care (Effective 01/01/18)	Average Daily Cost of Care (Effective 01/01/18)
$8,234.10	$270.71

Notes:

- Nursing Home personal needs allowance increased from $50 to $65 effective with the benefit month of October 2013.
- ICF/ID and Basic Care personal needs allowance increased from $85 to $100 effective with the benefit month of October 2013.

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DESIGNER GENES
A·DOWN·SYNDROME·SUPPORT·NETWORK

HB 1115
House Human Services
Tuesday, January 8, 2019

Chairman Weisz and Members of the House Human Services Committee:

My name is Roxane Romanick and I'm representing Designer Genes of ND, Inc., as their Executive Director. Designer Genes represents 220 individuals with Down syndrome and their families across the state of North Dakota which is over 30% of the estimated number of individuals with Down syndrome who reside in our state. Designer Genes' mission is to strengthen opportunities for individuals with Down syndrome and those who support them to earn, learn, and belong.

I am here today to ask for your consideration of amending the language in HB 1115 in Section 32 (Page 27, lines 5 and 6) to increase the income level to the federally allowed limit of 300% of the federal poverty level. Based on the 2018 federal poverty guidelines, this would mean that a family of 4 who has a child with a disability as defined by the Social Security Administration making $75,300 (after exclusions) could have the child covered by Medicaid. (https://familiesusa.org/product/federal-poverty-guidelines) Families with children with Down syndrome, who do not meet the criteria for eligibility for any of the Medicaid waivers that are available may be able to obtain coverage for state plan Medicaid services, such as various therapies by this increase. This is one of the solutions that advocates have provided to the Department in looking at gaps in services for ND children with special health care needs.

Thank you for your time. I'd be willing to answer any questions.

Roxane Romanick
Executive Director
Designer Genes of ND, Inc.
701-391-7421 info@designergenesnd.com

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FAMILY VOICES OF NORTH DAKOTA®
Navigating Crossroads to Hope

HB 1115
House Human Services
Tuesday, January 8, 2019

Chairman Weisz and Members of the House Human Services Committee:

My name is Donene Feist from Edgeley, North Dakota. I am here today as the Family Voices of North Dakota State Director.

The Medicaid Buy-in is an important piece of HB 1115 for a number of reasons. In 2007, ND passed this legislation which directed the Department of Human Services to establish and implement a buy-in program under the federal Family Opportunity Act enacted as part of the Deficit Reduction Act of 2005 [Pub. L.109-171; 120 Stat. 4; 42 U.S.C 1396] to provide medical assistance and other health coverage options to families of children with disabilities. The FOA as it passed in Congress gave states the option to create a Medicaid "buy in" or purchase coverage under the Medicaid program as a supplement for families of children with disabilities.

With the passage of the Family Opportunity Act in North Dakota 2007, families have benefited through Buying In to Medicaid in the following ways:

- Children with significant disabilities can receive the health care services they need to reach their potential. Children will no longer be denied care or have limited care and so their health will most likely improve because they are given the care they need at the appropriate time and spend less time in the emergency rooms or hospitals which will bring down the cost of care.
- Fewer parents will have to choose between paying for the health care for their child or other necessary family expenses such as food, clothing and shelter.
- Fewer parents will have to place their child out of the home in order to access appropriate health services or forgo custody of their child in order to access appropriate health services.

Parents of children with disabilities were unjustly punished for working hard to support and provide for their families. When passed this bill was a major step forward for the families who have been denied opportunities so that their children with special health needs and disabilities can get the care they need. It removed some of the barriers that prevented families from staying together and staying employed—while giving hope and freedom to those who deserve it most

The Medicaid Buy In is crucial to middle-income families across North Dakota that have children with disabilities who require expensive health care. My hope is that we will continue to build upon what we started 12 years ago. Many middle-income families in North Dakota that have children with significant disabilities do not have access to affordable and adequate health insurance to cover their children's chronic health care needs. There remains a gap to this day. Most employer provided health insurance does not provide for the comprehensive medical care that these children need. This must be clearly understood. Just because families have health insurance does not mean their needs are being met. Many

of these families are under insured as private insurance simply does not meet the health needs of these complex children.

The coverage they need is available through Medicaid, but they cannot access it because their family earnings are too high to qualify. Medicaid by all standards provides the most comprehensive health care for this population of children. Far too many of these families are faced with the stark choice of becoming impoverished in order to gain access to Medicaid as their only feasible health care option for their children. Other equally unacceptable options that these families have to consider are an out-of-home placement or the relinquishment of custody of their child with a disability so that they will ensure Medicaid coverage of their child's health care needs. These families have to face bankruptcy, impoverishment, or the loss of their child to secure what most American families take for granted - comprehensive health care for their children. This program provides reasonable solutions: access to health care and assistance as Medicaid would be a supplement family's health care insurance buy allowing them to Buy-In to acquire appropriate health care coverage for their child.

In our own personal story, years ago, because of our son's health needs, we faced medical bankruptcy, and it is an ugly situation to be in. In comparison to the many other families our story is just one of many. His costs were not as extensive as many other families that I have worked with, yet there I was facing bankruptcy. I believe this program saved others from facing the same fate.

As parents it is our job to do what you have to do to meet the needs of your children. Those of you who may not have a child with special needs or a disability, just for a moment envision the most frightening moment you had in raising your child. In those moments you protect, nurture and simply put do what needs to be done to help your child get through. Now envision your own child having a significant medical issues and taking care of the health needs of these children day in and day out. Imagine deciding whether to buy milk or drive your child to therapy, not being able to go to the dentist because the other medical bills were just too high.

These families are faced with decisions that no family should have to face. The choices we make often shuffle between necessity and basic human needs. While we are masters of pulling ourselves up by our boot straps, that ability gets harder and harder. We become exhausted, isolated and feel defeated. This comes from personal experience, and yet somehow in that weakness there is strength to keep going because here is this kiddo who keeps you moving forward.

Would we as his parents done anything differently...actually no, there were NO other options. In providing his health care needs, we went deeper and deeper into debt, what choice did we have?? I say, Absolutely! He talks, he communicates, he obtained his masters in counseling and behavioral health and he exceled. Had we not gone the distance, had we given up and be beaten would he be doing these things...we will never know, as it wasn't something we took lightly or willing to compromise. The passage in North Dakota was too late to assist our personal situation, but like the families that is has helped has made a difference.

Families shouldn't have to impoverish themselves to get the help they need for their children, worry about whether a pay raise will raise their income eligibility and they lose Medicaid as a vital support for their family. For families of children with disabilities and special health care needs, they were in a state of emergency. This program changed that course.

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In continuing to build upon what was passed 12 years ago, we would like you to consider raising the eligibility for families up to 300% of the federal poverty level as passed in Congress in 2005. A significant problem is many families fall through the cracks. In effect, the system is forcing parents to choose between near-poverty and their children's health care. We need to fix that. Based on the 2018 federal poverty guidelines, a family of 4 who has a child with a disability as defined by the Social Security Administration making $75,300 (after exclusions) could have the child covered by Medicaid. Health care costs have sky rocketed, while wages have remained a bit stagnant. In expanding to 300% of the FPL as intended by Congress, will close the health care gap for North Dakotas most vulnerable children, and enable these families. It is also an essential investment in the health and independence of these young people that will strengthen North Dakota families and children.

Medicaid's comprehensive benefits should serve as a model for all children and youth needing specialized health care services, whether publicly or privately funded. For children and youth whose primary private health coverage benefits are limited, secondary health care coverage, like Medicaid, is essential.

This program is pro-work because it lets parents work without losing their children's health coverage, pro-family because it encourages parents to work and build a better life for their children, and it's pro-taxpayer because it means more parents continue to earn money, pay taxes and pay their own way for Medicaid coverage for their children.

Additionally, we agree with the Departments changes to provide in-home services to children with extraordinary medical needs and to children up to the age of fourteen diagnosed with an autism spectrum disorder who would otherwise meet institutional level of care through the Medicaid waivers.

In closing, let us remember as each of us makes decisions that will affect children—whether we are parents, educators, health professionals, or government officials—it is our duty to consider if that decision either affirms or denies a child's most basic human rights.

Let's continue to embrace the needs of families and move us forward in the right direction, increasing the FPL for the Medicaid Buy In program would do just that.

Again, I thank you for allowing me the time to provide input on this vital bill for families

Donene Feist
PO Box 163, Edgeley, North Dakota
Phone: (701) 493-2634
fvnd@drtel.net

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North Dakota Hospital Association Est. 1934

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: 2019 HB 1115
House Human Services Committee
Representative Robin Weisz, Chairman
January 8, 2019

Good afternoon Chairman Weisz and Members of the House Human Services Committee. I am Melissa Hauer, General Counsel of the North Dakota Hospital Association. I am here to testify regarding 2019 House Bill 1115 and ask that you give this bill, in its current form, a **Do Not Pass** recommendation.

Our concern is with section 27, page 21, of the bill which provides an unlimited amount of time to the Department of Human Services to make a decision on a Medicaid provider review request.

Current law, at section 50-24.1-24, N.D.C.C., provides the procedure for a healthcare provider to request review of denial of, or reduction in, payment for a Medicaid claim. A provider has 30 days in which to request such a review. Within thirty days after that request, the provider must provide all documents, written statements, exhibits, and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item. The department then must issue its final decision within 75 days.

The primary objective of this law is to provide a procedure for providers to appeal a denial of, or reduction in, the payment of a Medicaid claim. The 75 day time period for a final decision assures order and promptness in reviewing a provider's appeal of a denial. If there is no

deadline by which the department must make a final decision, providers will suffer unfair consequences. The mandatory statutory timeframe was put in place for a reason. While waiting for the department to issue a final decision, a healthcare provider has to operate without payment, or with reduced payment. If the department is seeking recoupment of claims paid, the provider must maintain those funds in case repayment is ultimately ordered. These cases can involve substantial amounts of money. For example, in a recent review case, the department sought recoupment from a provider in the amount of $251,916.26. The provider requested review but did not receive a final decision for approximately 225 days. Without a final decision deadline, providers have no way to know when, or if, the payment denial or reduction will be rectified. The review process should not be allowed to go on indefinitely.

Hospitals can certainly appreciate that, since this law was enacted, more time may be necessary to go through documents and make decisions and that these appeals may have increased due to federal auditing requirements, but the department should be held to some standard of timeliness, just as providers are. If a provider were to file a request for review beyond the 30-day deadline, the request would be dismissed as untimely. Both parties should have certainty about the process. There should be a reasonable deadline by which the department must issue its final decision. Without such a deadline, an appeal right is meaningless.

We oppose the bill in its current form and ask that you give it a **Do Not Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,
Melissa Hauer, General Counsel
North Dakota Hospital Association

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PROPOSED AMENDMENTS TO HOUSE BILL NO. 1115

Page 1, line 1, remove "a new section to chapter 12-44.1,"

Page 1, line 2, remove the first comma

Page 1, line 2, replace "a" with "two"

Page 1, line 2, replace "section" with "sections"

Page 1, line 3, remove "payment of claims receives on behalf of inmates,"

Page 1, line 4, remove the first "and"

Page 1, line 4, after "persons" insert ", and documentation requirements for claims processing regarding Medicaid and Medicare eligible individuals"

Page 1, line 7, after "50-24.1-12" insert ", 50-24.1-14"

Page 1, line 9, after "50-24.1-33" insert ", 50-24.1-34"

Page 1, line 12, remove "and"

Page 1, line 13, after the second comma insert "and"

Page 1, line 13, remove ", 50-24.1-34, and 50-24.1-38"

Page 1, line 14, after "persons" insert "; and to provide an effective date"

Page 1, remove lines 16 through 21

Page 2, after line 20, insert:

"**SECTION 5.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medicaid and Medicare eligible individuals.

The department may not require prior authorization, additional documentation not required by Medicare, and additional prescription requirements of durable medical equipment and supplies in order to process a claim for Medicaid-eligible individuals who are also eligible for Medicare when an item has been paid by Medicare unless the item is not covered by Medicaid."

Page 17, after line 26, insert:

"**SECTION 22. AMENDMENT.** Section 50-24.1-14 of the North Dakota Century Code is amended and reenacted as follows:

50-24.1-14. Responsibility for expenditures.

~~Expenditures~~Notwithstanding section 50-24.1-34, expenditures required under this chapter are the responsibility of the federal government or the state of

North Dakota."

Page 21, line 1, after "days" insert "of receipt of the notice of request for review, when the department has denied payment for a medical assistance claim or reduced the level of service payment for a service and within seventy-five days"

Page 21, line 2, after "review" insert ", when the department has recouped or adjusted a claim, or part of a claim, following an audit"

Page 27, after line 23, insert:

"**SECTION 34. AMENDMENT.** Section 50-24.1-34 of the North Dakota Century Code is amended and reenacted as follows:

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

The department of human services shall process claims submitted by enrolled medical providers on behalf of inmates at county jails. Each county shall pay the department for the paid amount for the claims processed and also a processing fee for each claim submission. The department shall establish a processing fee ~~that may not exceed thirty dollars~~ and shall update the fee annually on July first. The processing fee must be based on the ~~annual~~actual costs to the department of the claims processing operations divided by the annual volume of claims submitted. The department shall invoice each county for payment of the processing fee. ~~Beginning July 1, 2011, the department of human services shall increase the claims processing fee to recover the cost of the Medicaid claims system changes. The department shall deposit the portion of the fee associated with recovering the costs of the Medicaid claims system changes in the general fund.~~"

Page 29, line 20, remove ", or as soon thereafter as possible"

Page 30, line 23, after the third comma insert "and"

Page 30, line 23, remove ", 50-24.1-34, and 50-24.1-38"

Page 30, after line 24, insert:

"**SECTION 38. EFFECTIVE DATE.** Section 5 of this Act becomes effective on January 1, 2020."

Renumber accordingly

Amendment prepared by the Department at the request of Representative Porter

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#1 pg.1

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.

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PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1115

Page 5, line 21, remove the overstrike over "~~equal~~"

Page 5, line 21, remove "up"

Page 21, line 11, after "notice" insert "of request"

Page 21, line 11, replace "if" with "when"

Page 21, line 14, replace "if" with "when"

Page 21, line 14, after "adjusted" insert "a"

Renumber accordingly

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North Dakota Hospital Association Est. 1934

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: 2019 HB 1115
Senate Human Services Committee
Senator Judy Lee, Chairman
March 4, 2019

Good morning Chairman Lee and Members of the Senate Human Services Committee. I am Melissa Hauer, General Counsel of the North Dakota Hospital Association. I am here to testify regarding engrossed House Bill 1115 and ask that you give this bill, in its current form, a **Do Not Pass** recommendation.

Our concern is with section 28, page 20, of the bill which provides an unlimited amount of time to the Department of Human Services to make a decision on a Medicaid provider review request if that appeal arises from an audit.

Current law, at section 50-24.1-24, N.D.C.C., provides the procedure for a healthcare provider to request review of denial of, or reduction in, payment for a Medicaid claim. A provider has 30 days in which to request such a review from the Department. Within 30 days after that request, the provider must provide all documents, written statements, exhibits, and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item. The Department then must issue its final decision within 75 days.

The primary objective of this law is to provide a procedure for providers to appeal a denial of, or reduction in, the payment of a Medicaid claim. The 75 day time period for a final decision assures order and promptness in reviewing a provider's appeal of a denial. If there is no deadline by which the Department must make a final decision, providers will suffer unfair

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consequences. While waiting for the Department to issue a final decision, a healthcare provider has to operate without payment, or with reduced payment. If the Department is seeking recoupment of claims paid, the provider must maintain those funds in case repayment is ultimately ordered. These cases, especially those that arise from an audit, can involve substantial amounts of money. Without a final decision deadline, providers have no way to know when, or if, the payment denial or reduction will be rectified. The review process should not be allowed to go on indefinitely.

The decision deadline in this statute was addressed in two recent North Dakota supreme court opinions (Sanford Healthcare Accessories, LLC v. N.D. Dep't of Human Services, et al., 2018 ND 35, and St. Alexius Medical Center v. N.D. Dep't of Human Services, 2018 ND 36), in which the Department failed to decide medical providers' appeals within the statutorily required 75-day deadline. Based on audits, the Department determined in these cases that it was entitled to recoup overpayments made to the providers. The amounts in controversy in these cases were substantial: $164,809 and $96,140. The Department took 225 days to issue its decision in one case and 236 days in the other case. While the supreme court decided these cases on other grounds, the district court's comments on the lack of timeliness of the Department's decisions are helpful as background as to how these cases impact providers. In one case, the district court noted that the mandatory statutory timeframe is in place for a reason. While waiting for the Department to issue its final decision, the hospital had to maintain the funds. The Department did not issue its final order for nearly triple the amount of time allowed under the law. The court indicated that while it could appreciate that more time may have been necessary to sift through documents and to organize them, the Department provided no explanation as to why it did not request more time.

The district court in the other case concluded the decision was not in accordance with the law because the Department failed to comply with the statutory time requirement for issuing its decision under N.D.C.C. § 50-24.1-24(5). The court ruled the statute requires the Department to issue its final decision within seventy-five days of receipt of the notice of request for review, the legislature intended the Department issue its decision within a reasonable time frame, and the seventy-five day time limit may be extended for a reasonable amount of time upon a showing of good cause. The court explained the Department far exceeded the seventy-five days allowed by statute and it was not persuaded by the Department's arguments that the decision was delayed

because the documents submitted by the provider were disorganized and that the provider was not prejudiced by the delay.

Hospitals can certainly appreciate that more time may be necessary to go through documents and make decisions in some cases and that these appeals may have increased due to federal auditing requirements, but the Department should be held to some standard of timeliness, just as providers are. If a provider were to file a request for review beyond the 30-day deadline, the request would be dismissed as untimely. Both parties should have certainty about the process. There should be a reasonable deadline by which the Department must issue its final decision in provider appeals, no matter whether the appeal arose from an audit. Without such a deadline, an appeal right is meaningless. The Department should be required to issue its final decision within a specified time period and, if it cannot, it should be required to provide good cause to the court for why it will not be able to meet that deadline. This gives both parties a fair process by which an independent third party can determine whether the additional time is necessary for the Department to issue its decision.

For these reasons, we oppose the bill in its current form and ask that you give it a **Do Not Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,
Melissa Hauer, General Counsel
North Dakota Hospital Association