

Testimony
Department of Human Services
Health Services Committee
Senator Judy Lee, Chairman
July 24, 2012

Chairman Lee, and members of the Interim Health Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I appear before you to provide information regarding federal health care initiatives, including how they will affect access to health care in the state.

There are many initiatives, grants, and demonstrations that are currently available for consideration by states. I have captured some in my testimony, and if there is interest in any other initiative, the Department would be willing to research its applicability to North Dakota Medicaid. Much of the information in my testimony is taken directly from the Centers for Medicare and Medicaid Services (CMS) website and policy guidance.

Program Integrity

Provider Enrollment and Screening

Section 6401(a) of the Affordable Care Act, as amended by section 10603 of the Affordable Care Act, amends section 1866(j) of the Social Security Act (the Act) adds a new paragraph "(2) Provider Screening." Section 1866(j)(2)(A) of the Act requires the Secretary, in consultation with the Department of Health and Human Services' Office of the Inspector General, to establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under Medicare, Medicaid, and CHIP. Section 1866(j)(2)(B) of the Act requires the Secretary to determine the level of screening to be conducted according to the risk of fraud, waste, and abuse with respect to the category of provider

or supplier. Section 1866(j)(2)(C) of the Act requires the Secretary to impose a fee on each institutional provider of medical or other items or services or supplier, to be used by the Secretary for program integrity efforts. Section 6401(b) of the Affordable Care Act amends section 1902 of the Act to add paragraph (a)(77) and (kk), which include requirements for States to comply with the process of screening providers and suppliers and imposing temporary enrollment moratoria for the Medicaid program as established by the Secretary under 1866(j)(2) and (7) of the Act.

The Department will be issuing a Request for Proposal for a vendor to assist with the implementation of the screening requirements (licensing lists, checking Social Security Administration Death Master File, site visits, etc.).

Termination of Provider Participation

Section 6501 of the Affordable Care Act amends section 1902(a)(39) of the Social Security Act (the Act) and requires State Medicaid agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan.

The Department checks the two federal exclusion lists for newly-enrolling providers and will be issuing a Request for Proposal for a vendor to check the federal exclusion lists and the list of individuals and entities terminated under Medicare and other State Medicaid plans, for all Medicaid providers on a monthly basis.

Recovery Audit Contractor (RAC)

Section 6411(a) of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program amends section 1902(a)(42) of the Social Security Act (the Act) and requires States to establish a RAC program to enable the auditing of claims for services furnished by Medicaid providers.

Pursuant to the statute, these Medicaid RACs must: (1) identify overpayments; (2) recoup overpayments; and (3) identify underpayments.

The Department has entered into a contract with Cognosante. It is expected that Cognosante will begin their audits of North Dakota Medicaid providers in September 2012.

Electronic Health Records

The Recovery Act amends the Medicaid statute to provide for a 100 percent Federal financial participation (FFP) match for State expenditures for provider incentive payments to encourage Medicaid health care providers to purchase, implement, and operate certified electronic health record (EHR) technology.

For the 2011 payment year, for North Dakota Medicaid Incentive Payments: 91 professionals applied and 16 hospitals applied. The Department expects to make around \$7 million of incentive payments before August 31, 2012. For the 2012 payment year, attestation must be for Meaningful Use Stage 1. To date, six hospitals and 28 professionals have registered their intent to attest.

International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD -10)

ICD-10 codes provide more robust and specific data that will help improve patient care. Entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be required to use the ICD-10 diagnostic and procedure codes.

Delay of ICD-10

CMS announced a proposed regulation on April 9, 2012 on HIPAA Administrative Simplification. The rule proposes a HIPAA standard health plan identifier and delays required compliance by one year (from October 1, 2013, to October 1, 2014) for new codes used to classify diseases and health problems.

The proposed change in the compliance date for ICD-10 would give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition to these new code sets.

The Department will be incorporating the ICD-10 changes in the new Medicaid Management Information System (MMIS). The system is expected to be ICD-10 compliant at go live, which is slated for October 2013.

Increase in Physician Reimbursement

Section 1202 of the Affordable Care Act, provides increased payments for certain Medicaid primary care services. Under this provision, certain physicians that provide eligible primary care services would be paid the Medicare rates in effect in calendar years (CY) 2013 and 2014 (or if greater, the Medicare rate in effect in 2009) instead of their usual state-established Medicaid rates, which may be lower than federally established Medicare rates. Increased payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine or related subspecialists. States will receive 100 percent FFP for the difference between the Medicaid state plan payment amount as of July 1, 2009, and the applicable Medicare rate. The increase

applies to a specific set of services and procedures that CMS designates as “primary care services”.

The Department does not expect to receive the 100 percent FFP, as the North Dakota Medicaid physician fees were greater than the Medicare fees as of July 1, 2009. The analysis of the payments for vaccine administration will be completed once the final rule is published.

Comprehensive Primary Care Initiative

The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients.

The Department provided a letter of support for the application submitted by Blue Cross/Blue Shield of North Dakota; however, their project was not funded as part of this initiative. We will watch the efforts of the projects selected.

Strong Start for Mothers and Newborns

This initiative is a joint effort between CMS, the Health Resources and Services Administration (HRSA), and the Administration on Children and Families (ACF).

Overview

The Strong Start initiative supports reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns.

The Medical Services Division has written a letter of support and has provided information to Sanford Health for their application for this funding.

Adult Quality Grants: Measuring and Improving the Quality of Care in Medicaid (Announced July 17, 2012)

On July 13, 2012, CMS released a two-year funding opportunity announcement open to all 50 States, the District of Columbia, and territorial Medicaid agencies. This grant opportunity, funded by the Affordable Care Act, is designed to support State Medicaid agencies in building capacity to collect, report, and analyze data on the Initial Core of Set of Health Care Quality Measures for adults enrolled in Medicaid. A total of 56 grant awards are available in the amount of up to \$1 million for each 12-month budget period over the two-year project period (an estimated total of up to \$2 million per grantee).

The Department is exploring this grant funding, as a means to support establishing systems to collect and report quality measures and to work with providers to improve the quality of services, as called for in the Affordable Care Act.

Integrated Care Models (Announced July 10, 2012)

CMS has issued the first two letters in a series of communications that provides States with guidance on designing and implementing care delivery and payment reforms that improve health, improve care, and reduce costs

within Medicaid programs. These letters describe the policy considerations for creating "Integrated Care Models" (ICMs), which could include (but are not limited to) medical/health homes, Accountable Care Organizations (ACOs), ACO-like models, and other arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care.

Staff from the Medical Services Division will be participating in the upcoming webinars on this announcement to determine if there are applications for the North Dakota Medicaid program.

Balancing Incentive Payment Program

The Patient Protection and Affordable Care Act includes a program to incentivize states to offer home and community-based services as a long-term care alternative to nursing homes. The State Balancing Incentive Payment Program creates an opportunity for North Dakota to receive a temporary enhanced Federal Medical Assistance Percentage (FMAP) for home and community-based services (HCBS) expenditures for Long Term Support Services (LTSS) under the North Dakota Medicaid program. The increased matching payments are tied to the percentage of a State's non-institutional LTSS spending and North Dakota would receive a two percent increase in FMAP for Home and Community-Based Services expenditures.

The Balancing Incentive Payment Program also requires states to implement structural changes, including a statewide No Wrong Door/Single Entry Point System, conflict-free case management services, and a core standardized assessment instrument.

If the Department applied, North Dakota must achieve benchmarks of 50 percent of total Medicaid expenditures for non-institutional LTSS no later than October 1, 2015. According to CMS data for FFY 2009*, North Dakota had a percentage of 28 percent of LTSS spending for HCBS; therefore, North Dakota would need to achieve an increase of 22 percent of total Medicaid

expenditures for non-institutional LTSS by October 1, 2015. Institutional LTSS would also increase during this time. (*The Department has recently confirmed with CMS that data from 2009 must be used, as this is what was specified in statute.)

The Department does not believe we are in a position to obligate future legislative sessions to increase LTSS spending to achieve the 50 percent benchmark, so we have not applied for this funding; however, we plan to include this as an optional adjustment request as part of the 2013-2015 Budget submission.

As the Department explores the various initiative, grants and demonstrations available, we consider any required state match or sustainability requirements, as well as the availability of staff resources to manage existing program requirements.

I would be happy to any questions you may have.