Testimony
Department of Human Services
Human Services Committee
Representative Alon Wieland, Chairman
July 31, 2012

Chairman Wieland, members of the Human 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 the historical caseloads and program utilization for the Medical Services Division and long-term care continuum programs and the estimated impact of the Affordable Care Act on the Department's anticipated caseloads and budget, including information on the full-time equivalent positions authorized during the 2011 special legislative session.

Affordable Care Act

The Affordable Care Act (ACA) was enacted in March 2010. The ACA (as enacted), required each state to expand Medicaid coverage for all individuals under the age of 65 with incomes up to 138 percent of the federal poverty level. The ACA called for the expansion to be implemented by January 1, 2014.

Eligibility Levels at 138 percent of the Federal Poverty Level
Effective April 1, 2012

		Monthly		Annual
Family Size		138% of FPL		138% of FPL
1		$1,285		$15,415
2		$1,740		$20,880
3		$2,196		$26,345
4		$2,651		$31,809

To finance coverage for the newly eligible individuals, the ACA included provisions for states to receive 100 percent federal funding for Calendar Years (CY) 2014 through 2016, 95 percent federal financing in CY 2017, 94 percent federal financing in CY 2018, 93 percent federal financing in CY 2019, and 90 percent federal financing for CY 2020 and subsequent years.

In 2010, the Department prepared a preliminary estimate of the impact of the ACA, including the Medicaid expansion. The estimate included the impact of providing coverage for the "newly" eligibles, and coverage for "previously" eligibles. It also included estimates of the impact on coverage for children who may switch between the Children's Health Insurance Program (CHIP) and Medicaid as well as the impact on the cost for covering the medically needy coverage group. The preliminary projection estimated that North Dakota expenditures could increase by $106 million through 2019 and that Medicaid enrollment could increase by as much as 50 percent.

Medicaid Expansion and Affiliated Areas Impacts

On June 28, 2012, the Supreme Court upheld the 2014 Medicaid expansion; however, they struck down the mandate indicating that the federal government could not withhold all federal Medicaid funding if a state chooses to not expand Medicaid. Therefore, the decision about whether to expand the Medicaid program will be left to each state.

This opinion has resulted in a number of questions that need to be addressed. Both the Department and the National Association of

Medicaid Directors have submitted numerous questions to the Centers for Medicare and Medicaid Services (CMS).

Examples of questions that have been submitted:

- *Can a state choose to expand Medicaid to 100 percent of the Federal Poverty Level (FPL) rather than the 133 percent (plus 5 percent income disregard)?*
  If a state expands to a level lower than 133 percent of the FPL, is the state still eligible for the enhanced federal funding?

- *Can a state phase-in an expansion to 133 percent of the FPL?*
  Is the state still eligible for the enhanced federal funding?

- *If the state chooses to not expand in 2014, but at a later date, is the enhanced federal funding available?*

- *Can CMS confirm that individuals with income between 100 percent FPL and 133 percent FPL will be eligible for cost sharing subsidies and tax credits to purchase coverage through the Exchange?*

Once we have the answers to the questions submitted, the Department will be reanalyzing the impact of the Medicaid expansion and affiliated areas that was prepared in 2010. We expect the analysis with various scenarios to be available for the 2013 Legislative Assembly.

Even if North Dakota chooses not to expand Medicaid, there will still be impacts to the Medicaid program and Medicaid expenditures. On

July 16, 2012 the Congressional Research Service issued a Memorandum, which provides an analysis of the effect of the Supreme Court's decision on the Medicaid expansion.

This analysis notes:

"The Court's decision only limited this new grant program's *enforcement* mechanism; it did not specifically affect, change or limit any other Medicaid or ACA provisions."

"…all other provisions of the Medicaid statute, both current and in the ACA are "severed" from this remedy, and so remain "fully operative" as provided in the law and should 'function in a way consistent with Congress' basic objectives in enacting the statute.'"

"Following the Supreme Court's decision in NFIB, some have argued that the states are no longer required to comply with the ACA maintenance of effort provision (MOE), and the modified adjusted gross income provision (MAGI) because these requirements should be considered part of the ACA Medicaid expansion…..A careful reading of the Court's holding supports the conclusion that these two provisions are unaffected by the Supreme Court's ruling, and are enforceable under the current Medicaid statute."

"If states choose not to participate in the Medicaid expansion, given the Court's severability analysis, the MAGI standards would still be applicable to other parts of the state's Medicaid program, CHIP program and for determining an individual's eligibility for federal subsidies toward the purchase of private health coverage through the state exchanges."

Therefore, even though the expansion is now a state option, moving to Modified Adjust Gross Income (MAGI) does not appear to be a state option. The policy and information technology changes that will be needed to support conversion to MAGI in Medicaid and CHIP are underway and will continue. The Department expects other affiliated areas to be impacted because the ACA was upheld. We still expect an increase in enrollment due to the individual mandate and the outreach efforts that are expected as part of the ACA. In addition, the ACA calls for strengthening of program integrity efforts, and includes provisions to improve quality of care and access. We hope to know more in the weeks and months to come and will be better able to quantify the affiliated impacts on the Medicaid program and Medicaid expenditures.

Full-time Equivalent Positions

During the 2011 special legislative session, seven full-time equivalent (FTE) positions were authorized for the Department to assist with the workload resulting from the ACA. The following chart provides a status of these FTE.

Position	Requested Start Date	Actual or Anticipated Start Date
Economic Assistance Policy Trainer	April 1, 2013	April 2013
Child Support Enforcement Attorney	January 1, 2012	September 2012
Medical Services		
Eligibility Policy	January 1, 2012	February 6, 2012
Program Integrity	January 1, 2012	January 17, 2012
Nurse	October 1, 2012	October 2012
SURS Analyst *	January 1, 2013	January 2013
Administrative Support	January 1, 2013	January 2013

* Surveillance and Utilization Review System (SURS)

I would be happy to answer any questions.

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Monthly Average Caseload Comparison - Medical Assistance, Long Term Care and Developmental Disability Grants

Maggie Anderson, Director, Medical Services

	2005 - 2007 Biennium			2007 - 2009 Biennium			2009 - 2011 Biennium			Budgeted
	Actual 2006	Actual 2007	Biennial Average	Actual 2008	Actual 2009	Biennial Average	Actual 2010	Actual 2011	Biennial Average	2011-13 Biennium
Total Medicaid Recipients	38,878	38,833	38,856	41,435	42,231	41,833	46,027	46,351	46,189	*
Medical Service										
Inpatient Hospital	909	843	876	1,228	1,151	1,189	1,229	1,188	1,209	1,227
Outpatient Hospital	6,396	4,949	5,673	7,824	8,397	8,111	8,920	8,707	8,813	9,252
Physician	17,667	15,542	16,605	20,171	21,436	20,804	23,806	23,538	23,672	24,360
Net Drugs	19,883	15,907	17,895	--- Not Available ---			18,580	19,240	18,910	17,854
Dental	2,893	2,830	2,861	2,976	3,142	3,059	3,942	3,913	3,928	3,841
Healthy Steps	3,278	3,764	3,521	4,006	3,470	3,738	3,368	3,718	3,543	4,026
Long Term Care										
Nursing Facilities (& Hospice)**	110,289	126,222	118,255	109,182	102,286	105,734	100,684	99,635	100,159	102,058
Basic Care**	27,025	25,647	26,336	25,761	27,470	26,616	30,856	35,334	33,095	32,651
SPED	1,240	1,321	1,280	1,434	1,360	1,397	1,299	1,278	1,288	1,350
Expanded SPED	127	116	122	109	106	108	116	122	119	137
HCBS Waiver	279	241	260	244	256	250	287	304	295	327
Targeted Case Management	342	342	342	427	416	421	460	494	477	488
Personal Care Option	512	571	542	570	569	569	617	621	619	671
Tech. Dependent Waiver	-	-	-	1	1	1	1	1	1	2
Medically Fragile Waiver	-	-	-	-	1	1	2	3	2	9
PACE	-	-	-	-	10	5	41	53	47	85
Children's Hospice Waiver	-	-	-	-	-	-	-	-	-	17
Developmental Disability Grants	2,765	3,027	2,896	3,131	3,235	3,183	3,326	3,293	3,309	*

* Recipient information is not available as budget is based on Units of Service for individual categories.

** Nursing Facilities and Basic Care caseload represents the average number of "Days" paid for recipients in a month. All other services represent recipients served.