Presentation to Joint Legislative Committee on Governmental Operations
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DHHS Response to Questions Directed from Legislative Fiscal Research

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Legislative Question 1: .Identify each item in the HB 200 Conference Report that requires federal approval prior to implementation.

a. For each item, indicate if a SPA has been prepared and the date submitted to CMS.
b. If a SPA has not yet been submitted, provide the anticipated submission date.
c. What is the impact of the delay on the budgeted reduction target?

DHHS RESPONSE: A total of 44 state plan amendments (SPAs) are required to accomplish the budget reductions set forth in HB 200. Of the 45 required amendments a total of 41 have been submitted. A list of Medicaid changes and required SPAs is attached reflecting dates of submission and CMS approvals to date. To date, we have received approval from CMS on 21 of the SPAs, all but one being approved on either October 20th or 21st. We anticipate a minimum $26.7 million dollar impact from the delay in achieving CMS' approval.

Legislative Question 2: What are the other Medicaid liabilities, including paybacks, contracts, etc., that were not included in the FY 2011-12 certified budget?

a. Describe each liability and the estimated 2011-12 fiscal impact.

DHHS RESPONSE: The following items totaling over $126 million are current year liabilities or costs faced by the Medicaid program that were not included in the budget but will require state dollars for payment.

- $40,923,072 repayment of previously overdrawn federal Medicaid funds. (This is a partial repayment of approximate $300 million overdraft of federal funds from an error in 2008 which was discovered in early 2009. DHHS and CMS agreed to an initial payment and quarterly payments of approximately $10 million each quarter until repaid. Two payments have been made this fiscal year.).
- $41,734,368 repayment of Personal Care Service (PCS) funds from an audit of 2005-2007 claims by the Office of Inspector General related to improper billings or inadequate documentation of services by providers.
- $28,074,087 reduction in federal drug rebates resulting from changes in federal methodology which was finalized in August 2011.
- $8,634,432 in various other federal repayments.
- $6,000,000 in PCS claims paid (through December) for services under appeal which Office of Administrative Hearings (OAH) have discontinued hearing appeals until ruling by federal judge for over 2,000 Medicaid recipients.
- $1,100,000 for study required by CMS related to physician rates and access to care.

There are anticipated unbudgeted receipts that will partially cover these unbudgeted liabilities. These receipts include approximately $21,500,000 additional unbudgeted one-time benefit from

a retroactive application of the hospital assessments and $61,750,000 recovery of state dollars advanced for 2011 Qualified Public Hospital claims.

Legislative Question 3: Has the Department prepared the waiver required by Sec. 55.1 of Session Law 2011-398 (SB 781)?

a. Has the waiver been submitted to CMS?
b. If not, what is the reason for the delay?
c. If yes, is CMS approval anticipated in time for OAH to have final decision making authority on or before January 1, 2012?

DHHS RESPONSE: The waiver was submitted to CMS on August 11th at the end of the 60 day notice period required by CMS. Questions were subsequently received and additional information was provided to CMS on October 12th. It is not known at this time whether or not CMS approval will be granted in time for a January 1st implementation.

Legislative Question 4: Item 50 on Page G7 of the Conference Report budgets $90 million in savings to be realized by increasing CCNC enrollment. If the $90 million target cannot be achieved, Sec. 10.47 directs the Secretary to undertake whatever actions are necessary to affect the savings, including provider rate reductions and elimination/reduction of optional services.

a. How much of the $90 million savings was realized in the first quarter of FY 2011-12?
b. What is the Department's projection of the total savings to be realized by December 30, 2012?
c. Has the Department determined which provider rates shall be reduced and which optional services shall be reduced or eliminated effective January 1, 2012?

DHHS RESPONSE: While it is believed that CCNC has the capacity to accomplish the required savings for the biennium, the timing of enrollment of a greater number of aged and disabled population into the CCNC program will likely result in an inability to achieve the $90 million savings target for the current fiscal year. DHHS believes that CCNC will achieve a minimum savings in the current fiscal year of $51 million, but project a total savings of at least $204 million over the biennium which will meet aggregate budget targets for the biennium.

Section 10.47(d) of HB 200 would require that the Secretary adjust rates by up to two percent (2%) in an equal percentage for all Medicaid providers.

Legislative Question 5: S.L. 2011-145 directs the Department to adjust the Medicaid pharmacy dispensing fees so as to achieve $15 million in general fund savings from the increased use of generic prescriptions. If the $15 million target cannot be achieved, Section 10.48 requires the Department to reduce prescription drug rates.

a. Has the Department revised the dispensing rates?
b. Does the Department expect to realize at least $15 million savings from the dispensing rate revisions?
c. If not, has the Department calculated the amount of the pharmacy rate reduction needed to achieve $15 million target?

DHHS RESPONSE: Negotiations with the pharmacy industry were completed on October 14th to achieve this reduction as well as the reduction related to inflationary increases. New dispensing rates have been communicated and will be effective November 1st. Additionally, a

reduction in brand pricing from wholesale acquisition cost plus 7% to plus 6% will be implemented 1/1/12. All targeted reductions are expected to be achieved.

Legislative Question 6: Did the Department eliminate the inflationary increases as mandated by S.L. 2011-145?

a. Other than the exceptions allowed by Sec.10.43, were inflationary increases eliminated for all providers? If not, which providers were excluded and why?
b. Will the $62.8 million inflation savings target be realized for FY11-12?

DHHS RESPONSE: The inflation amount reflected in HB 200 was based upon inflation included in the proposed Medicaid rebase amount. Unfortunately, a portion of the inflation included in the rebase and in HB 200 represents increases in cost that are mandated by CMS and is outside of DHHS control. Approximately $9 million of the inflation amount is mandated under federal requirements and cannot be eliminated.

Three other inflationary adjustments have not been made that represents a net $13.7 million less than the targeted adjustment.

First, the elimination of the cost increases associated with pharmacy was not made as the actual cost of the drugs are not controlled by the State but determined under federal rules. Accordingly, to avoid pharmacists selling some drugs below their cost, an arrangement was negotiated with pharmacists to achieve the same savings through other initiatives in pharmacy. Accordingly, the required savings will be achieved from pharmacy.

The cost included in the inflation amount related to skilled nursing facilities was not based upon increases in rates due to inflationary costs, but rather the increased acuity of patients served in the nursing facilities. The Legislature adopted an approach called "case mix" for reimbursing nursing facilities several years ago. Under this approach, nursing facilities are reimbursed based upon the medical complexity or acuity of the patients in the facility. The elimination of the projected change in costs for increased acuity of the patients would effectively eliminate case mix reimbursement, as a result, DHHS was informed that the elimination of the case mix was not anticipated or desired by the Legislature. This impacts the targeted budget amount by approximately $12 million.

The inflationary costs related to state operated healthcare facilities were not implemented. Since Medicaid pays a substantial part of the operating costs of the State's facilities, and those facilities currently have unbudgeted costs, the result of eliminating this Medicaid inflation amount would mean that the State would lose the associated federal dollars and the costs would have to be paid with totally state dollars, thus costing the State more, rather than less. This amount represents approximately $1.7 million of the inflation amount.

Based upon the above adjustments and the timing for CMS approval of SPAs related to inflation or cost increases (CMS approval timing reduces impact by approximately $13 million), DHHS anticipates achieving approximately $27 million of the inflation adjustment in the current fiscal year.

Legislative Question 7: S.L. 2011-145 budgets $60,183,120 in FY11-12 savings to be realized by levying a 5.5 percent assessment on hospitals, CABHAs, and CAP/MR providers and by increasing the nursing facility assessment from 5.5 percent to 6.0 percent.

a. Were assessments levied on all providers as set forth in the bill? If not, which providers were excluded and why?
b. Does the Department to achieve the $60 million reduction target for the current fiscal year?

DHHS RESPONSE: To date, CMS has not approved any of the assessment related SPAs, but approval of the hospital assessment is anticipated and should be retroactive to January 1, 2010. We will not receive approval for an assessment related to CABHAs, because there is no category approved by CMS for just these providers. It is hoped that CMS approval of an assessment related to CAP/MR will be approved later in the fiscal year. Section 10.31(g) of HB 200 states that DHHS may implement an assessment program for "any willing provider category". Providers are generally not willing unless the assessment provides for an overall net benefit or break-even financial situation. To achieve a net benefit, the provider category must have a high Medicaid consumer base so that a broad base assessment can be recouped through increased Medicaid rates. To date, DHHS has not identified another "willing provider category". DHHS anticipates achieving approximately $47.3 million of the budgeted proceeds from assessments.

Legislative Question 8: The Department's plan for expanding the behavioral health 1915 b/c waiver is budgeted to achieve savings of $10.5 million in the current year and $52.5 million in FY12-13.

a. Is the waiver expansion plan presented to the Joint House and Senate HHS Appropriations Subcommittee in April 2011 on schedule?
b. If not, what is the impact on the $10.5 million savings target budgeted for the current fiscal year?

DHHS RESPONSE: The expansion of the 1915(b)/(c) waiver program is running approximately three (3) months behind schedule. This delay is to help ensure that the conversion of the LME's to at-risk managed care organizations is accomplished with a limited risk of failure. As the LME's prepare to convert, DHHS must also file a SPA to gain approval of the rates to be paid to each LME. The delay in transition will likely result in achieving a net savings of only $1.6 million in the current fiscal year, but a projected savings of approximately $52 million in the second year of the biennium.

Legislative Question 9: Has the Department reduced the Medicaid provider reimbursement rates as required in the budget?

a. Were any providers, except as provided in Sec. 10.31, excluded from the 2% rate reduction? If so, why?
b. Will the $46 million savings target be achieved?

DHHS RESPONSE: SPAs have been submitted to implement the two percent (2%) provider rate adjustments as set forth in HB 200. No providers were excluded other than those set forth in legislation. Because of the delay in approval, the rate adjustments will likely be implemented effective November 1st with an adjustment of 2.6% for the remainder of the current year to

achieve a full-year 2% reduction for the year. The rate adjustment should be within $2 million of the budget target.

Legislative Question 10: Has the Department adjusted the Medicaid optional and mandatory services as set in S.L. 2011-145?

a. Will the $16.5 million savings target be achieved?

DHHS RESPONSE: All adjustments to Medicaid optional and mandatory services are going through the Physician Advisory Group and CMS approvals for implementation. Because of delays in CMS approval and duplication of amounts in the budget legislation between rates and service adjustments ($2.5 million duplication), DHHS expects to achieve approximately $9.6 million of the budget savings in the current fiscal year.

Legislative Question 11: What is the projected Medicaid shortfall for the current fiscal year?

DHHS RESPONSE: Based upon the experience of the first three months of the fiscal year, and the pace of SPA approvals, DHHS projects a potential Medicaid cash shortfall of $139 million. As the year progresses and enrollment and utilization experiences are tracked, and all other adjustments begin to have the anticipated impact, the number will likely change.