Biennial Medicaid Report

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Biennial Report Overview and Table of Contents

The 2005 Legislature enacted House Bill 1460. The Bill directed the following:

> **"Biennial report on programs and services.** The department shall present a biennial report to the legislative council which provides a five-year historical analysis of the number of persons receiving services under the medical assistance program, the costs for rendering the services by program appropriations, the budget requested, the budget appropriated, and the actual expenditures for each of the preceding five years. The report must include a comparison of the state's experience with that of immediate surrounding states. Using actuarial tools, the report must project estimated usage trends and budget estimates for meeting those trends for the succeeding five-year period. The legislative council may request from the department actuarial reports in a format and timeline the legislative council determines necessary to monitor program policies and legislative appropriations."

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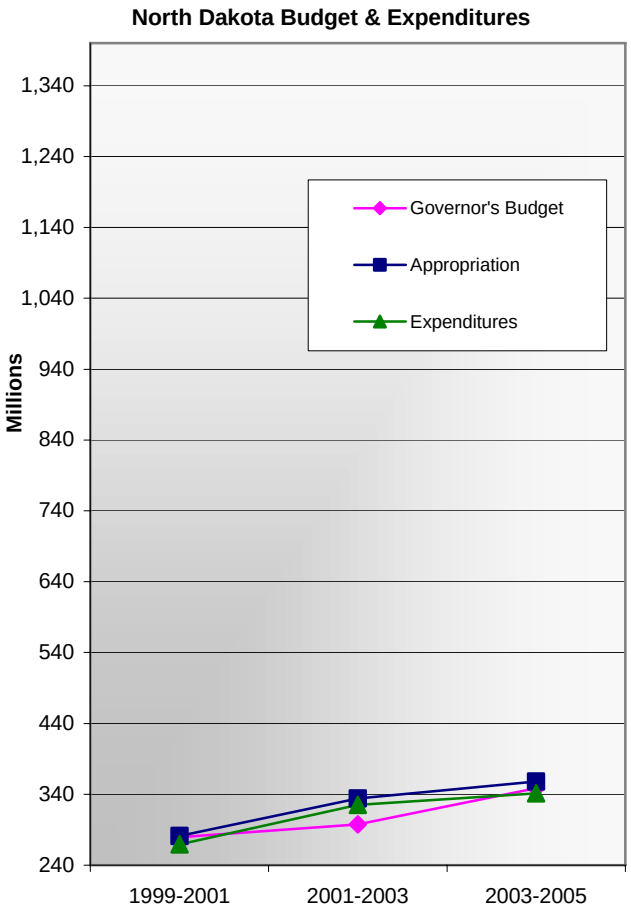
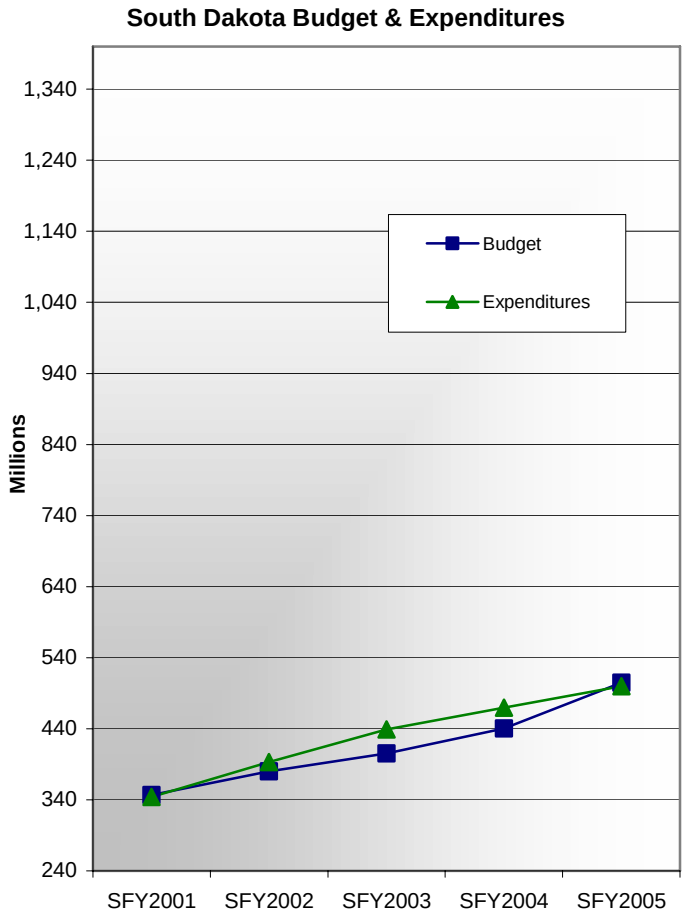
Comparison of Budget, Appropriation and Expenditures

North Dakota



South Dakota



North Dakota Data Table (for above chart)

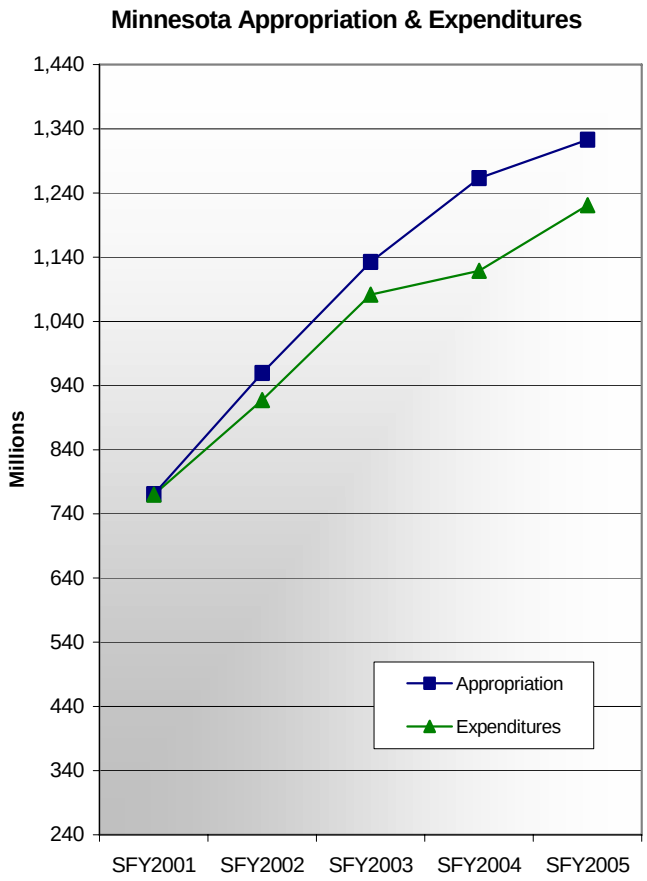
Biennium	Governor's Budget	Appropriation	Expenditures
1999-2001	279,488,784	280,986,517	269,158,669
2001-2003	297,575,846	334,168,737	324,975,311
2003-2005	348,435,117	358,038,292	341,091,890

South Dakota Data Table (for above chart)

Fiscal Year	Budget	Expenditures
SFY2001	346,571,388	344,210,375
SFY2002	380,048,165	393,160,869
SFY2003	405,082,738	439,100,452
SFY2004	440,520,634	469,482,042
SFY2005	504,602,348	499,739,392

* Data submitted by South Dakota contains nursing home costs and administrative costs.

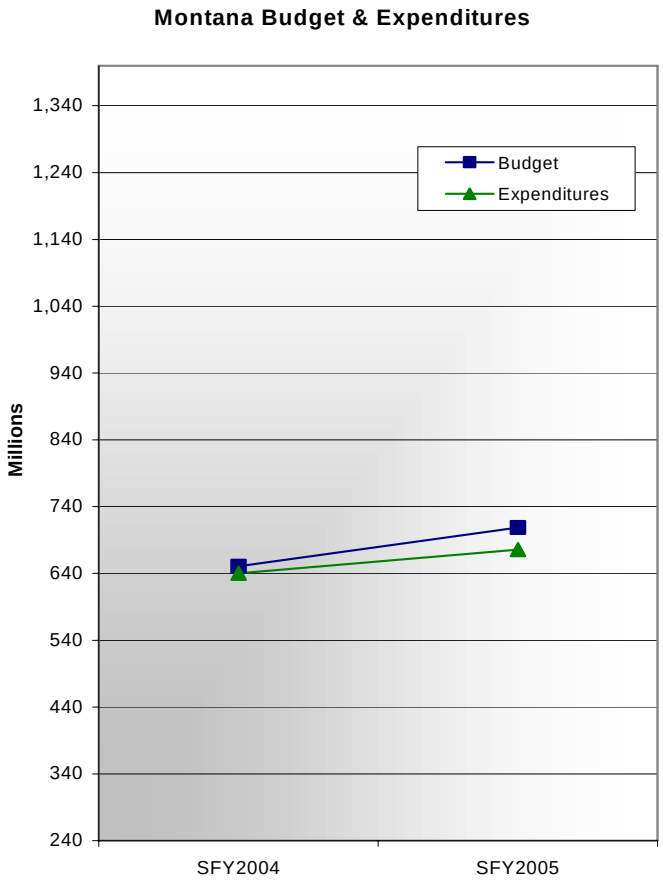
Minnesota



Minnesota Data Table (for above chart)

Fiscal Year	Appropriation	Expenditures
SFY2001	771,108,000	769,800,000
SFY2002	959,637,000	917,402,000
SFY2003	1,132,635,000	1,081,468,000
SFY2004	1,263,199,000	1,118,670,000
SFY2005	1,322,719,000	1,220,842,000

Montana

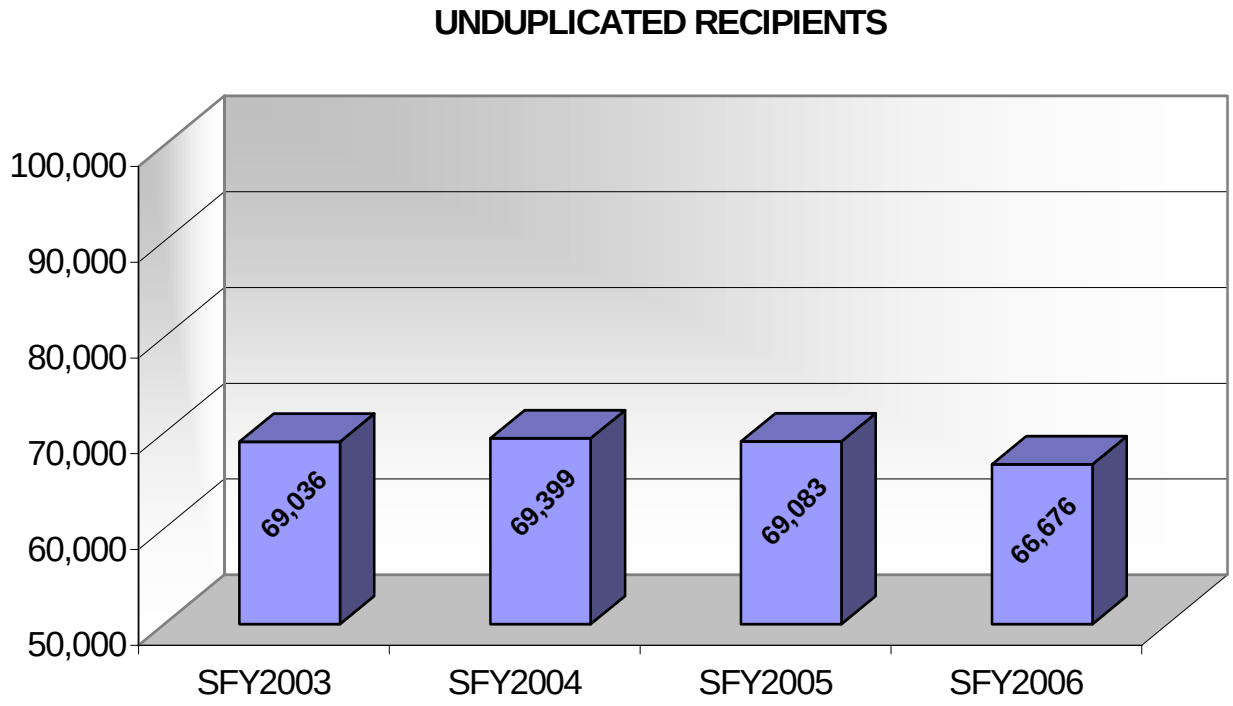


Montana Data Table (for above chart)

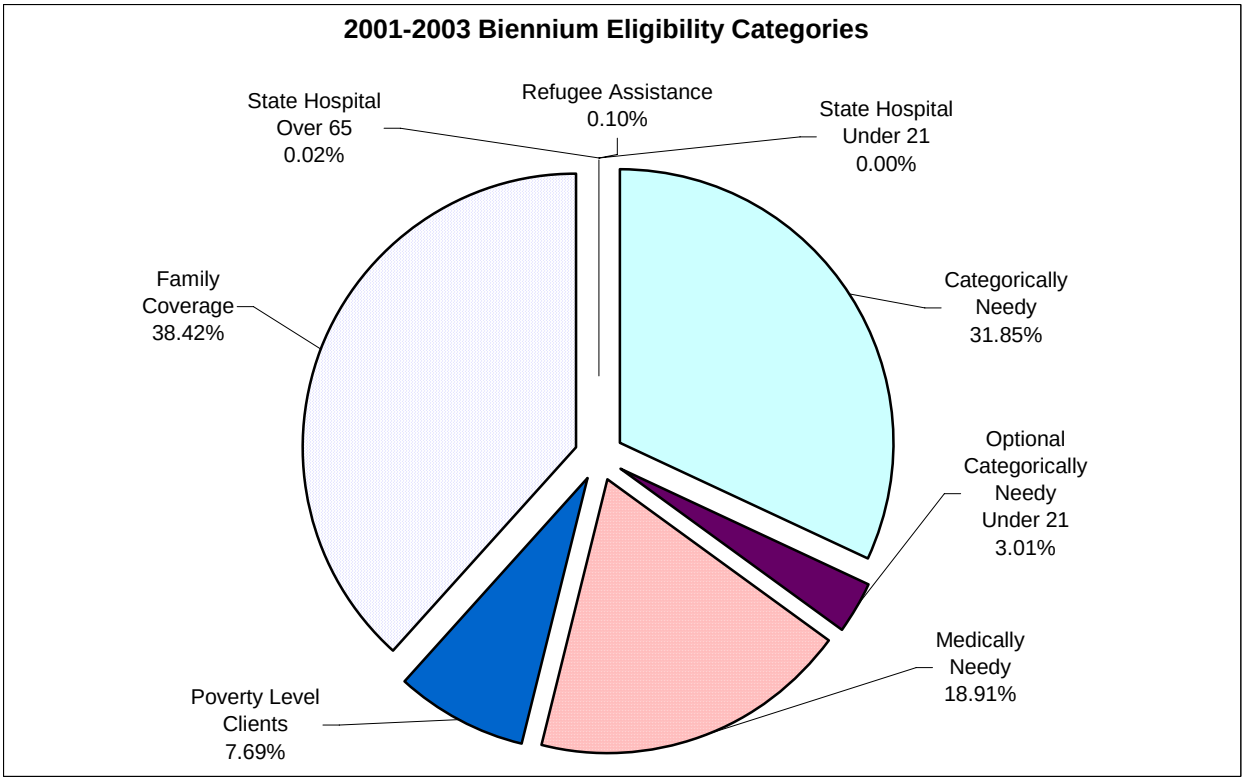
Fiscal Year	Budget	Expenditures
SFY2004	650,674,000	640,355,000
SFY2005	708,737,000	675,468,000

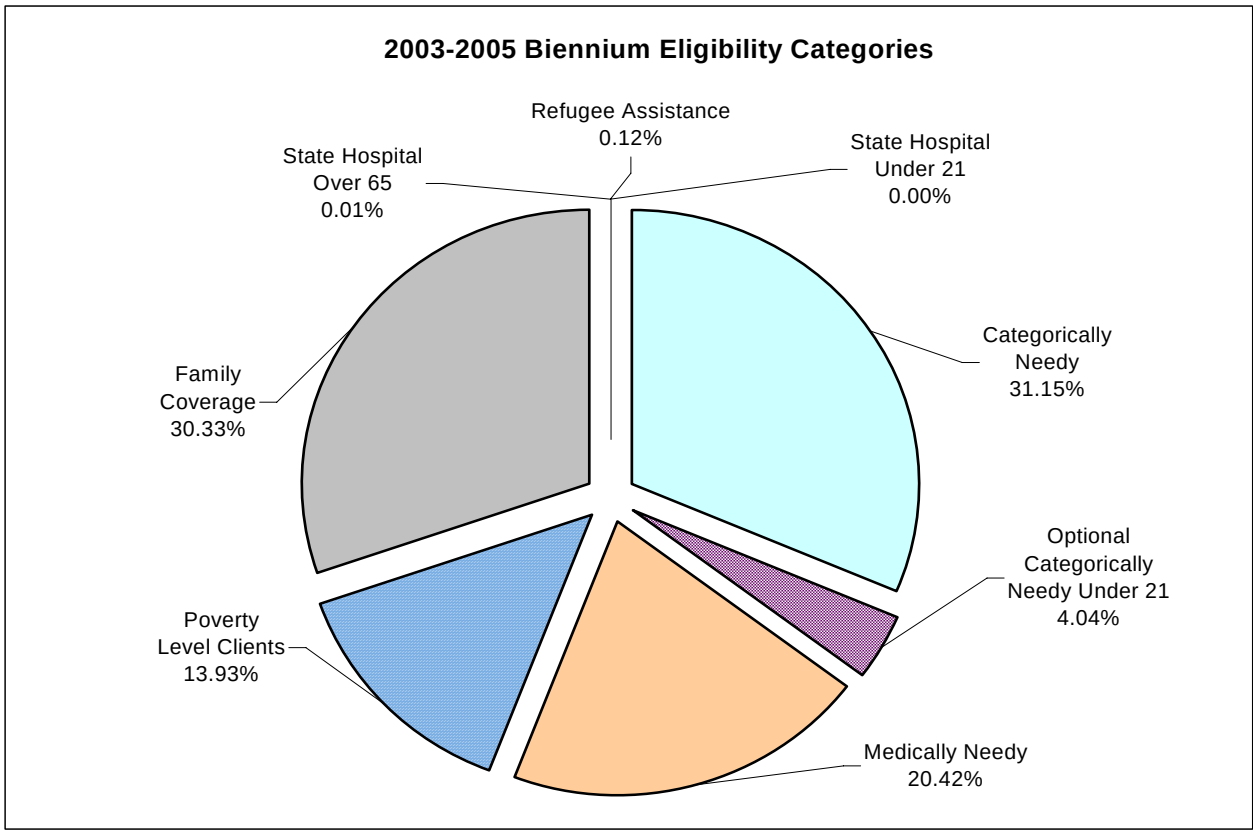
Persons Receiving Services

Eligibles Receiving Services (Recipients)

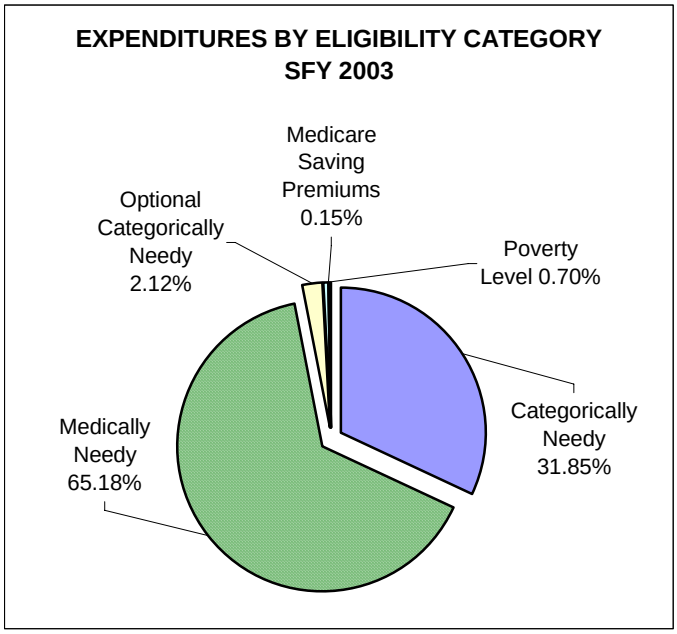


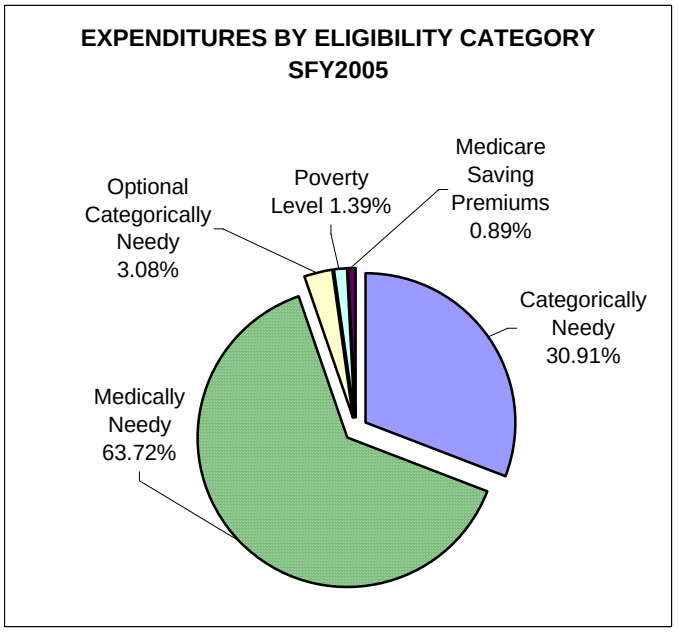
*Data is not available prior to SFY 2003 because of data conversion from HIPAA Implementation.

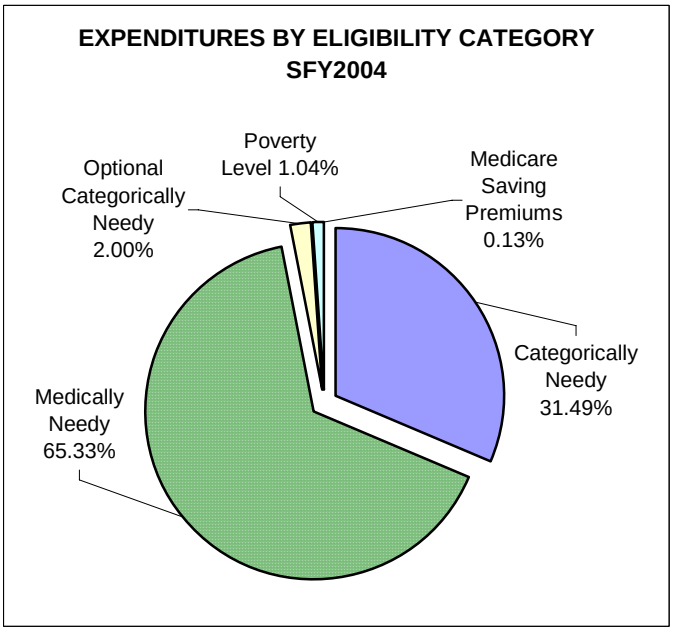

2001-2003 Biennium Eligibility Categories
State Hospital Over 65 0.02%
Refugee Assistance 0.10%
State Hospital Under 21 0.00%
Family Coverage 38.42%
Categorically Needy 31.85%
Optional Categorically Needy Under 21 3.01%
Medically Needy 18.91%
Poverty Level Clients 7.69%

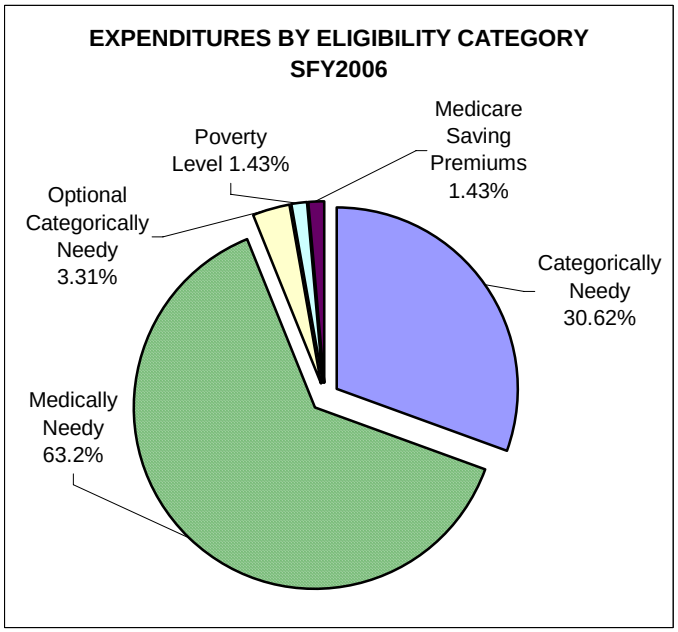

2003-2005 Biennium Eligibility Categories
Refugee Assistance 0.12%
State Hospital Over 65 0.01%
State Hospital Under 21 0.00%
Family Coverage 30.33%
Categorically Needy 31.15%
Optional Categorically Needy Under 21 4.04%
Poverty Level Clients 13.93%
Medically Needy 20.42%

Expenditures by Eligibility Category









Managed Care Information

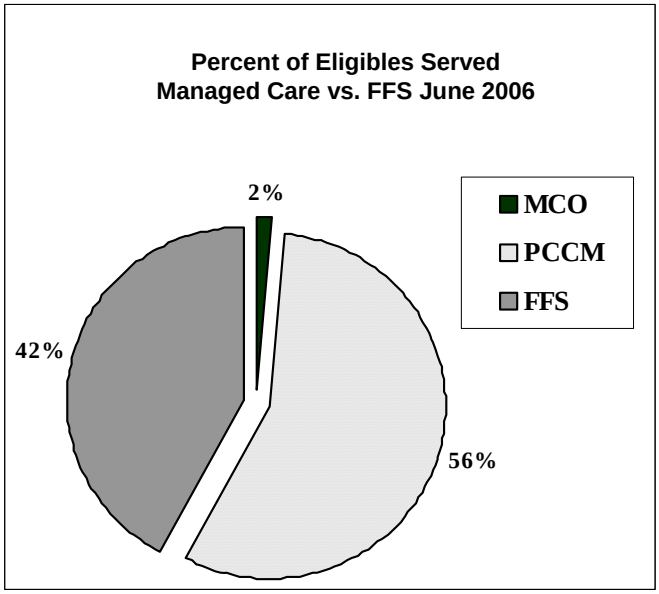
The purpose of managed care is to establish programs for Medicaid eligibles that manage the delivery of healthcare to control costs and assure quality in the health care services they receive.

The North Dakota Medicaid Managed Care Program (MMCP) currently requires low-income families and pregnant women to participate in managed care (i.e., those who meet poverty level or Temporary Assistance for Needy Families [TANF] eligibility requirements for Medicaid). This is approximately 60 percent of the total Medicaid population.

The MMCP currently consists of two programs: Primary Care Case Management (PCCM) and a Managed Care Organization (MCO), which are described in the following paragraphs.

Chart 1 shows the percentage of eligibles served through Managed Care versus Fee-For-Service (FFS) delivery systems.

Chart 1



PCCM (Program Start – January 1994)

PCCM is a managed care system through which a Primary Care Provider (PCP) contracts with Medicaid to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Recipients.

North Dakota Administrative Code (NDAC) 75-02-02-08 allows for Recipients to select from the following PCPs:

(1) A physician (family practice, internal medicine, general practice, obstetrician, pediatrician or osteopath
(2) A Federally Qualified Health Center (FQHC)
(3) A Rural Health Center (RHC), or an
(4) Indian Health Service (IHS) Center.

PCPs are paid a $2 per member per month case management fee. Health care services received by PCCM enrollees are paid on a FFS basis. Approximately 30,000 individuals are enrolled in the PCCM program.

MCO (Program Start – November 1997)

The MCO operates through a comprehensive risk contract between Medicaid and Blue Cross Blue Shield of North Dakota (BCBSND). BCBSND subcontracts with Altru Health System to provide health care services to MCO enrollees in Grand Forks, Pembina and Walsh counties.

The following services are "carved out" of the MCO benefit package and provided on a FFS basis: pharmacy, optometric and dental.

MCO enrollment has been maintained at approximately 750-800 enrollees per month since 2003. (Table 1 shows MCO enrollment as of January for the past five years).

Table 1

Fiscal Year	MCO Enrollment
2001	479
2002	463
2003	802
2004	774
2005	727
2006	819

Table 2 shows legislative appropriations versus expenditures for MCO capitation for the past three biennia.

Table 2

Biennium	Appropriation	Actual Expenditures
1999-2001	$3,028,860	$1,636,432
2001-2003	$2,231,652	$1,846,859
2003-2005	$2,811,801	$2,449,430

MMCP Expansion

Medical Services is researching the feasibility of expanding managed care to include the aged and disabled population. Staff members are also seeking expansion by pursuing additional comprehensive or partial-risk contracts with interested entities.

Pharmacy Services

Medicaid Pharmacy Services

Pharmacy services are optional for Medicaid; however, every state covers medications because of their cost effectiveness.

Federal Law requires that if a state includes pharmacy services, then the state must provide coverage of medications from manufacturers that participate in the drug rebate program, unless the state forgoes those rebates.

ND Pharmacy Services History

Program changes made since 2002 slowed the growth in the average cost of prescriptions. These changes included new edits and new pricing for generic drugs in 2002 and 2003 as well as implementation of prior authorization in 2004.

Calendar Year	Avg # of Rx/ person/ month	Avg $/Rx	Number of recipients filling Rx's
1997	3.9	$32.13	17,110
1998	4.025	$35.57	16,923
1999	4.15	$39.28	17,555
2000	4.33	$43.57	17,839
2001	4.4	$47.01	18,889
2002	4.34	$50.64	21,039
2003	4.18	$52.74	21,841
2004	4.36	$55.58	21,224
2005	4.44	$57.20	21,722

Pharmacy Services 2006 and Beyond

With the implementation of Medicare Part D and the transition of dual eligibles to pharmacy services outside of Medicaid, the changes are tremendous. Monthly pharmacy spend decreased from an average of $5.2 million per month to $2.3 million per month thus far. The number of recipients receiving prescriptions in a month decreased from 23,000 down to 17,600.

The average age of a pharmacy recipient has dropped from the mid 40's to the lower 20's, which shows in the top medications, with ADHD, antibiotics, and asthma medications moving to the top 10.

Drug Class	Amount Paid	% of Drug Spend	Cumulative % Drug Spend
Antipsychotics	$336,221.89	14.50%	14.50%
Anticonvulsants	$246,596.94	10.70%	25.20%
Antidepressants	$183,804.50	7.90%	33.10%
ADHD	$175,227.83	7.60%	40.70%
Antibiotics	$154,581.90	6.70%	47.40%
Asthma	$145,945.55	6.30%	53.70%
Narcotics	$75,313.64	3.30%	57.00%
Diabetes	$65,835.13	2.80%	59.80%
Cholesterol	$47,942.32	2.10%	61.90%
PPI's (Prilosec)	$43,315.67	1.90%	63.70%
Hypertension	$42,475.15	1.80%	65.60%
Sleeping pills	$38,057.29	1.60%	67.20%
Birth Control	$36,433.20	1.60%	68.8%

Table Reflects April 2006 Paid Claims Data, per Medstat Monthly Report

All dollar amounts are pre-drug rebate collections and represent combined state and federal funds.

Over 40% of the total drug spend is from the top four drug classes which are psych related. The top products in the #2 and #3 drug classes have recently gone generic, and we hope that this provides some savings.

In-Patient Hospital Services

With the exception of inpatient psychiatric, rehabilitation, out-of-state, and long-term care hospitalizations, acute inpatient hospital services are paid using a prospective payment system based on classification, to a diagnostic related groups (DRG). This is the same payment mechanism used by Medicare, Blue Cross Blue Shield, and Workforce Safety and Insurance.

DRGs use client diagnosis and procedures to classify an acute care stay into one of 550 groupings. Payment is then made by multiplying the hospital's base rate (which was established in 1994 and has been inflated annually based on legislative appropriation) times the relative weight for the DRG and adding a capital payment for each discharge.

Over the past four years, the average Medicaid payment has increased from $2,382 to $2,821 per discharge, the total DRG payments from all funding sources as a percentage of charges has decreased from 49.4% in 2003 to 46.7% in 2006. The average hospital charges per discharge have increased 22.2% from $7,692 in 2003 to $9,402 in 2006.

Medicaid utilization as a percent of total hospital days has remained steady at 12.1% over the past 3 years. Deliveries and births account for the majority of Medicaid DRGs and as a percentage of total discharges have increased from 45.8% (3,974 discharges) in 2003 to 50.1% (4,778 discharges) in 2006. The average cost to Medicaid for a birth or a delivery has remained relatively the same with an average of $2,225 per discharge in 2003 and an average of $2,206 in 2006.

Psychiatric and rehabilitation stays are paid based on a fixed per diem rate, which is the same rate for all hospitals or distinct part units. There is a limit of 21 days for psychiatric inpatient care per occurrence and 30 days for rehabilitation inpatient care per occurrence (subject to a limit of 45 days total per year).