# House Bill 1012

House Appropriations | Human Resources Division
Representative Nelson, Chairman

Medical Services Detail | Sarah Aker | Executive Director

January 23-24, 2025

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# Our Vision

North Dakota is the healthiest state in the nation.

# Our Mission

HHS fosters positive, comprehensive outcomes by promoting economic, behavioral and physical health, ensuring a holistic approach to individual and community well-being.

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# Acronyms

ADL – Activity of Daily Living
AMP - Average Manufacturer Price
BCBS ND – Blue Cross Blue Shield of North Dakota
CAH – Critical Access Hospital
CCBHC – Certified Community Behavioral Health Clinic
CFR – Code of Federal Regulation
CMS – Centers for Medicare & Medicaid Services
CON – Certificate of Need
CY – Calendar Year
DME – Durable Medical Equipment
DOCR – ND Department of Corrections & Rehabilitation
DRG – Diagnosis Related Group
DSH – Disproportionate Share Hospital
D-SNP – Dual Eligible Special Needs Plan
DUR – Drug Use Review
EAPG – Enhanced Ambulatory Patient Groups
EPSDT – Early, Periodic, Screening, Diagnosis, & Treatment
FFM – Federally Facilitated Marketplace
FFP – Federal Financial Participation
FFS – Fee for Service
FFY – Federal Fiscal Year (October 1 – September 30)
FMAP – Federal Medical Assistance Percentage
FPL – Federal Poverty Level
FQHC – Federally Qualified Health Center
FTE – Full Time Equivalent
GME – Graduate Medical Education
HCBS – Home and Community Based Services
HHS – ND Department of Health & Human Services
HIE – Health Information Exchange
HIN – Health Information Network
HSC – Human Service Center
HSZ – Human Service Zone
IAPD – Implementation Advance Planning Document
ICF – Intermediate Care Facility
IHS – Indian Health Services
IMD – Institution for Mental Disease
LOC – Level of Care
LS – Long Stay
LTC – Long Term Care
MCO – Managed Care Organization
MDRP - Medicaid Drug Rebate Agreement
MFCU – Medicaid Fraud Control Unit
MLR – Medical Loss Ratio
MMIS – Medicaid Management Information System (Claims Processing System)
MOE – Maintenance of Effort
NEMT – Non-Emergency Medical Transportation
NF – Nursing Facility
NFIP – Nursing Facility Incentive Program
OAPD – Operational Advance Planning Document
OOS – Out of State
PACE – Program of All Inclusive Care for the Elderly
PA – Prior Authorization
Part D – Medicare Prescription Drug Program
PDL – Preferred Drug List
PDMP – Prescription Drug Monitoring Program
PDPM – Patient Driven Payment Model
PDN – Private Duty Nursing
PERM – Payment Error Rate Measurement
PHE – Public Health Emergency
PMPM – Per Member Per Month
PPS – Prospective Payment System
PRTF – Psychiatric Residential Treatment Program
PUPM – Per Utilizer Per Month
QRTP – Qualified Residential Treatment Program
QSP – Qualified Service Provider
RFP – Request for Proposal
RHC – Rural Health Clinic
RVU – Relative Value Unit
Rx - Prescription
SA – Service Authorization
SFY – State Fiscal Year (July 1 – June 30)
SNAP – Supplemental Nutritional Assistance Program
SPA – State Plan Amendment
SSA – Social Security Administration
SSP – Self Service Portal
SSI – Supplemental Security Income
TANF – Temporary Assistance for Needy Families
Title XIX – Medicaid
Title XXI (CHIP) – Children's Health Insurance Program
TMSIS – Transformed Medicaid Statistical Information System
TPL – Third Party Liability
UPL – Upper Payment Limit
UR – Utilization Review
UTI – Urinary Track Infection
VBP – Value Based Purchasing
WIC – Women, Infant, Children Program

# Medical Services Presentation Roadmap

- Key Medicaid Tenets
- Long Term Care
  - 2025 – 2027 Budget & Other Resource Requirements
- Medical Services
  - 2025 – 2027 Budget & Other Resource Requirements
- Summary

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# Key Medicaid Tenets

- Entitlement Program
  - Anyone who meets eligibility rules has a right to enroll and be served in Medicaid
    - HCBS waivers can be limited by a total number of slots.
  - Federal financial support
- Partnership with the Federal Government
  - Federal mandates and regulations obligate state action and expenditures
  - Federal approval required for changes to Medicaid program
- Not a traditional grant
  - Open ended funding source; no cap on total federal funds
  - Cost sharing model; State funding match required for use of federal funds

# **Rate Methodology Guiding Principles:** Traditional Medicaid

- Predictable
- Consistent
- Transparent
- Data Driven
- Population Focused
- Quality & Outcomes Oriented
- Incentivizes Innovation, Efficiency & Community Based Care

# Long Term Care

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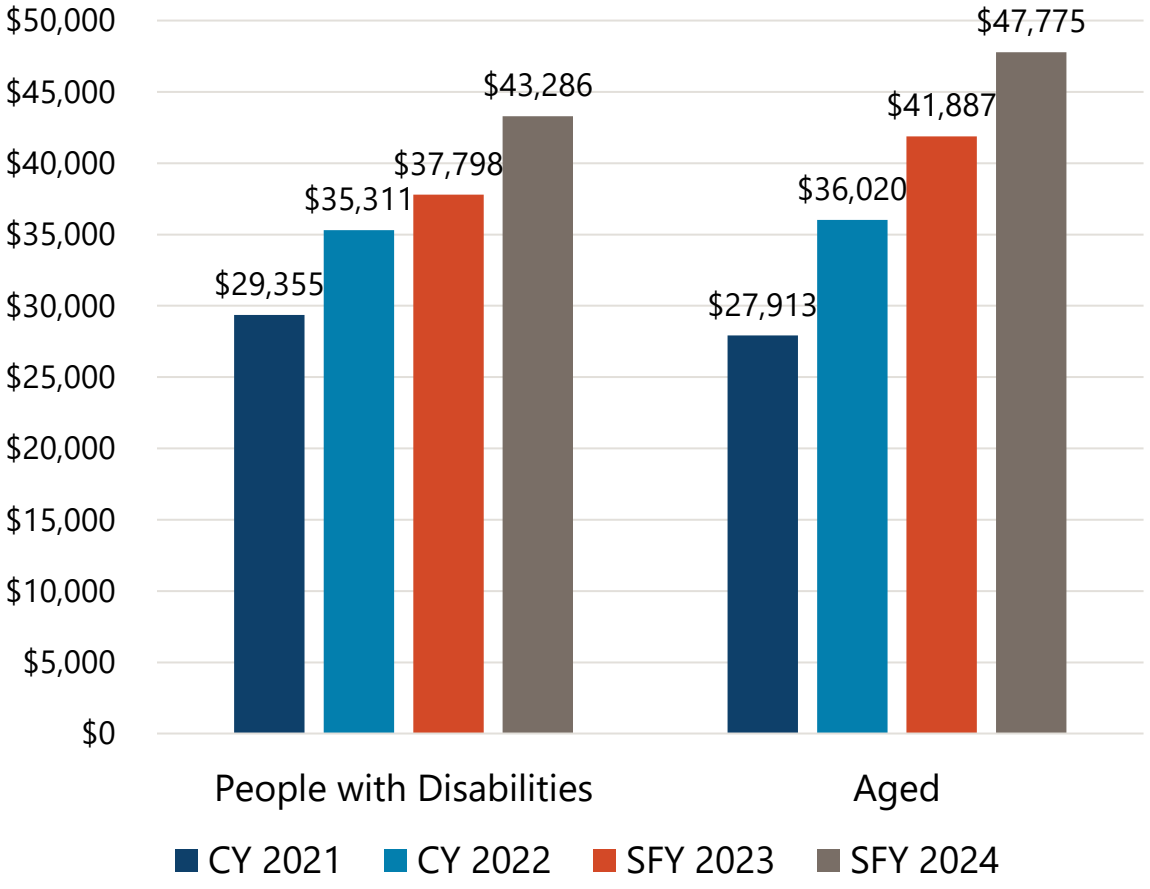
# Per Capita Expenditures: Aged & People with Disabilities

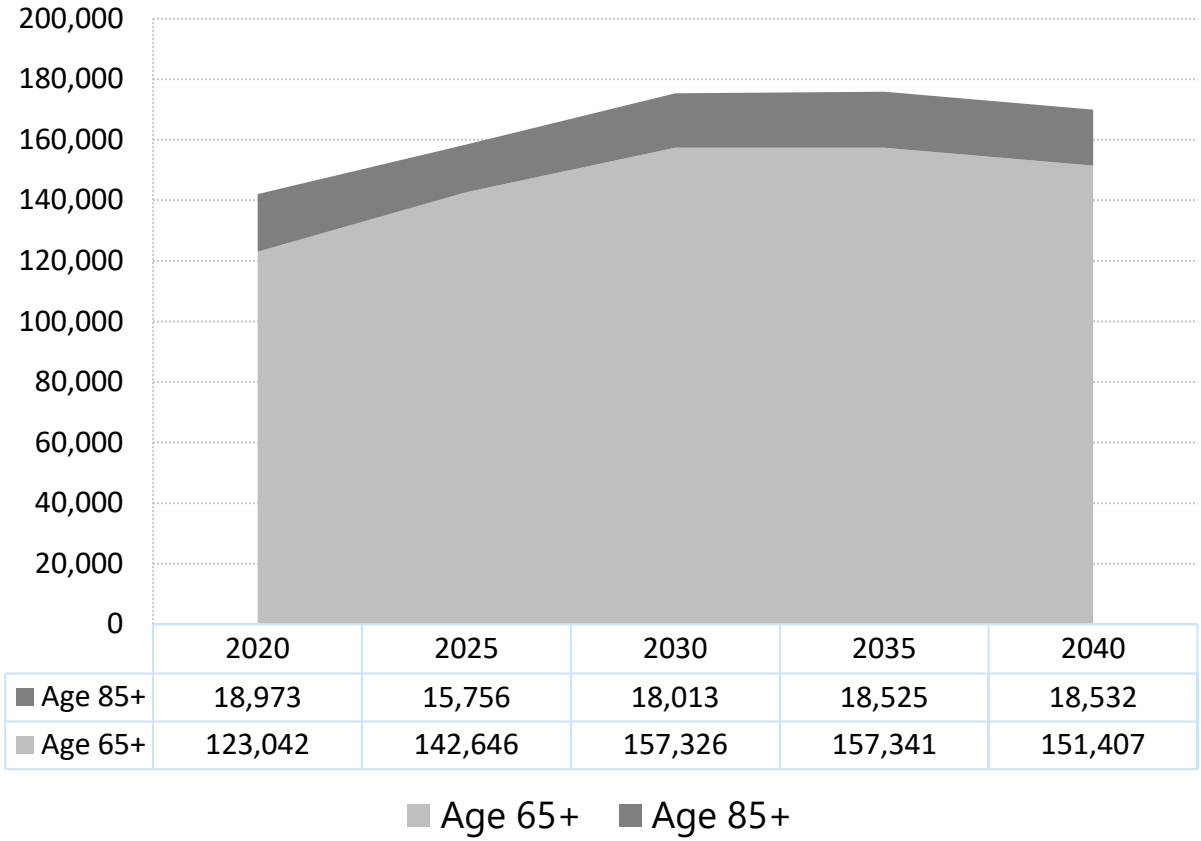



- ND Medicaid ranked **1st for Aged per capita** expenditures.
- ND Medicaid ranked **7th for People with Disabilities per capita** expenditures.

Note: CY 2021 and CY 2022 Data obtained from Medicaid and CHIP Scorecard - Medicaid Per Capita Expenditures. SFY 2023 and SFY 2024 numbers calculated from ND TMSIS data.

# Who we serve

## Older adults and adults with physical disabilities make up a growing percentage of North Dakota's population




| | 2020 | 2025 | 2030 | 2035 | 2040 |
|---|---|---|---|---|---|
| Age 85+ | 18,973 | 15,756 | 18,013 | 18,525 | 18,532 |
| Age 65+ | 123,042 | 142,646 | 157,326 | 157,341 | 151,407 |

*Source: 2024 ND State Data Center Population Projections*

- The population age 65+ is expected to experience the **largest period of growth between now and 2035**
  - People age 65+ represent 18-19% of ND population
  - **Age 85+** consistently represents approx. 15% of total pop age 65+ but the **number of people** in that age group will **grow by 3,000** between now and **2035**

**7 in 10**

*Americans 65+ will need LTC services for an average of 5 years*

# Long Term Care Eligibility

## Functional Need

- Individuals must have a level of care that indicates a need for long term care.
- Assessments are used to measure an individual's needs. The assessment can help shape the care plan in addition to verifying eligibility.
- Functional needs can also drive acuity-based payments to providers.

+

## Financial Need

### Income Limit

Income is any item an individual receives in cash or in-kind that can be used to meet basic needs.

Some Medicaid members must "spend down" their income to qualify for Medicaid. Members in an institution retain a personal needs allowance.

### Asset Limit

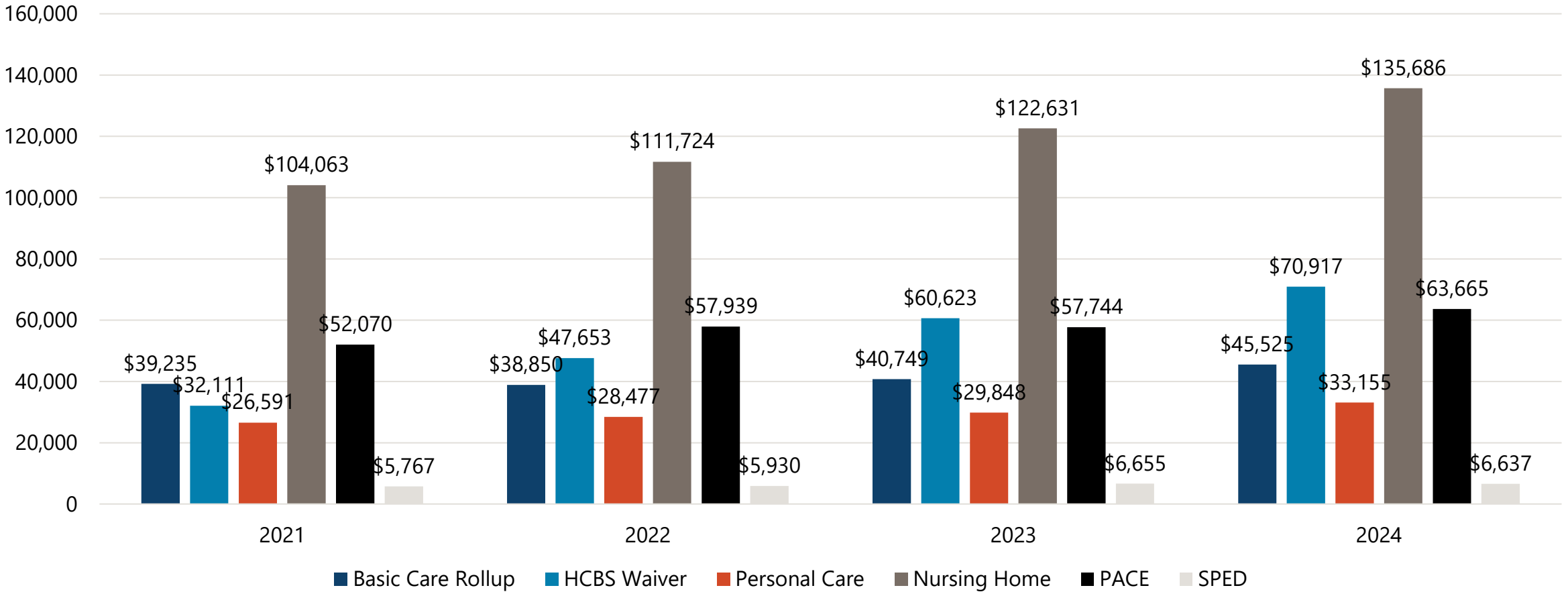
Single: $3,000
Married: $6,000

**Note:** Special Spousal Impoverishment rules apply when the individual's spouse is not applying or not in a medical facility.

Medicaid LTC eligibility includes a 5-year lookback period to ensure that assets were not gifted or sold under fair market value.

**Related Bill:**
House Bill 1485 | Relating to the Personal Needs Allowance Amount for Eligible Beneficiaries

# Where the Long-Term Care Budget Goes
## Average Cost per Person




Note: Basic Care Rollup includes both Basic Care Personal Care and Room and Board

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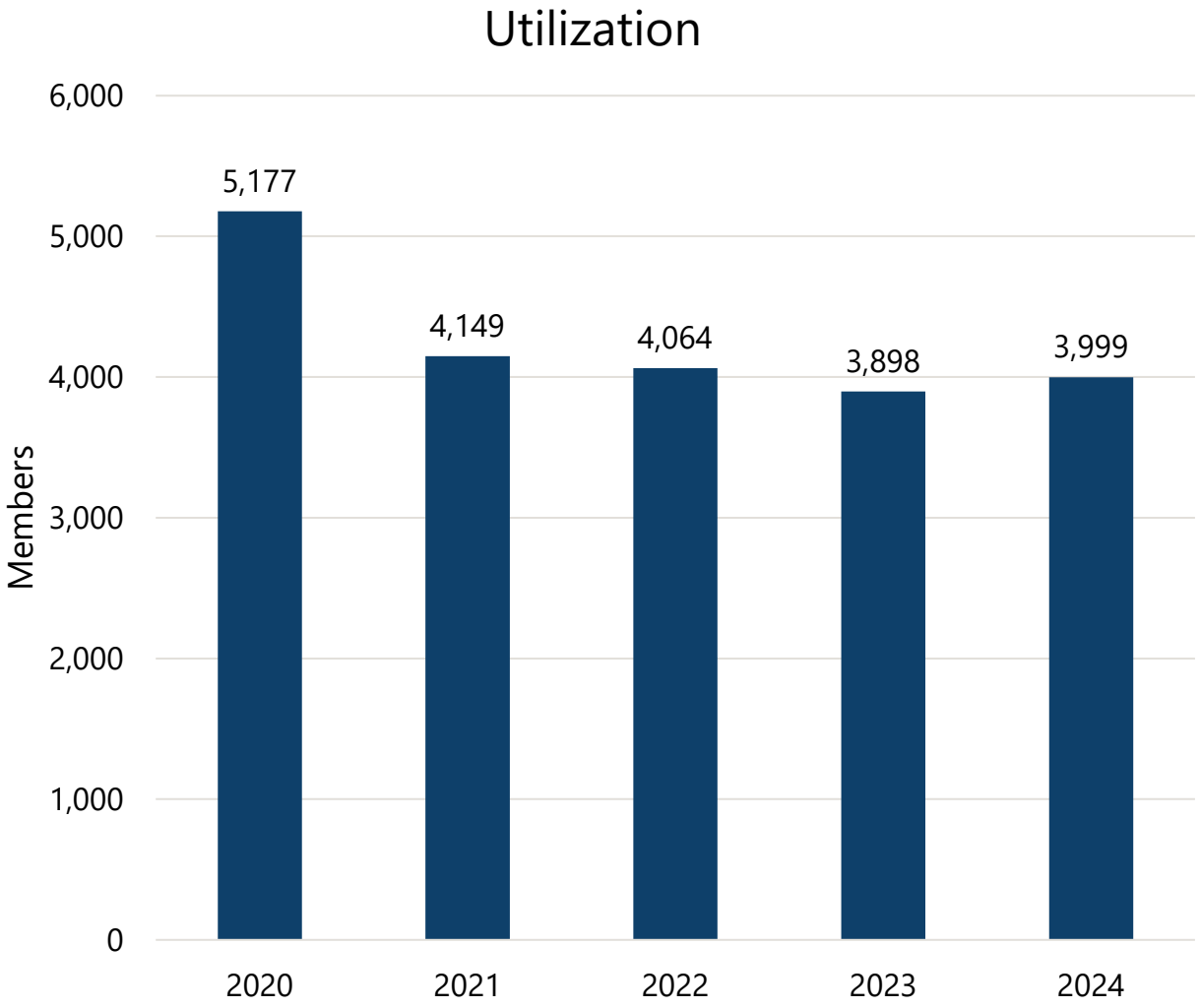
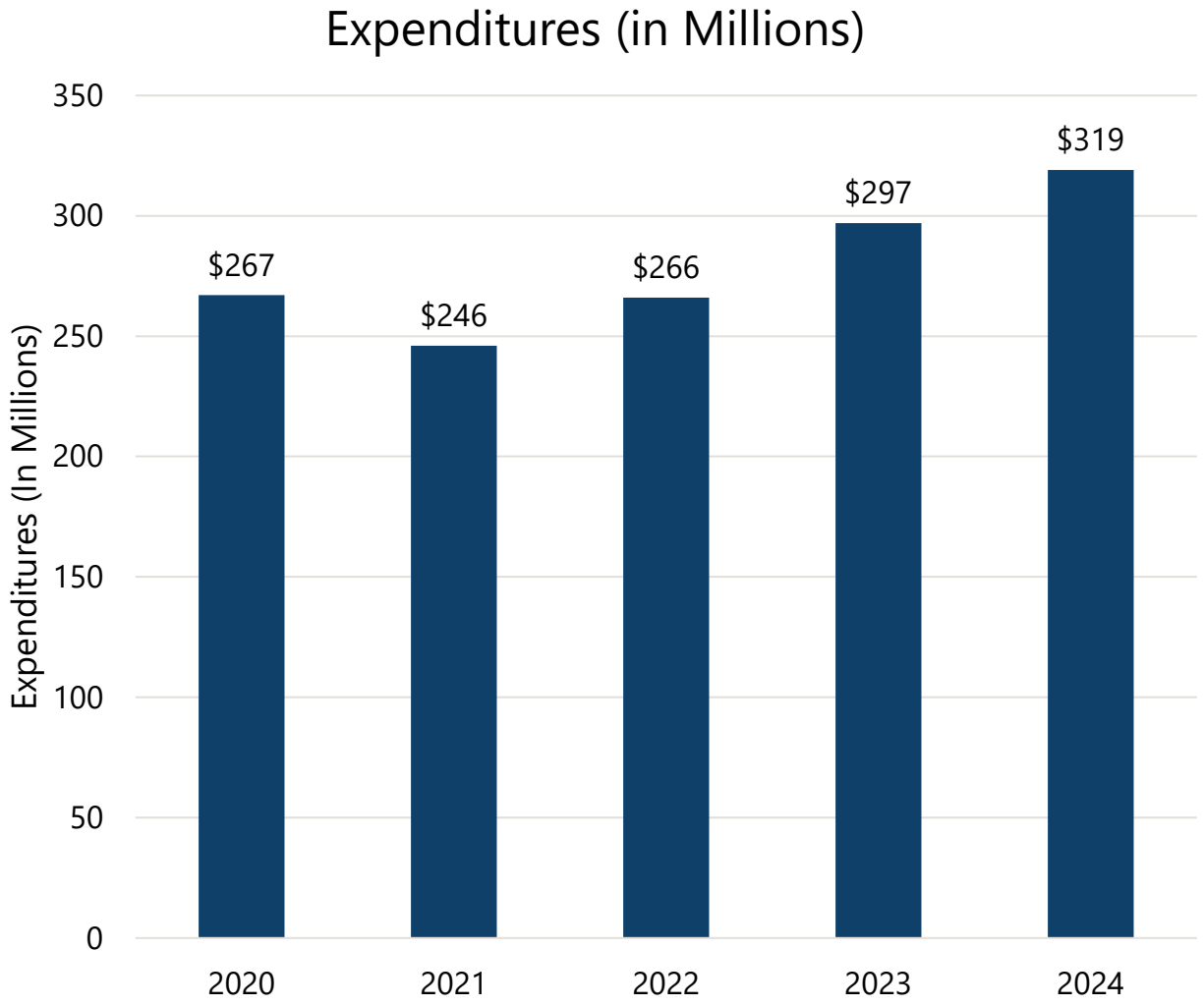
# Nursing Facility Utilization & Expenditures

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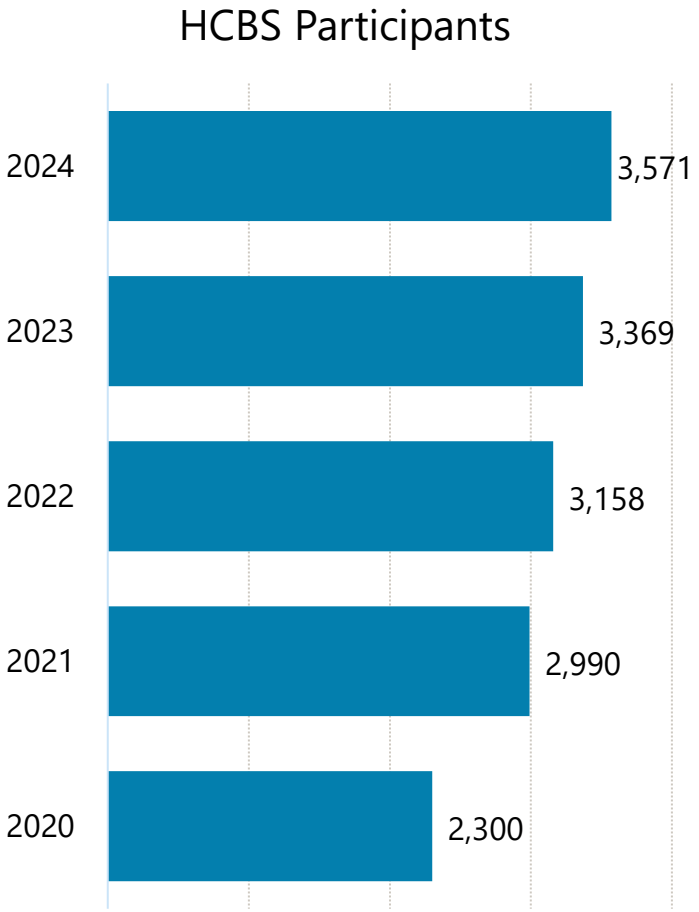
# More North Dakotans are choosing home-based community care options every year

- ✓ The **demand** for in-home and community-based services has continued to **increase.**
- ✓ More HCBS participants have **complex needs** (medical and behavioral health) that increase the amount of time and skills necessary to provide **quality services.**
- ✓ **Rising acuity levels** have created a demand for more **complex services** and providers who can employ higher trained staff including **nurses and supervisory** staff.




54% increase since 2020

What is HCBS?
**Services** delivered in an **integrated setting**.

What is an integrated setting?
A private home, apartment etc., owned or rented by the individual or their family, or an individual adult foster care setting.

# Cost to Continue: Home and Community Based Services Growth

## Ongoing

| Total | $64,814,924 |
|---|---|
| General | $36,977,113 |
| Federal | $27,837,811 |

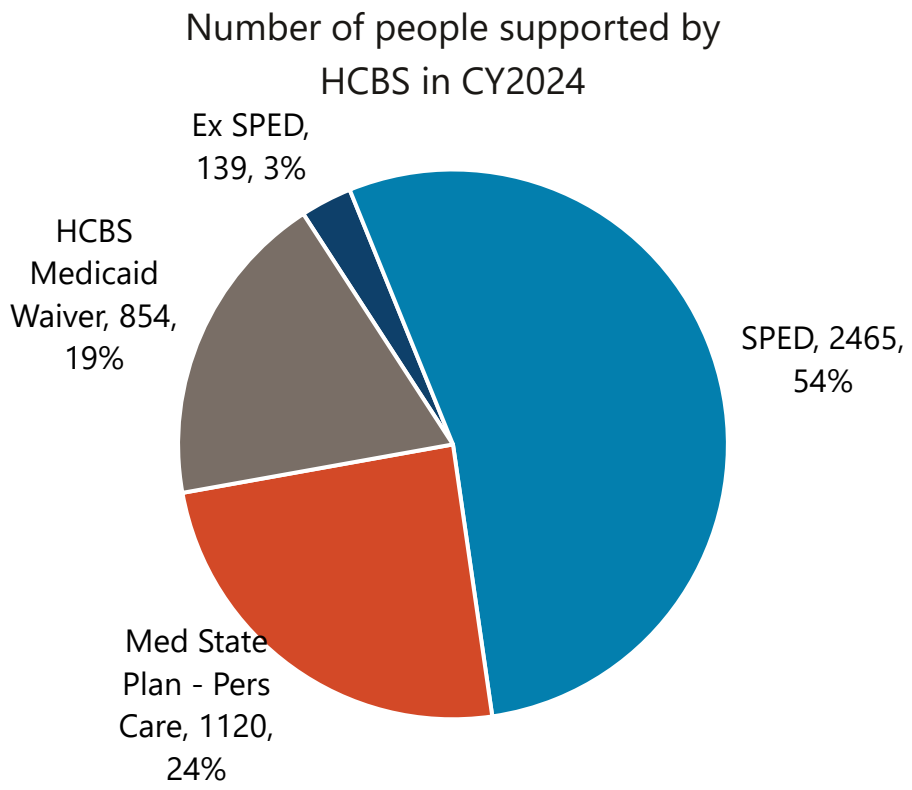
The original submission of cost-to-continue related costs for HHS neglected to include HCBS Growth that is typically part of the calculation; the omission was an error and not reflective of change in policy or operation.

Demand for home and community-based services has continued to increase.

This is reflective of the growing number of North Dakota residents who are entering age ranges where health issues become more prevalent, as well as the success of the state's efforts to both divert and transition people from living in institutional settings.

# Home-based community care options older adults and adults with physical disabilities

**3,571**




*Source: NDHHS HCBS Caseload Data Nov 2024 (unduplicated count)*

- Primarily serves older adults and individuals with physical disabilities
- Recipients must be both functionally and financially eligible
- May have client cost share based on income
- Federal and state funds
- Recipients range in age from 17-104 years old

## Adult & Aging Services

# HCBS Case Management

### HCBS Case Managers

Provide the support and structure needed to connect eligible people in need of in-home and community- based care to qualified service providers (QSPs) in their community.

What do they do?

- Determine eligibility
- Conduct person-centered planning
- Assess needs
- Authorize services
- Monitor for health and safety
- Provide support and guidance to family caregivers

**73** and **4**

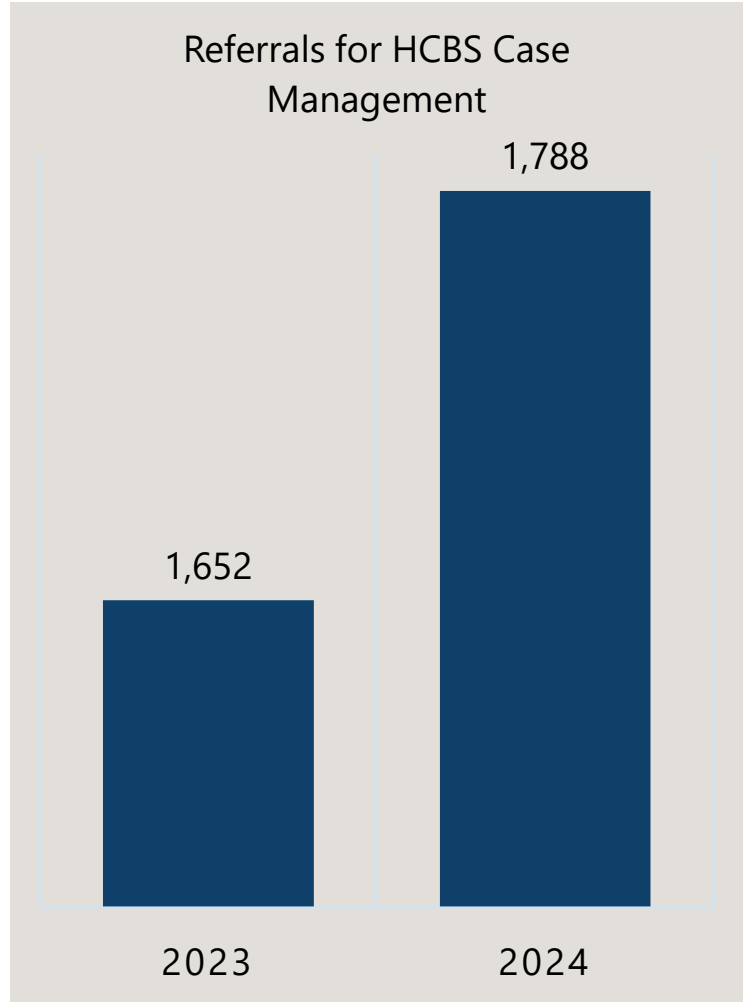
73 HCBS case managers and 4 Basic Care case managers are supervised by Adult & Aging Services

**150** and **80**

On average, 150 new referrals and 80 new cases opened for HCBS each month

**4,329**

Provided Case Management to **3,538** HCBS recipients and **791** Medicaid Basic Care residents in 2024

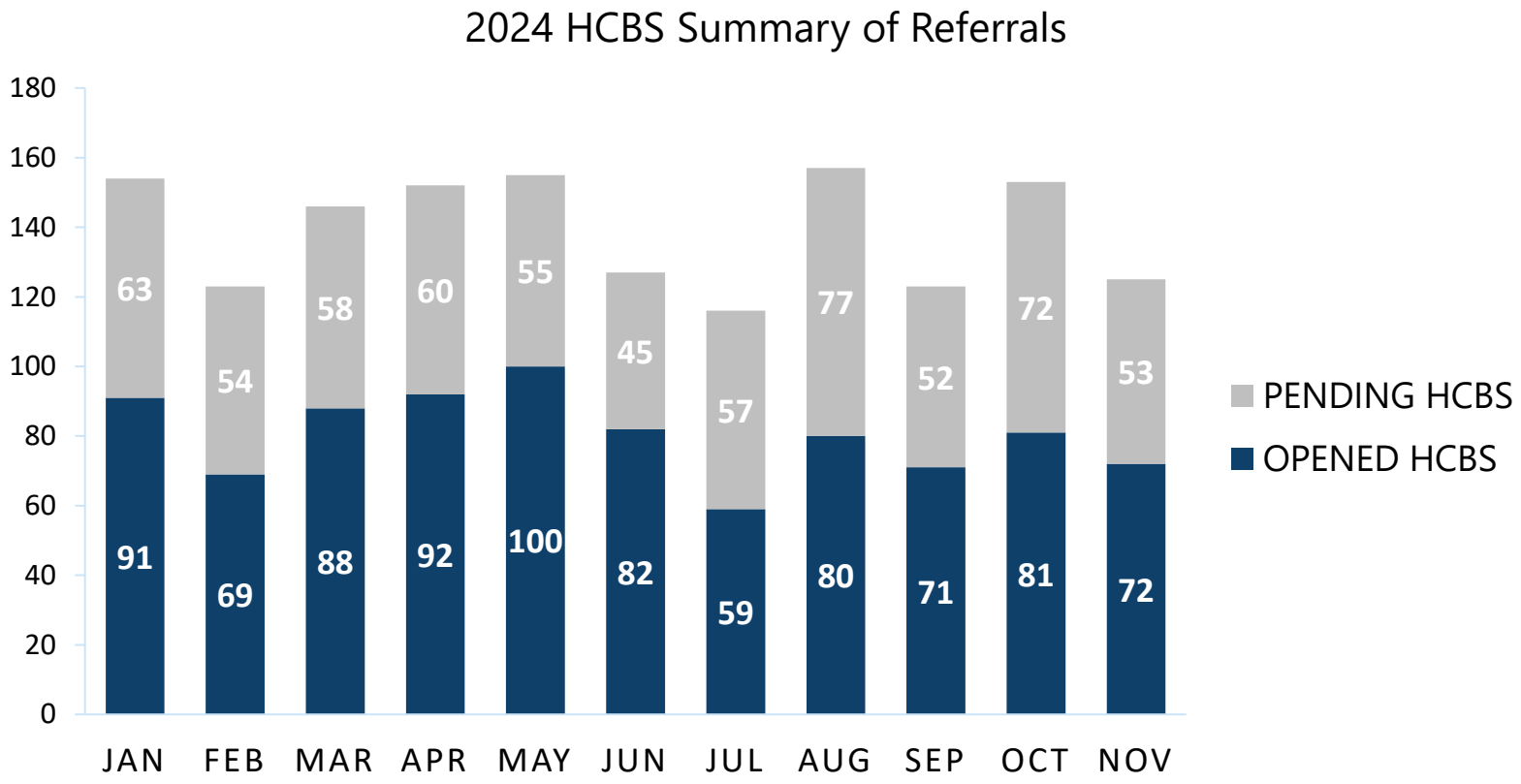


## Adult & Aging Services

# HCBS Case Managers handle pending cases, new referrals and case closures

The nature of HCBS work means that caseloads are constantly changing -- there are many cases opening and closing each month due to:

- ✓ Changes in chronic health conditions
- ✓ Medical emergencies (stroke, falls) that increase level of disability and need for assistance
- ✓ Death



## Adult & Aging Services

# Supporting QSPs who deliver care is a top priority

## Qualified Service Providers (QSPs)

Agency and individual independent contractors who enroll to provide various HCBS

**1,359**
Qualified Services Providers (QSPs) provide services

**206**
Agency QSPs

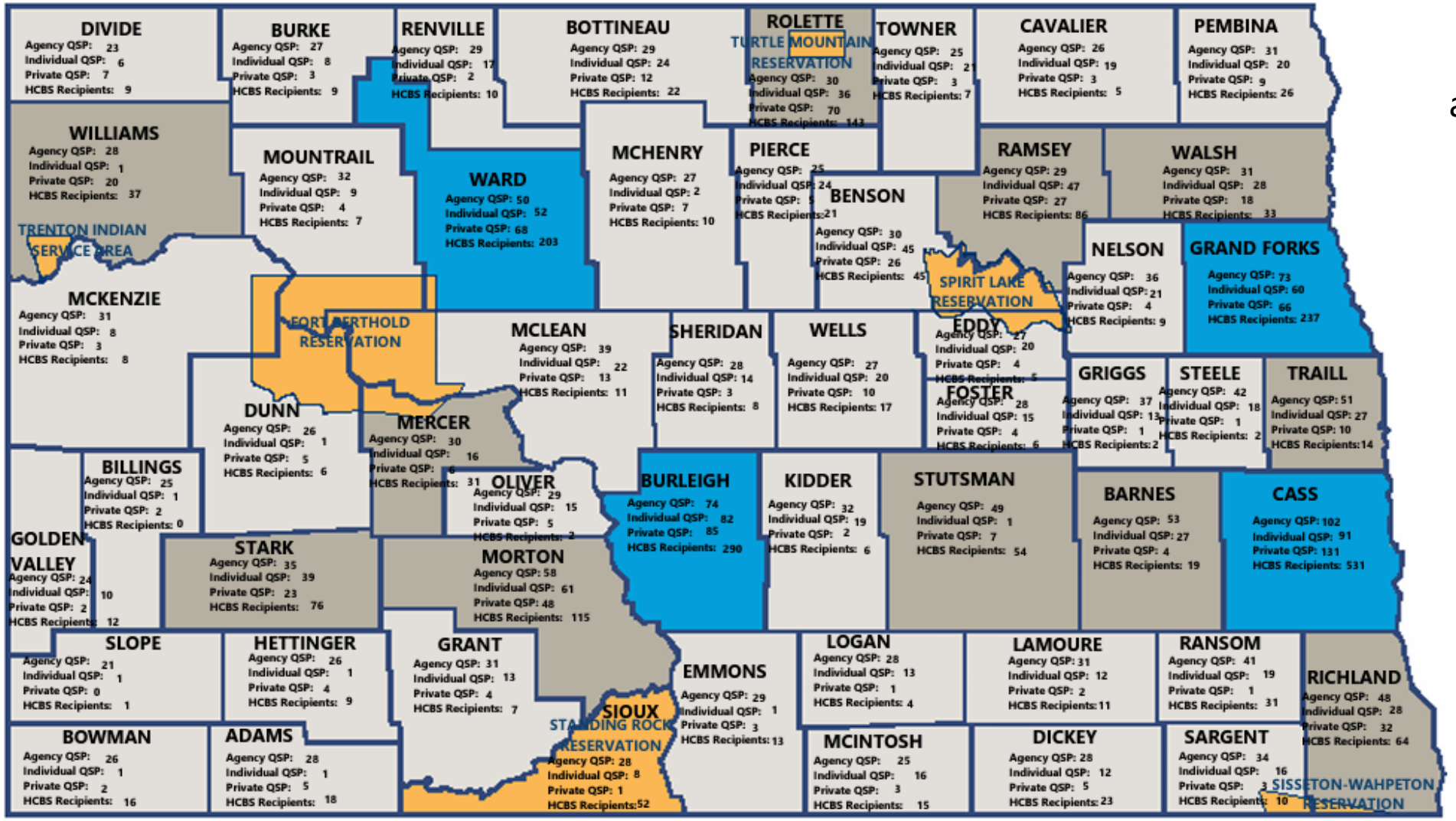
**1,153**
Individual QSPs

**What motivates individual QSPs to enroll as a provider?**
*Someone important to them needed care.*

Agency QSPs ranked the rate of compensation as the most important factor to retain employees.

*UND Independent QSP Survey Oct 2024*

# HCBS Qualified Service Providers (QSPs) by County




QSP map
available on HHS website

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# Types of SUPPORT SERVICES available via HCBS

| | | | | | |
|---|---|---|---|---|---|
| Adult Day Care | Adult Foster Care | Adult Residential Care | Homemaker | Home Delivered Meals | Non-Medical Transportation |
| Case Management | Chore | Community Support Services/ Residential Habilitation | Non - Medical Transportation Escort | Nurse Education | Personal Care - daily rate |
| Community Transition Services | Companionship | Emergency Response System | Personal Care - unit rate | Personal Care - Assisted Living | Respite |
| Environmental Modification | Extended Personal Care | Family Home Care | Supervision | Supported Employment | Transitional Living |

Note: Lighter blue shading indicates service included in EBR *Qualified Service Provider Targeted Rate Increase* request

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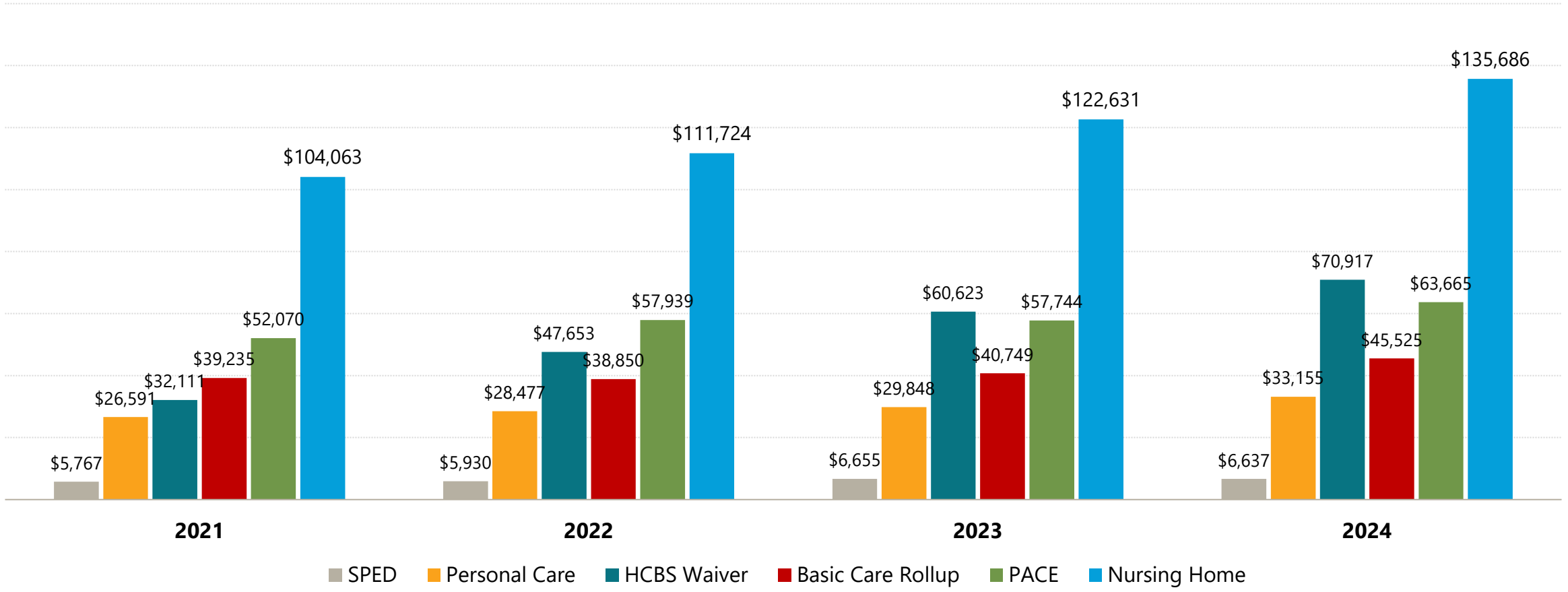
# Average spending per person per year

## Long-Term Care services and supports




Note: Basic Care Rollup includes both Basic Care Personal Care and Room and Board

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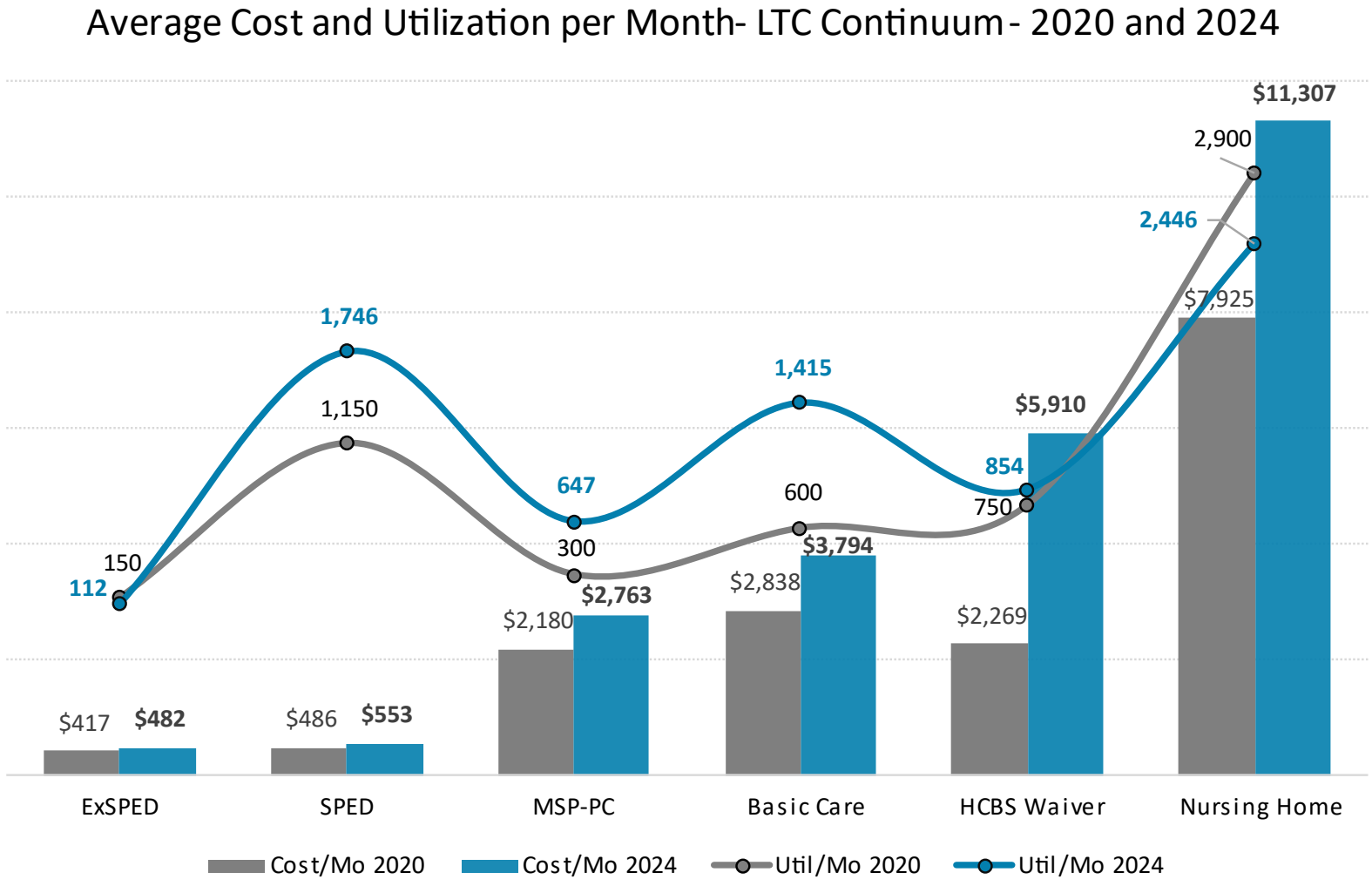
Connecting the Housing-Service Continuum to Budget

# Long Term Care Services and Supports

*Analysis of State Fiscal Year (SFY) 2020 and 2024 claims data | Average cost/month | Avg utilization/month*




Between 2020 and 2024, North Dakota saw an increase in utilization of services at the entry-levels of the continuum of long term services and supports and a decrease in utilization of nursing home care.

Costs continued to increase across all service lines with the most significant increases associated with care types that serve the highest acuity levels.

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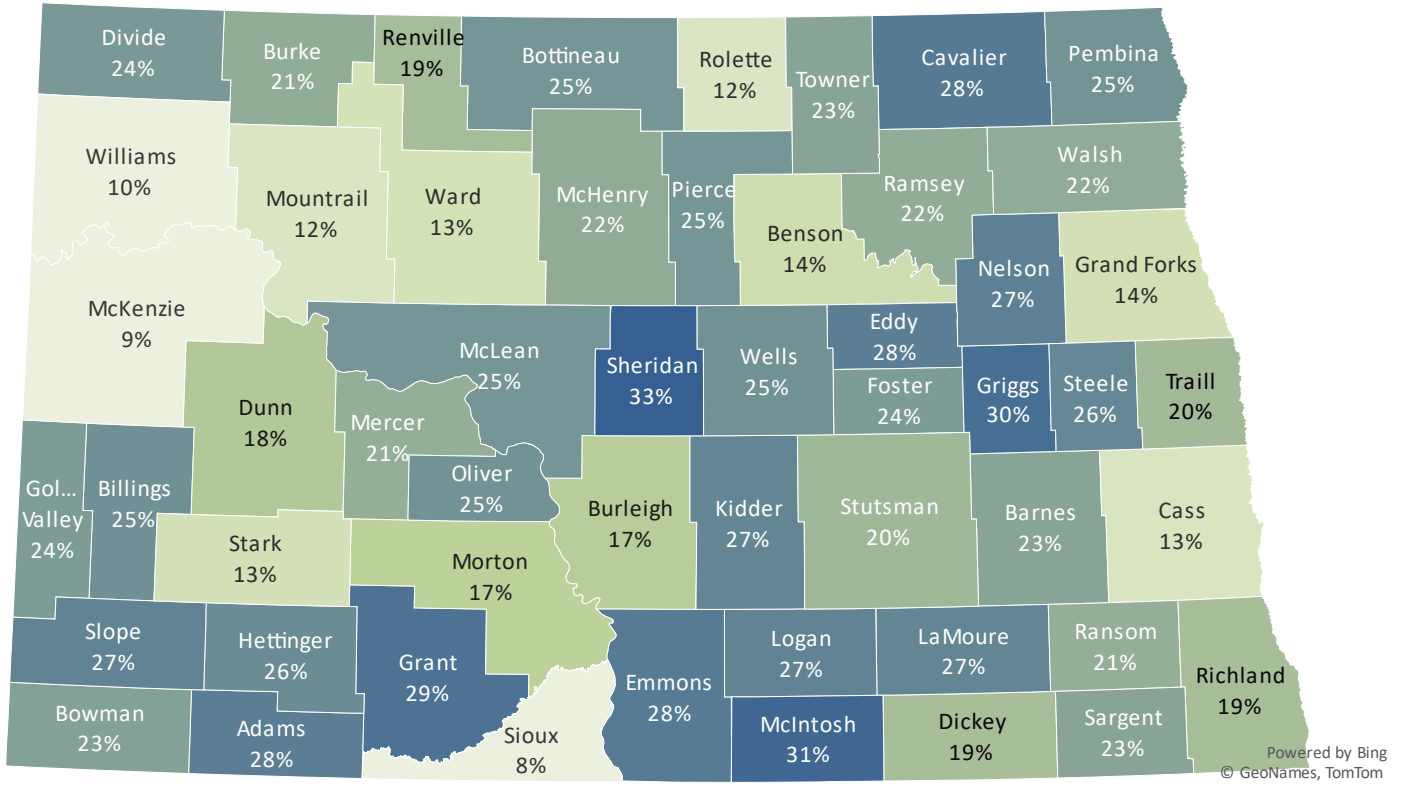
# There are several factors driving the need for the full array of Adult/Aging services and for HCBS generally

1. Population characteristics
   - % of people living alone
   - Age distribution
   - Disability prevalence
2. Demand
   - Shifting expectations about where/how to receive services
   - Technology-enabled environmental modifications
   - # of people needing services
3. Complexity of care needed
   - Co-occurrence of behavioral and physical health diagnoses

15.9% of ND population was age 65+ in 2022

*% of population age 65+ by county*

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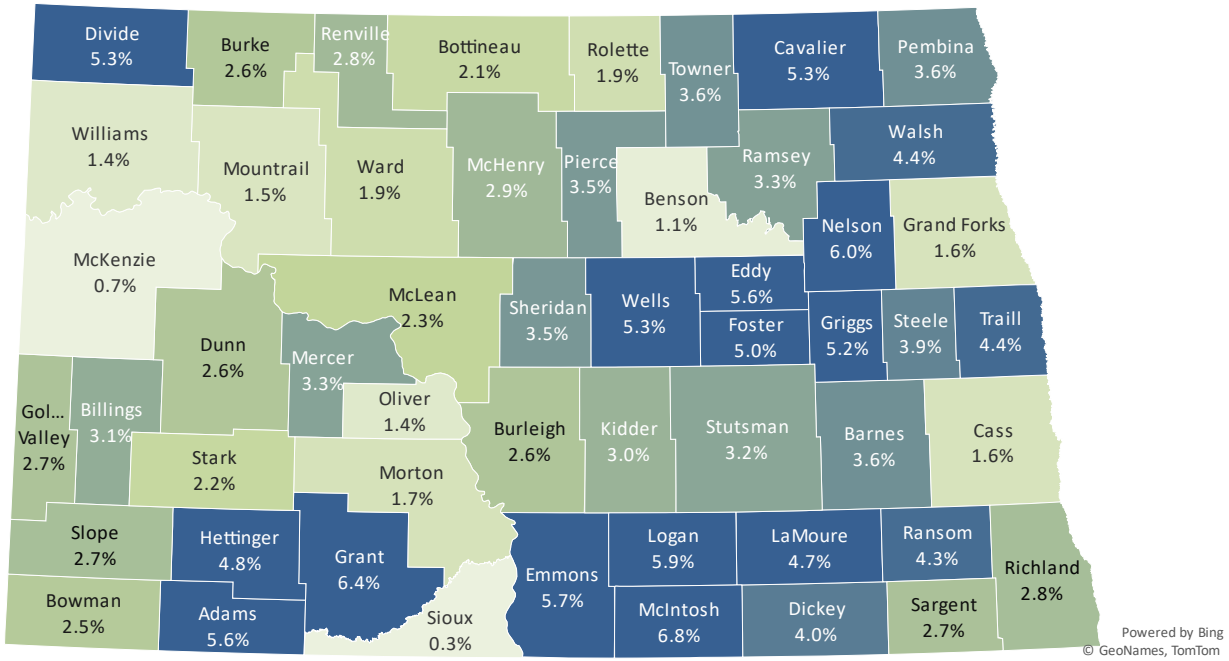
# The next 10 years will represent the most significant shift in demographics for ND and most US states

The patterns represented here (2022 data) will become more exaggerated between now and 2035

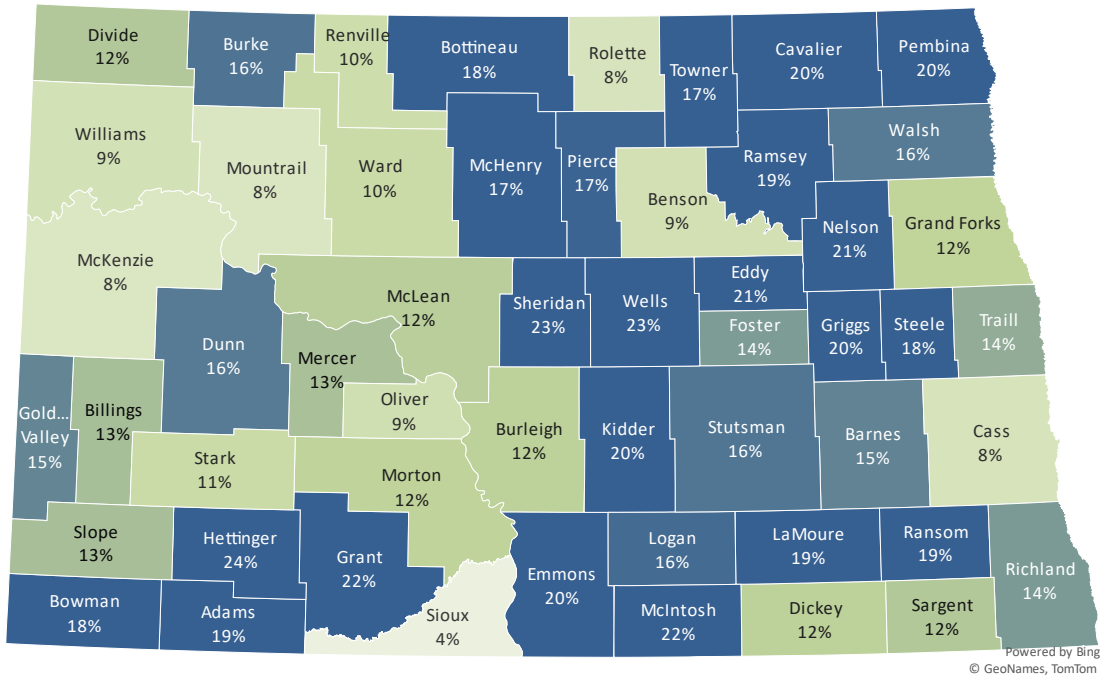
2.3% of ND population was age 85+ in 2022

*% of population age 85+ by county*




11.8% of ND households are someone age 65+ who is living alone

*% of households by county consisting of a person age 65+ who is living alone (2022)*




**59%** of current HCBS recipients **live alone** this is *above the national average* of 48%. → Lack of natural supports increases the need and amount of paid care necessary to maintain health and safety.

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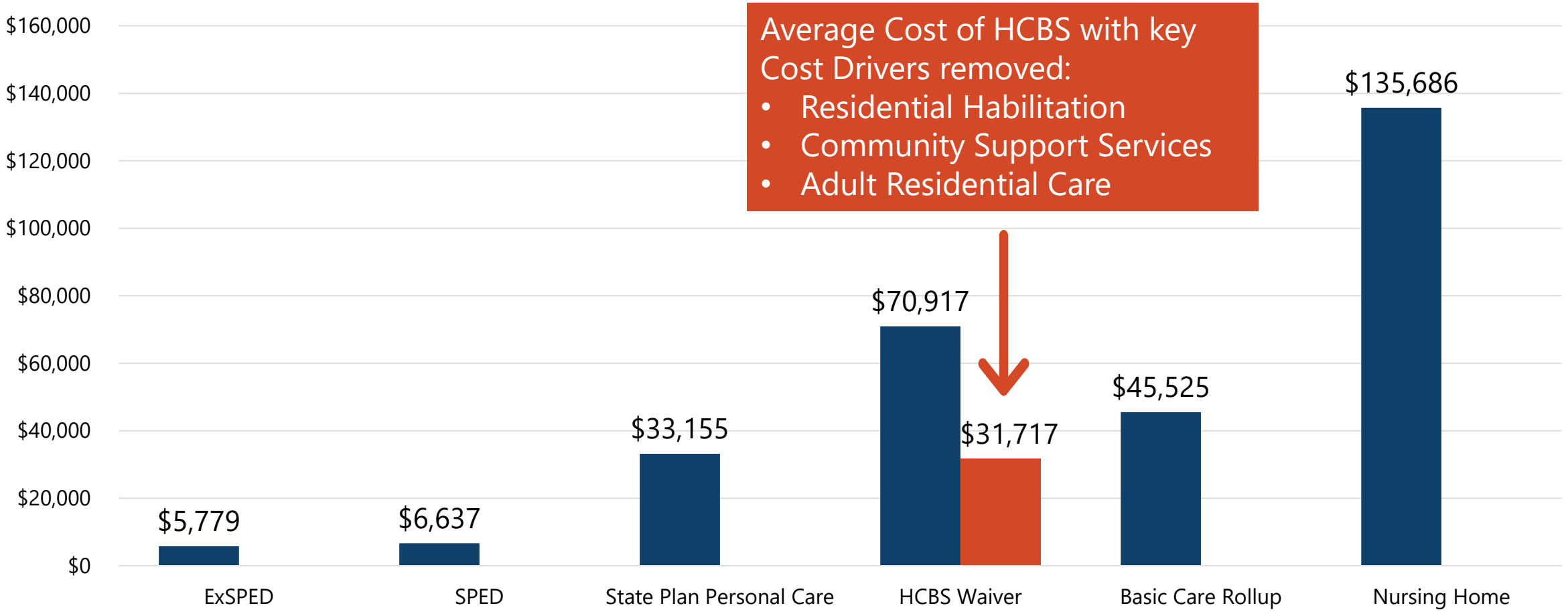
# SFY 2024 Long Term Care Continuum

## Average Cost Per Person

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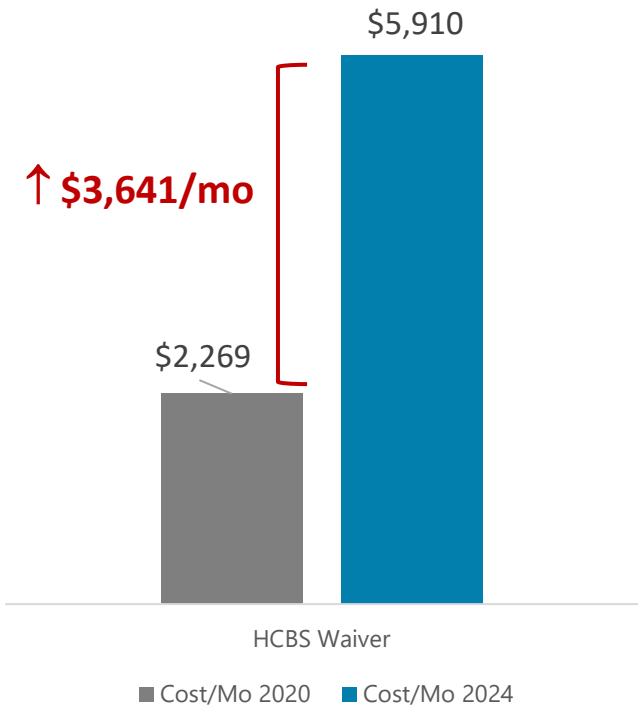
# What's driving HCBS Waiver cost growth?

Today's HCBS Waiver serves individuals with **unique and complex needs**, including individuals:

- Transitioning from the State hospital
- Discharging from local hospitals
- Transitioning home from a nursing facility
- Who have received a "needs cannot be met" denial from a nursing facility

From 2020 to 2024, average monthly per person HCBS Waiver costs grew by 160%




## Top HCBS Cost Drivers

1. **24-hour** delivery of complex cares
2. Prevalence of **serious mental illness** and **substance use disorder** in HCBS recipients
3. Increasing number of HCBS recipients with **complex medical** needs

## Cost driver #1

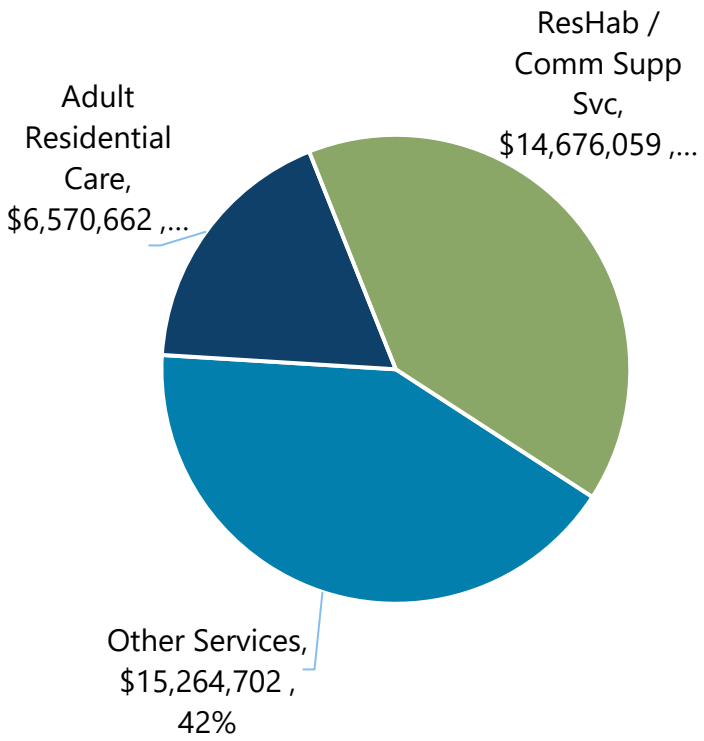
# 24-hour delivery of complex cares

### Adult Residential Care

- 24-hour residential services for individual with memory impairment or traumatic brain injury.
- Individuals have a daily need for a safe supervised structured environment, personal care, and medication supports.
- In SFY 24 **29%** (224) **of waiver participants** were enrolled in this service.
- Average cost per person per year = **$29,333**

### Residential Habilitation and Community Support Svcs

- Up to 24-hour all inclusive supports for individuals who meet a nursing facility level of care and require daily services.
- Service requires providers to have a nurse and a care coordinator with a minimum of a 4-year degree.
- In SFY 24 **16%** (121) of waiver participants are enrolled in this service.
- Average cost per person per year = **$121,290**




**16%** of waiver **participants** account for **40%** of the **cost** of care

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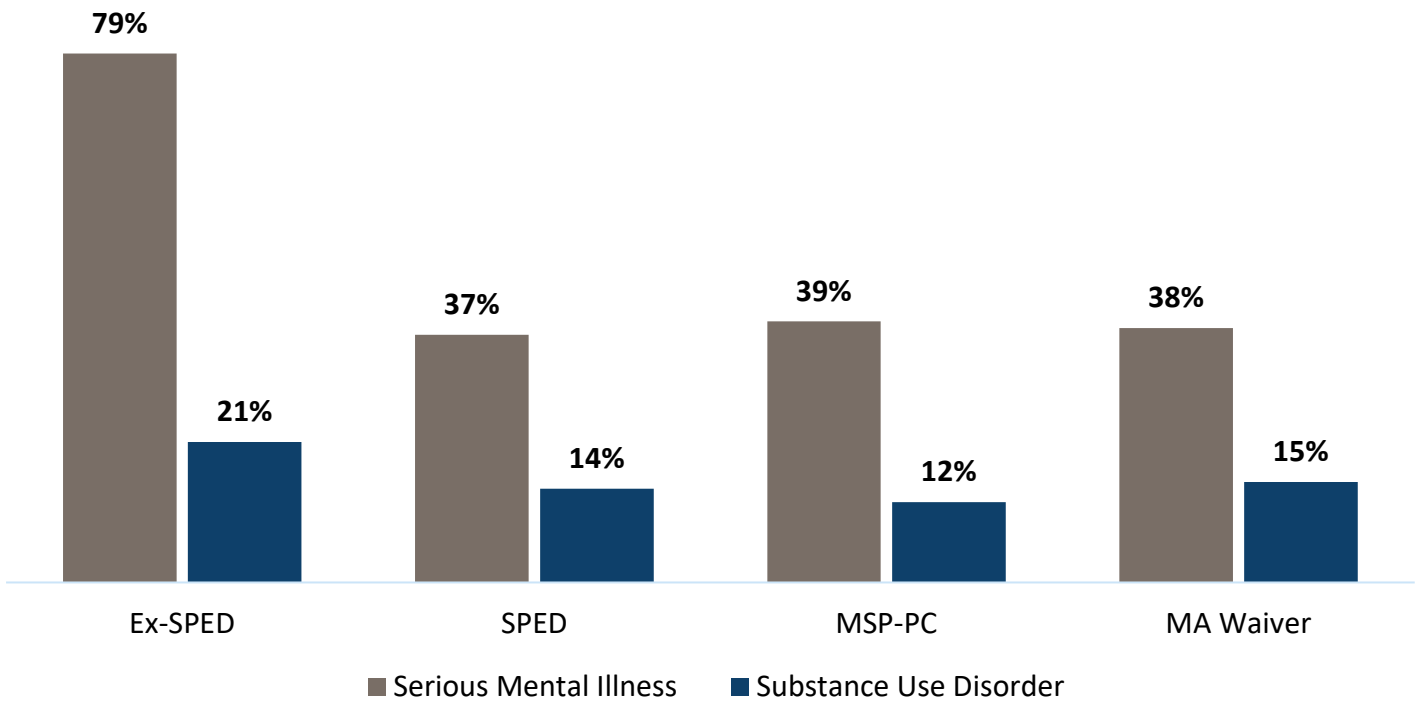
## Cost driver #2

# Prevalence of Behavioral Health Needs

- An increasing number of individuals seeking HCBS services have significant behavioral health needs, including diagnoses of serious mental illness and substance use disorders.
- Family home care and other family caregiver service modes are common modes of service delivery.
- Appropriate caregiver training is essential to prevent caregiver burnout but upskilling and supporting QSPs remains a barrier.

% of HCBS participants by type of service reporting Serious Mental Illness (SMI) or Substance Use Disorder (SUD) as a primary issue




*Source: NDHHS HCBS Case Management data system, 2024*

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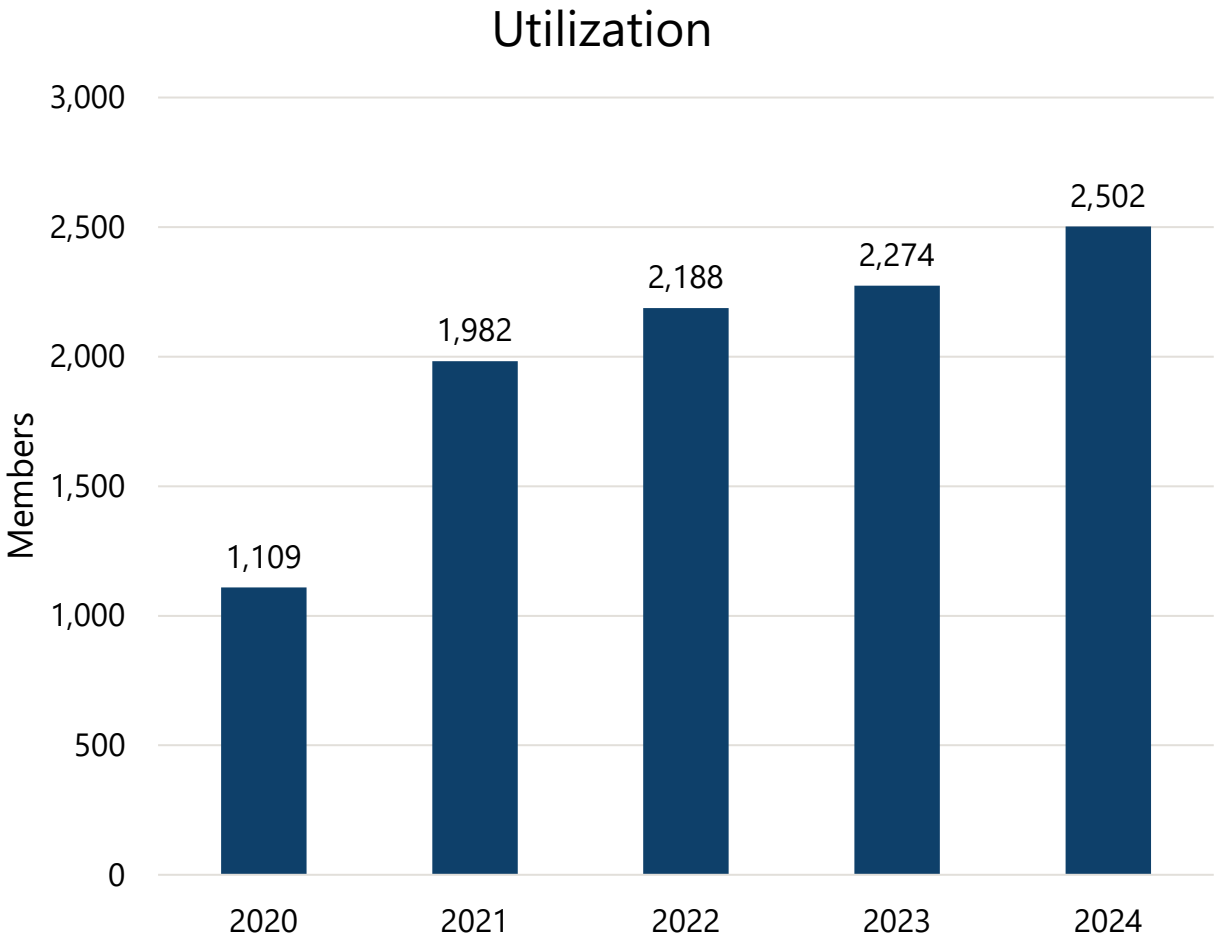
## Cost driver #3

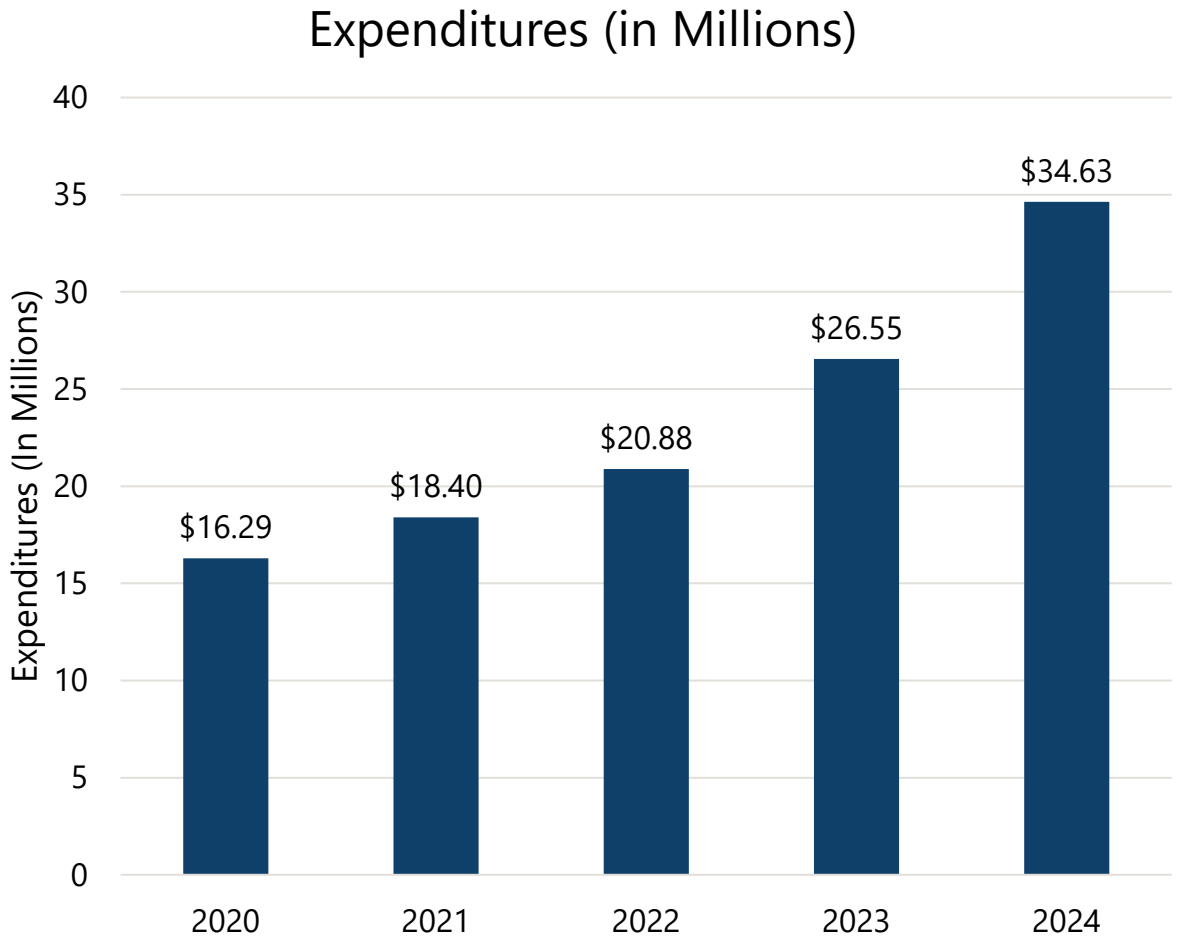
# Prevalence of Complex Medical Needs

| Common medical conditions reported by HCBS participants | Common medical tasks completed for HCBS participants |
|---|---|
| Osteo arthritis | Medication Administration |
| Chronic obstructive pulmonary disease (COPD) | Tracheostomy cares and suctioning |
| Stroke | PEG tube feedings and medications |
| Type 2 diabetes | Insulin administration including sliding scale |
| Paralysis | Port dressing changes |
| Heart Failure | Wound care |
| Age related physical impairment | IV Therapy |
| Dementia | Care coordination/ medical escort |
| Brain Injury | Foley catheter |

Primarily served with Residential Habilitation and Community Support services, with additional support from extended personal care and nurse education services

# Qualified Service Provider Utilization & Expenditures

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# Qualified Service Providers Targeted Rate Increase

## Ongoing

| Total | $5,392,656 |
|---|---|
| General | $3,595,104 |
| Federal | $1,797,552 |

Increase impacts the HCBS Waiver, DD Waiver, Autism Waiver, SPED, and Ex-SPED. Services impacted include nursing, personal care, respite, companionship, and homemaker services.

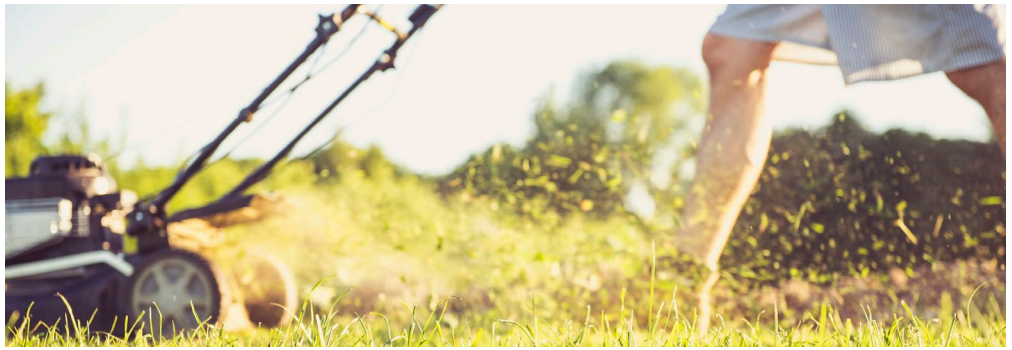
- ND's rates lag states in the region.
  - South Dakota did a comprehensive rate study of in-home providers in 2023 that reviewed baseline and benchmark wages and other costs for Qualified Service Provider services.

| Select Qualified Service Provider Agency Rates per 15-minute unit | | | | | |
|---|---|---|---|---|---|
| | ND | MN | MT | SD | WY |
| Personal Care | $8.05 | $5.95 | $8.92 | $10.88 | $8.53 |
| Homemaker | $7.14 | $7.90 | - | $10.88 | $6.62 |
| Respite | $7.93 | $9.64 | $6.02 | $10.53 | $7.50 |
| Companion | $7.14 | $7.90 | - | $10.53 | $7.60 |
| Nursing | $17.64 | $12.46 | $19.30 | $22.60 | $19.15 |

# QSP rate increases target areas of highest need

## QSP Nursing Services

- **Nurse Education** – assessment, nursing plan of care development and training
- **Extended Personal Care** - hands-on medical care tailored to individual's needs, including skilled or nursing care
- **Updated Agency Rate -** $19.71 per 15-min unit



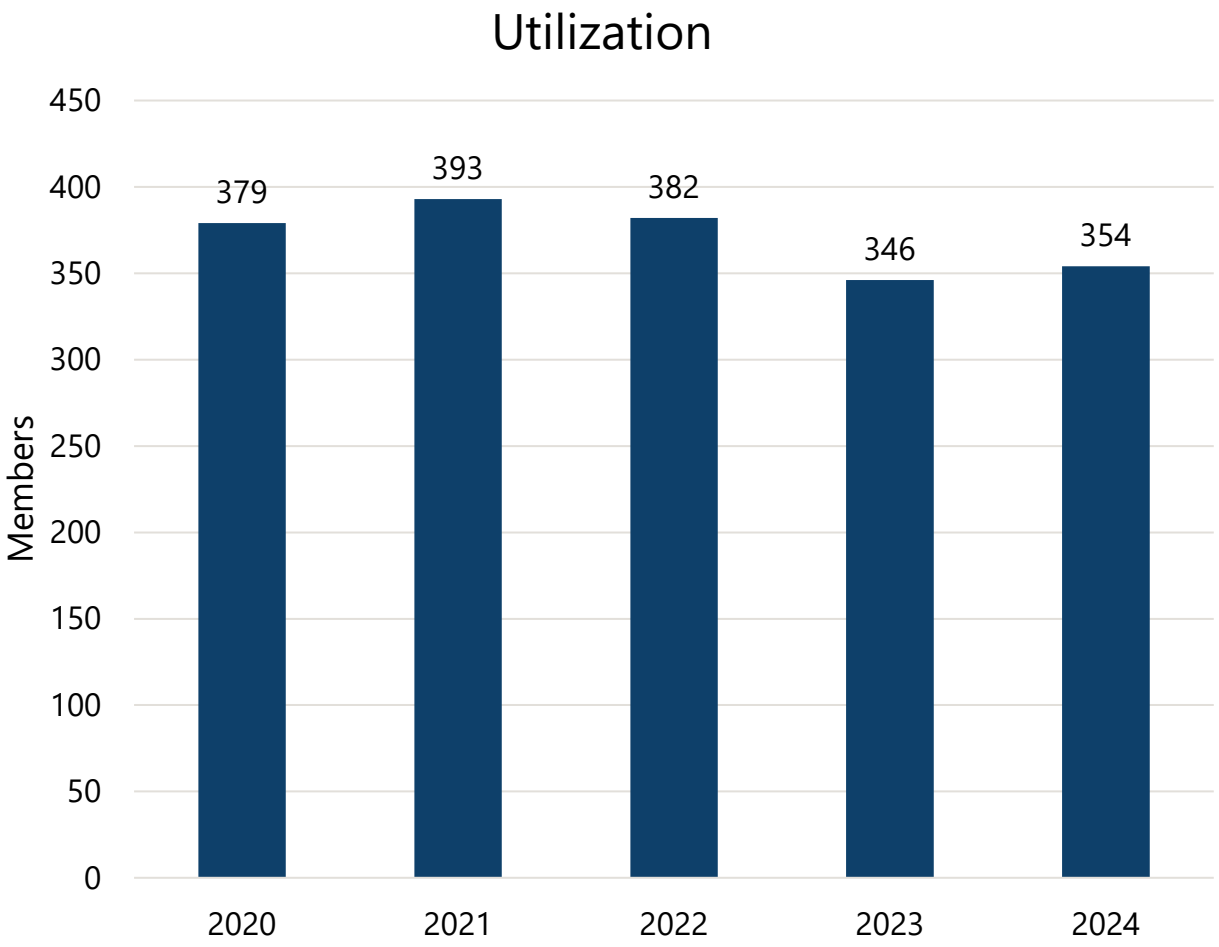
## QSP Aide Services

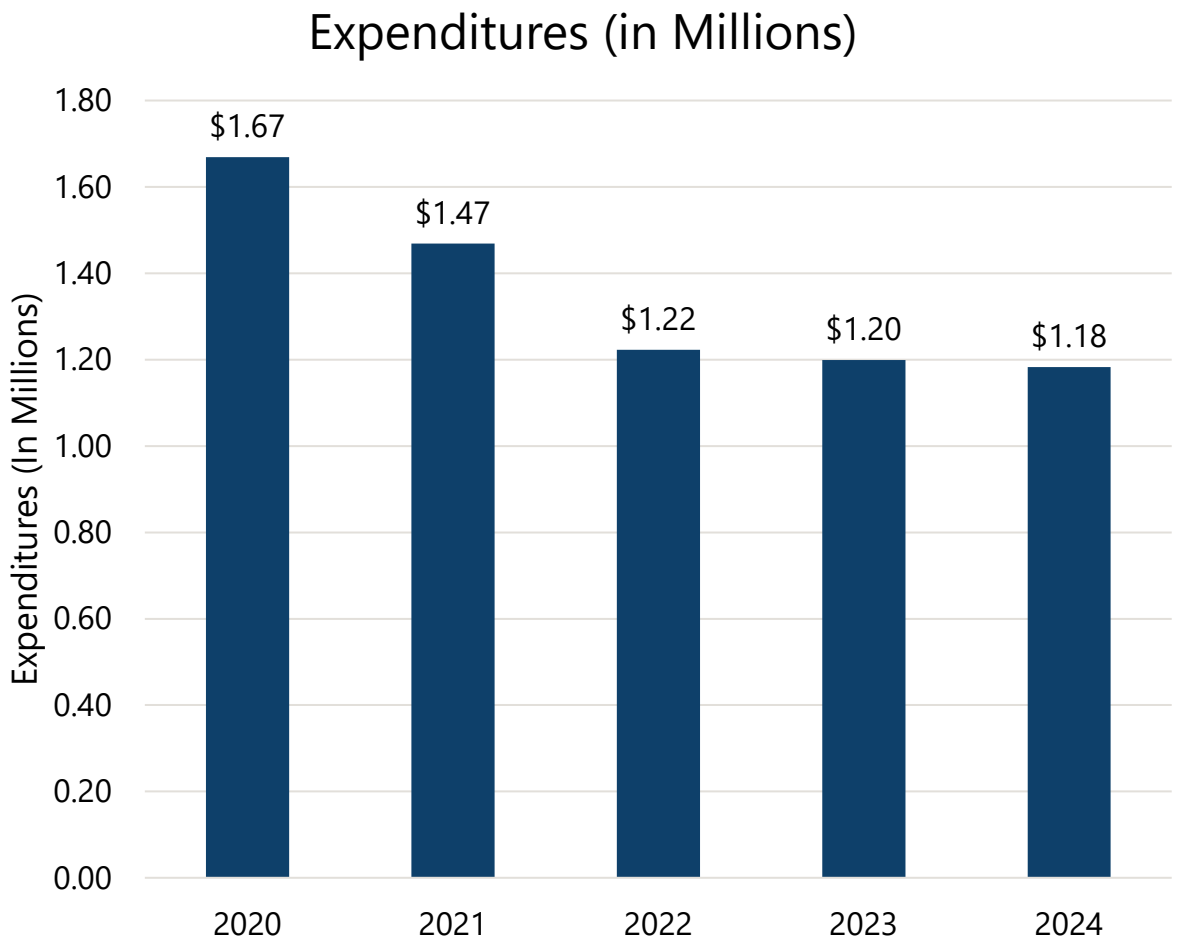
- **Homemaker** – housework, meal prep, laundry, shopping assistance
- **Chore** – Heavy cleaning, snow removal, lawn care
- **Personal Care** (unit rate) – help with personal hygiene, mobility etc.
- **Respite** – short break for caregivers
- **Supported Employment** – on the job support to remain employed
- **Transitional Living** – independent living skills training
- **Updated Agency Rate -** $9.40 per 15-min unit

## QSP Companion Services

- **Non-Medical Transportation – Escort** – help with mobility while shopping, banking etc.
- **Companionship** – socialization to reduce isolation
- **Supervision**- monitoring to ensure safety for people with cognitive impairment
- **Updated Agency Rate -** $9.10 per 15-min unit

# Home Health Utilization & Expenditures

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# Private Duty Nursing & Home Health Targeted Rate Increase

## Ongoing

| Total | $2,471,536 |
|---|---|
| General | $1,235,768 |
| Federal | $1,235,768 |

Increase rebases home health rates based on cost report information and aligns private duty nursing rates with home health skilled nursing.

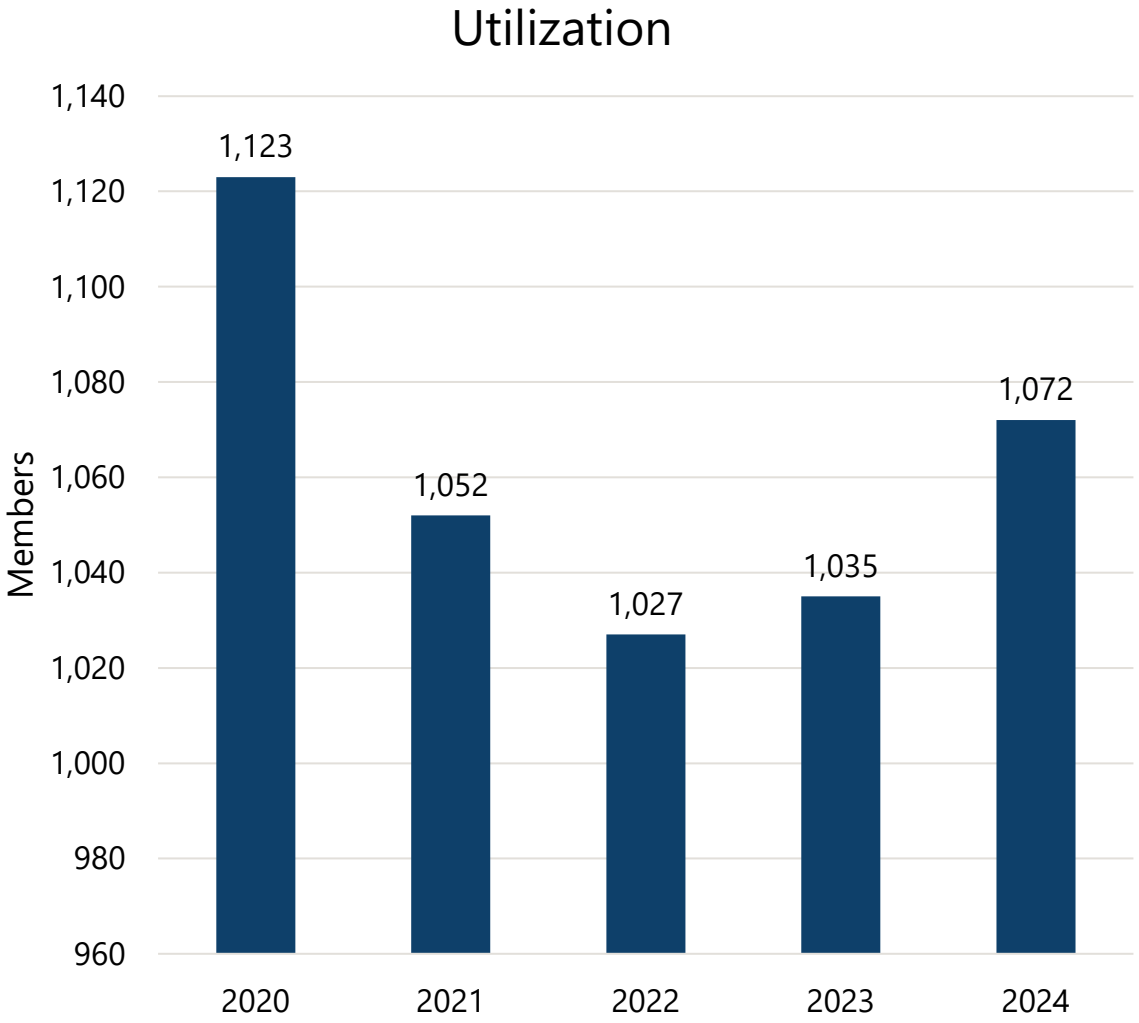
Included in Medical Services Budget

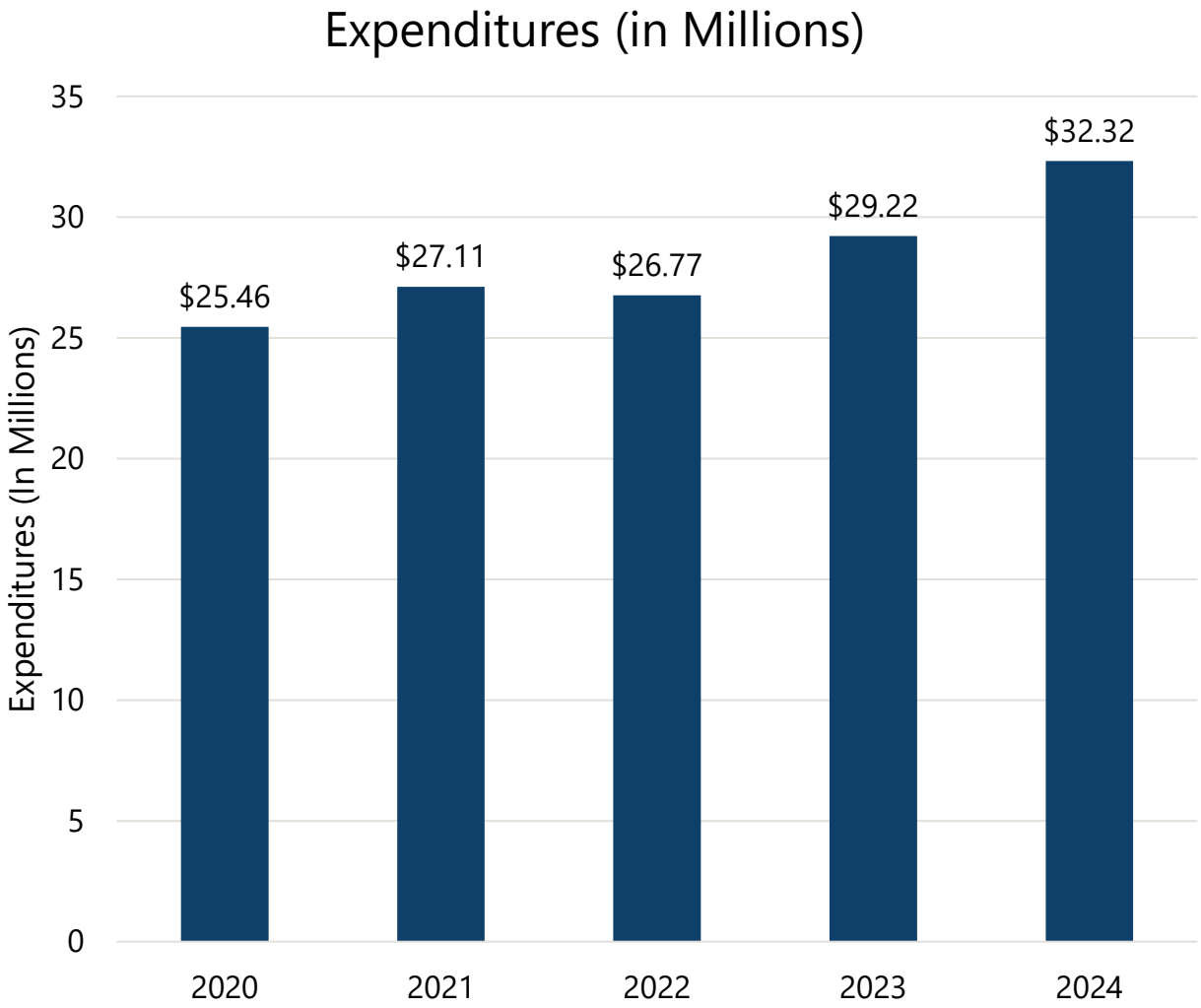
- Private Duty Nursing rates lag Home Health which may disincentivize agencies from serving patients with long term care needs.

| Home Health Rate, RN | Private Duty Nursing, RN |
|---|---|
| $140.57 (per visit) | $66.83 (per hour) |

- Home Health rates have not been rebased since 2004.
- Current SFY25 average rate for Home Health is $140.57 per visit.
  - Rebase projected to increase average rate to $219 per visit.

# Basic Care Utilization & Expenditures




Note: Basic Care Expenditures include both Basic Care Personal Care and Room and Board

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# Basic Care, Assisted Living & Adult Residential Concerns

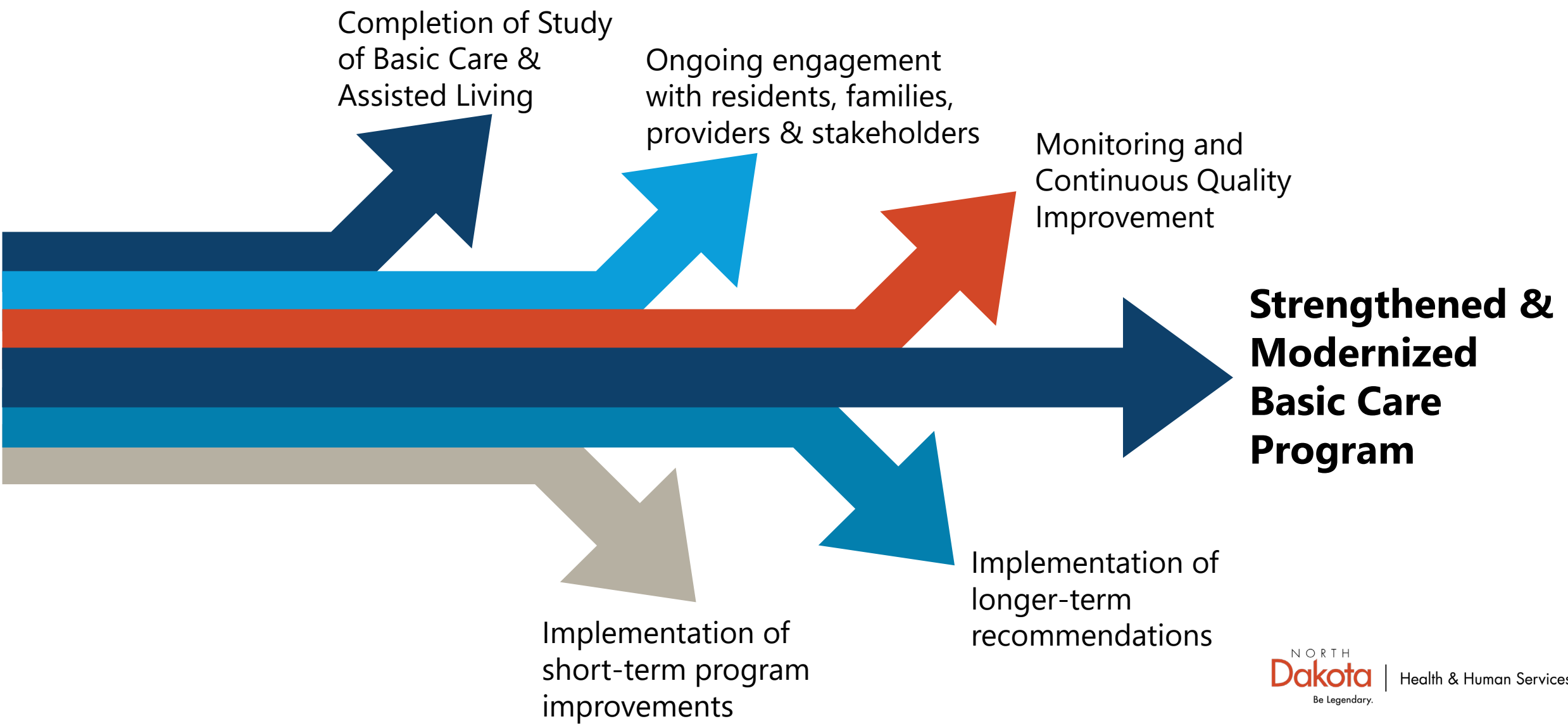
## Top Health Response Section Concerns

- Infrequent Basic Care Facility Surveys (33-year inspection cycle)
- Lack of Assisted Living Licensure Standards

## Top Medical Services Division Concerns

- Family Confusion
- Licensure Based on Payer Source
- Federal Funding Risk
- HCBS Settings Rule Compliance
- Department of Justice Risk

# Basic Care Strategy

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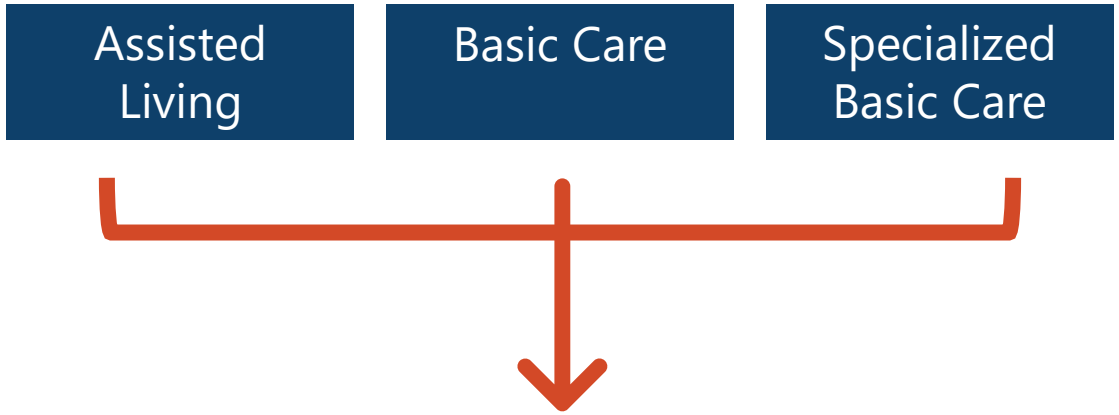
# Basic Care Study Recommendations

1. Streamline licensing by creating a new single licensure type to cover both assisted living and Basic Care facilities.
2. Strengthen existing assisted living and Basic Care policy and create additional policies to reflect current requirements within the program, incorporate best practices, and align with State and federal requirements, as applicable.
3. Develop and implement State-led universal assisted living and Basic Care training and materials to educate all stakeholders.
4. Adopt strategies to improve and expand the current service and programmatic array within Basic Care to integrate residents more comprehensively into the community.
5. Update regulatory oversight process based on implementation of recommendations.




**New Streamlined Licensure**

- HCBS Focused; Reduced Institutional Licensure Requirements
- Regulatory Partnership based on Collaboration & Incremental Enforcement
- Eligible for HCBS Waiver Participation & Reimbursement
- Allows Providers to Design their Service Array
- Supports More Choices for Elders & Families

# Basic Care Study Recommendations

6. Implement quality improvement initiative requirements for Basic Care facilities to improve quality of care and align facilities with best practices.
7. Update regulations to use publicly available indexes for cost trending to align more consistently with observed trends in provider costs.
8. Implement a Fair Rental Value (FRV) methodology to reimburse Basic Care provider property costs.
9. Implement tiered add-on payments for residents with increased ADLs care need and align reimbursement methodologies.

**New Streamlined Licensure**

- HCBS Focused; Reduced Institutional Licensure Requirements
- Regulatory Partnership based on Collaboration & Incremental Enforcement
- Eligible for HCBS Waiver Participation & Reimbursement
- Allows Providers to Design their Service Array
- Supports More Choices for Elders & Families

Person-Centered Sustainable
**Funding Model**
Incentivizing Continued Improvement & Innovation

**Related Bills:**
House Bill 1550 | Relating to a nursing and basic care facility loan guarantee program
House Bill 1619 | Relating to a long-term care facility infrastructure loan fund

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# Provider Inflation
## Ongoing

| Total | $5,396,854 |
|---|---|
| General | $3,294,874 |
| Federal | $2,101,980 |

Increase includes the following inflation of provider rates for the 2025-2027 biennium:

- SFY 2026: 1.5%
- SFY 2027: 1.5%

- Provider inflation is applied to provider rates in accordance with the rate methodology for the service.
  - Most provider rates paid from a fee schedule are updated each July 1.
  - Inflation is used as the adjustment factor to inflate costs forward from provider cost reports for most cost-based providers.
    - Some providers use a standardized index in place of inflation.

| Appropriated Inflation, SFY 2019 - 2024 | | | | | |
|---|---|---|---|---|---|
| 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| 2.0% | 2.5% | 2.0% | 0.25% | 3.0% | 3.0% |

# 2025 – 2027 Budget & Other Resource Requirements

Long Term Care

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# Decision Package Detail

## By Ongoing, One-Time and Funding Source

| Decision Package | Decision Package Grouping | General | Federal | Total | |
|---|---|---|---|---|---|
| HCBS Growth | Cost to Continue | $36,977,113 | $27,837,811 | $64,814,924 | Ongoing |
| Value Based Purchasing[1] | Compliance & Quality | $1,000,000 | $1,000,000 | $2,000,000 | Ongoing |
| QSP/HCBS Targeted Rate Increase | Services - DOJ | $3,595,104 | $1,797,552 | $5,392,656 | Ongoing |
| Provider Inflation | Additional Executive Decision Packages | $3,294,874 | $2,101,980 | $5,396,854 | Ongoing |
| Private Duty Nursing & Home Health Targeted Rate Increase[2] | Services - DOJ | $1,235,768 | $1,235,768 | $2,471,536 | Ongoing |

Note:
1. Value Based Purchasing will be included in the Medical Services Budget slides.
2. Private Duty Nursing & Home Health Targeted Rate Increase is located in the Medical Services Budget.

# Comparison of budgets and funding

## By Budget Account Code

| DESCRIPTION | 2023-2025 LEGISLATIVE BASE | 2025-27 EXECUTIVE BUDGET RECOMMENDATION | Increase/ (Decrease) |
|---|---|---|---|
| 71x Grants, Benefits, & Claims | 962,042,944 | 1,067,715,015 | 105,672,070 |
| **Total Operating & Grants** | **$ 962,042,944** | **$ 1,067,715,015** | **$ 105,672,070** |
| **Total** | **$ 962,042,944** | **$ 1,067,715,015** | **$ 105,672,070** |
| | | | |
| **Total General** | **$ 486,676,583** | **$ 562,728,792** | **$ 76,052,209** |
| **Total Federal** | **$ 474,554,361** | **$ 504,086,223** | **$ 29,531,861** |
| **Total Other** | **$ 812,000** | **$ 900,000** | **$ 88,000** |

# Grants

| DESCRIPTION | 2023-25 BIENNIUM AMOUNT | INCREASE/ (DECREASE) | 2025-27 EXECUTIVE BUDGET RECOMMENDATION TOTAL | GENERAL FUND | FEDERAL FUND | OTHER FUND |
|---|---|---|---|---|---|---|
| Community of Care | $ 330,000 | $ - | 330,000 | $ 330,000 | $ - | $ - |
| Personal Needs Allowance SSI | 193,200 | - | 193,200 | 193,200 | - | - |
| **GENERAL FUND** | **$ 523,200** | **$ -** | **$ 523,200** | **$ 523,200** | **$ -** | **$ -** |
| **FEDERAL FUND** | **-** | **-** | **-** | **-** | **-** | **-** |
| **OTHER FUND** | **-** | **-** | **-** | **-** | **-** | **-** |
| **GRAND TOTAL** | **$ 523,200** | **$ -** | **$ 523,200** | **$ 523,200** | **$ -** | **$ -** |

# Grants on a Walkthrough

| DESCRIPTION | 2025-27 BASE BUDGET | COST TO CONTINUE | FMAP | SAVINGS PLAN | UNDERFUNDING | TOTAL CHANGES | TO GOVERNOR |
|---|---|---|---|---|---|---|---|
| NURSING FACILITIES | $ 734,744,666 | $ 24,671,319 | $ (2,541,549) | $ (8,000,000) | $ - | $ 14,129,770 | $ 748,874,436 |
| BASIC CARE | 72,887,128 | (6,415,521) | - | - | - | (6,415,521) | 66,471,607 |
| PACE PYMT ALL-INCL CARE ELDRLY | 29,356,221 | (5,620,776) | - | - | - | (5,620,776) | 23,735,445 |
| AGED & DISABLED WAIVER | 54,112,132 | 19,524,971 | - | - | - | 19,524,971 | 73,637,103 |
| SPED | 22,402,748 | (628,767) | - | - | - | (628,767) | 21,773,981 |
| EXPANDED SPED | 1,313,728 | (3,238) | - | - | - | (3,238) | 1,310,490 |
| PERSONAL CARE SERVICES | 33,664,038 | 7,277,063 | - | - | - | 7,277,063 | 40,941,101 |
| TARGETED CASE MANAGEMENT | 940,828 | 359,559 | - | - | - | 359,559 | 1,300,387 |
| CHILDREN'S MED FRAGILE WAIVER | 814,760 | (434,562) | - | - | - | (434,562) | 380,198 |
| CHILDREN'S HOSPICE WAIVER | 76,950 | (5,425) | - | - | - | (5,425) | 71,525 |
| AUTISM WAIVER | 10,906,545 | 962 | - | - | - | 962 | 10,907,507 |
| AUTISM VOUCHER | - | - | - | - | - | - | - |
| **TOTAL FUNDS** | **$ 961,219,744** | **$ 38,725,585** | **$ (2,541,549)** | **$ (8,000,000)** | **$ -** | **$ 28,184,036** | **$ 989,403,780** |
| **GENERAL FUND** | **$ 484,992,253** | **$ 28,188,129** | **$ 15,974,519** | **$ (12,000,000)** | **$ -** | **$ 32,162,648** | **$ 517,154,901** |

| DESCRIPTION | TO GOVERNOR | INFLATION | SERVICES - COST TO CONTINUE | COMPLIANCE & QUALITY | SVC - DOJ | TOTAL CHANGES | TO HOUSE |
|---|---|---|---|---|---|---|---|
| NURSING FACILITIES | $ 748,874,436 | $ - | $ - | $ 2,000,000 | $ - | $ 2,000,000 | $ 750,874,436 |
| BASIC CARE | 66,471,607 | 1,502,258 | - | - | - | 1,502,258 | 67,973,865 |
| PACE PYMT ALL-INCL CARE ELDRLY | 23,735,445 | 536,421 | - | - | - | 536,421 | 24,271,866 |
| AGED & DISABLED WAIVER | 73,637,103 | 1,624,836 | 51,432,058 | - | 5,392,656 | 58,449,550 | 132,086,653 |
| SPED | 21,773,981 | 492,092 | 7,863,400 | - | - | 8,355,492 | 30,129,473 |
| EXPANDED SPED | 1,310,490 | 29,617 | (15,134) | - | - | 14,483 | 1,324,973 |
| PERSONAL CARE SERVICES | 40,941,101 | 925,269 | 14,913,272 | - | - | 15,838,541 | 56,779,642 |
| TARGETED CASE MANAGEMENT | 1,300,387 | 29,389 | - | - | - | 29,389 | 1,329,776 |
| CHILDREN'S MED FRAGILE WAIVER | 380,198 | 8,592 | 380,198 | - | - | 388,790 | 768,988 |
| CHILDREN'S HOSPICE WAIVER | 71,525 | 1,616 | 6,502 | - | - | 8,118 | 79,644 |
| AUTISM WAIVER | 10,907,507 | 246,763 | (9,765,372) | - | - | (9,518,609) | 1,388,898 |
| AUTISM VOUCHER | - | - | - | - | - | - | - |
| **TOTAL FUNDS** | **$ 989,403,780** | **$ 5,396,854** | **$ 64,814,924** | **$ 2,000,000** | **$ 5,392,656** | **$ 77,604,434** | **$ 1,067,008,214** |
| **GENERAL FUND** | **$ 517,154,901** | **$ 3,294,874** | **$ 36,977,113** | **$ 1,000,000** | **$ 3,595,104** | **$ 44,867,091** | **$ 562,021,992** |

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# Comparison of budget expenditures and projections

## By Budget Account Code

| DESCRIPTION | 2023-25 LEGISLATIVE BASE | Expended as of 12/31/2024 | PROJECTION THROUGH 6/30/2025 | UNDER/(OVER) BUDGET |
|---|---|---|---|---|
| 71x Grants, Benefits, & Claims | 962,042,944 | 641,912,745 | 936,626,339 | 25,416,605 |
| **Total Operating & Grants** | **$ 962,042,944** | **$ 641,912,745** | **$ 936,626,339** | **$ 25,416,605** |
| **Total** | **$ 962,042,944** | **641,912,745** | **$ 936,626,339** | **$ 25,416,605** |
| | | | | |
| **Total General** | **$ 486,676,583** | **$ 318,917,543** | **$ 471,597,723** | **$ 15,078,860** |
| **Total Federal** | **$ 474,554,361** | **$ 322,995,202** | **$ 464,216,616** | **$ 10,337,745** |
| **Total Other** | **$ 812,000** | | **$ 812,000** | **$ (0)** |

# Who We Serve

Medical Services

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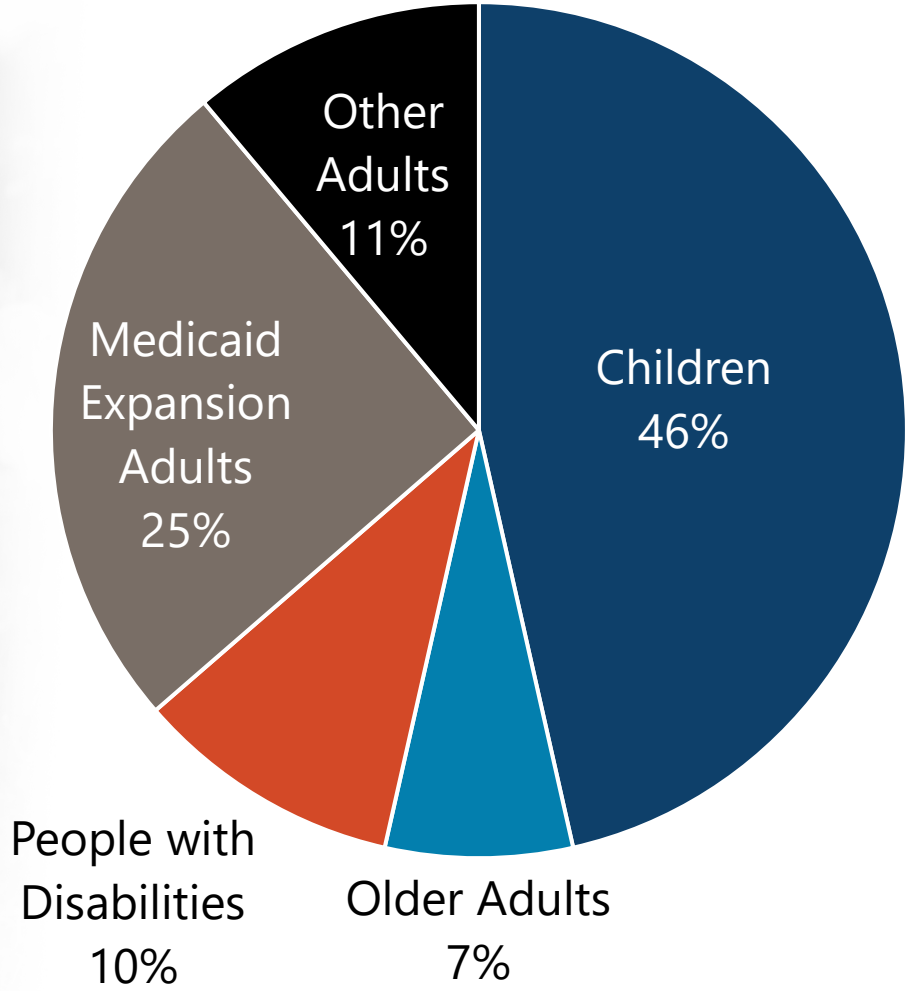
# Who is covered by North Dakota Medicaid?




**State Fiscal Year 2024**

- 152,273 Unduplicated Individuals
- 112,558 Average Monthly Enrollment

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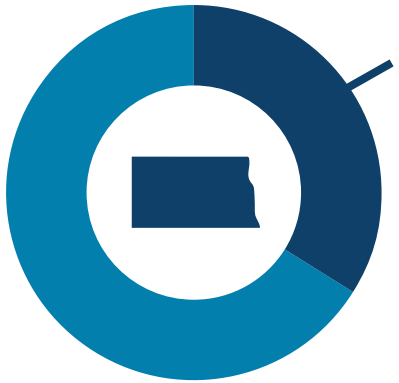
# Who We Serve

Nearly **1 in 7 North Dakotans** in any given month will have health coverage through Medicaid or CHIP

**52.5% nursing facility residents** are paid by Medicaid

Up to **1 of every 3 children** under the age of 19 in North Dakota has health coverage through Medicaid or CHIP



**34% of children born in North Dakota** will be on Medicaid or CHIP during their first year of life

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# Federal Poverty Level & HHS Programs

## 2024 CALENDAR YEAR FEDERAL POVERTY GUIDELINES

### Annual Amount at Various Income Percentage Levels

| Family Size | 34% | 100% | 130% | 138% | 175% | 185% | 205% |
|---|---|---|---|---|---|---|---|
| 1 | $5,120 | $15,060 | $19,578 | $20,783 | $26,355 | $27,861 | $30,873 |
| 2 | $6,950 | $20,440 | $26,572 | $28,207 | $35,770 | $37,814 | $41,902 |
| 3 | $8,779 | $25,820 | $33,566 | $35,632 | $45,185 | $47,767 | $52,931 |
| 4 | $10,608 | $31,200 | $40,560 | $43,056 | $54,600 | $57,720 | $63,960 |
| 5 | $12,437 | $36,580 | $47,554 | $50,480 | $64,015 | $67,673 | $74,989 |
| 6 | $14,266 | $41,960 | $54,548 | $57,905 | $73,430 | $77,626 | $86,018 |
| 7 | $16,096 | $47,340 | $61,542 | $65,329 | $82,845 | $87,579 | $97,047 |
| 8 | $17,925 | $52,720 | $68,536 | $72,754 | $92,260 | $97,532 | $108,076 |

| | |
|---|---|
| **Children** | **205%** |
| **Parent/Caretaker** | **34%** |
| **Expansion Adults** | **138%** |
| **Pregnant Women** | **175%** |
| **SNAP** | **130%** |
| **WIC** | **185%** |

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# North Dakota Medicaid Waivers

**1915(c) Home and Community Based Services (HCBS) Waivers**

- Autism Spectrum Disorder Waiver
- Children's Hospice Waiver
- Waiver for Medically Fragile Children
- Waiver for Home and Community Based Services
- Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver

- 1915(c) waivers have two components of eligibility:
  - Functional Need
    - Assessments are used to measure an individual's needs. The assessment helps shape the care plan in addition to verifying eligibility.
  - Financial
    - For waivers, only the income of the individual applying for the waiver's income is used to determine financial eligibility.
    - Allows coverage of disabled individuals at incomes higher than those that would traditionally qualify for Medicaid.

# HCBS Programs and Populations

| | Intellectual and Developmental Disabilities | Physical Disabilities | Behavioral Health |
|---|---|---|---|
| | Medicaid State Plan | | |
| Adults | Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver | Waiver for Home and Community Based Services<br>Programs for All Inclusive Care for the Elderly (PACE) | 1915(i) |
| | Medicaid State Plan | | |
| Children | Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver<br>Autism Spectrum Disorder Waiver | Waiver for Medically Fragile Children | 1915(i) |

Children's Hospice Waiver

Money Follows the Person

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# Medicaid Children Waiver Service Comparison

**Developmental Disabilities**

- Residential Habilitation
- Extended Home Health Care
- Behavioral Consultation
- Environmental Modifications
  - $40K for 5 years
- Equipment And Supplies
  - $5K per year
- Family Care Option
- In-home Supports
  - 300 hours per month
- Infant Development
- Respite
  - 600 hours per year

**Medically Fragile**

- Program cap of $25,300.00 to be used towards all waiver services except Case Management per fiscal year
- Case Management
- Institutional Respite
- Dietary Supplements
- Environmental Modifications
- Equipment & Supplies
- Individual and Family Counseling
- Transportation Services

**Autism**

- Respite
  - 40 hours per month
- Service Management
  - 16 hours per month
- Assistive Technology
  - $5K duration of waiver
- Community Connector
- Remote Monitoring

# Serving Children with Disabilities

**2021**

SB 2256: Legislative Management Study of Developmental Disability Services and Autism Spectrum Disorder Waiver and Voucher Programs

**2022**

North Dakota Developmental Disabilities Study
Recommended Children's Cross Disability Waiver to provide individual and family supports.

**2023**

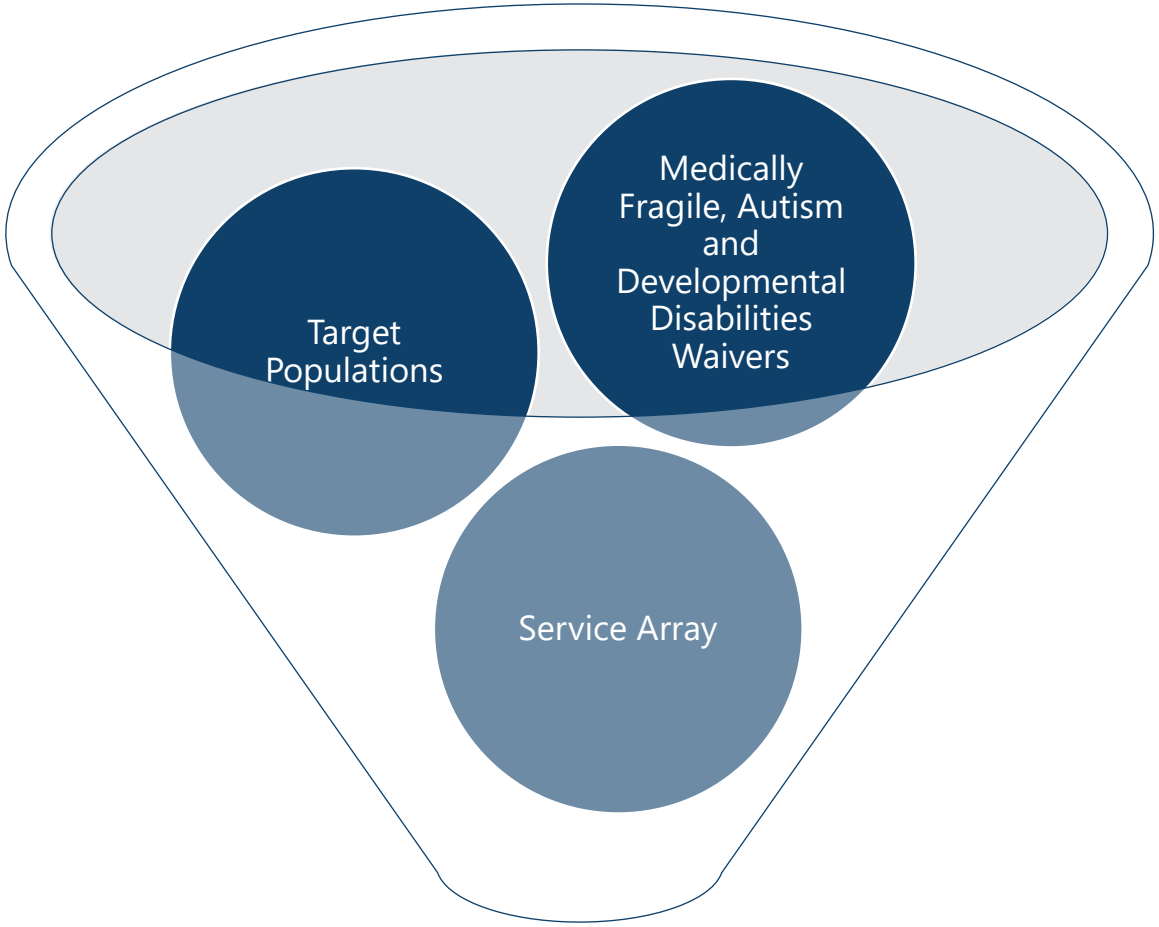
SB 2276: Established Cross Disability Advisory Council

**2024**

Cross Disability Advisory Council met monthly from December 2023 – May 2024 to provide input regarding design of new cross disability waiver.

Cross Disability Advisory Council compiled detailed recommendations in design of a potential new cross-disability children's waiver.

**2025**




**Cross Disability Children's Waiver** helps children and families gain independence, self-determination, social capital, economic sufficiency, and community inclusion.

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# Cross Disability Advisory Council

- Ensure the right people are getting the right amount of care, in the right environment
- Combine Existing Non-Residential Services in Current Children's Waivers
- Focus on Gaining Independence & Navigating Transitions
  - Family Training & Skill Building
- Flexibility for Families
- Case Management & Family Navigation
- Person and family focused outcomes

**Related Bills:**
Senate Bill 2113 | Relating to [...] Membership of the Cross Disability Advisory Council
Senate Bill 2305 | Relating to the family paid caregiver program and the cross-disability advisory council

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# Cross Disability Waiver Implementation

## Ongoing

| Total | $4,948,452 |
|---|---|
| General | $2,474,226 |
| Federal | $2,474,226 |

The Children's Cross-Disability Waiver is being designed to address existing disparities in access to home and community-based services for children with disabilities. This innovative waiver transforms the way support is provided, ensuring equitable access to essential services for children aged 3 to 21 who have mild to moderate support needs.

**2023-2025 Biennium Activities:**

1. Design and Test New Level of Care for Cross Disability Waiver and Developmental Disabilities Waiver
2. Design Cross Disability Waiver
   - Service Array
   - Access
   - Quality
   - Provider Qualifications & Rates
3. Start Building Service Infrastructure

**Funding will support:**

- Subject Matter Expertise
- Cross Disability Advisory Council Facilitator
- Service Infrastructure Development

# Who We Are

Medical Services Division

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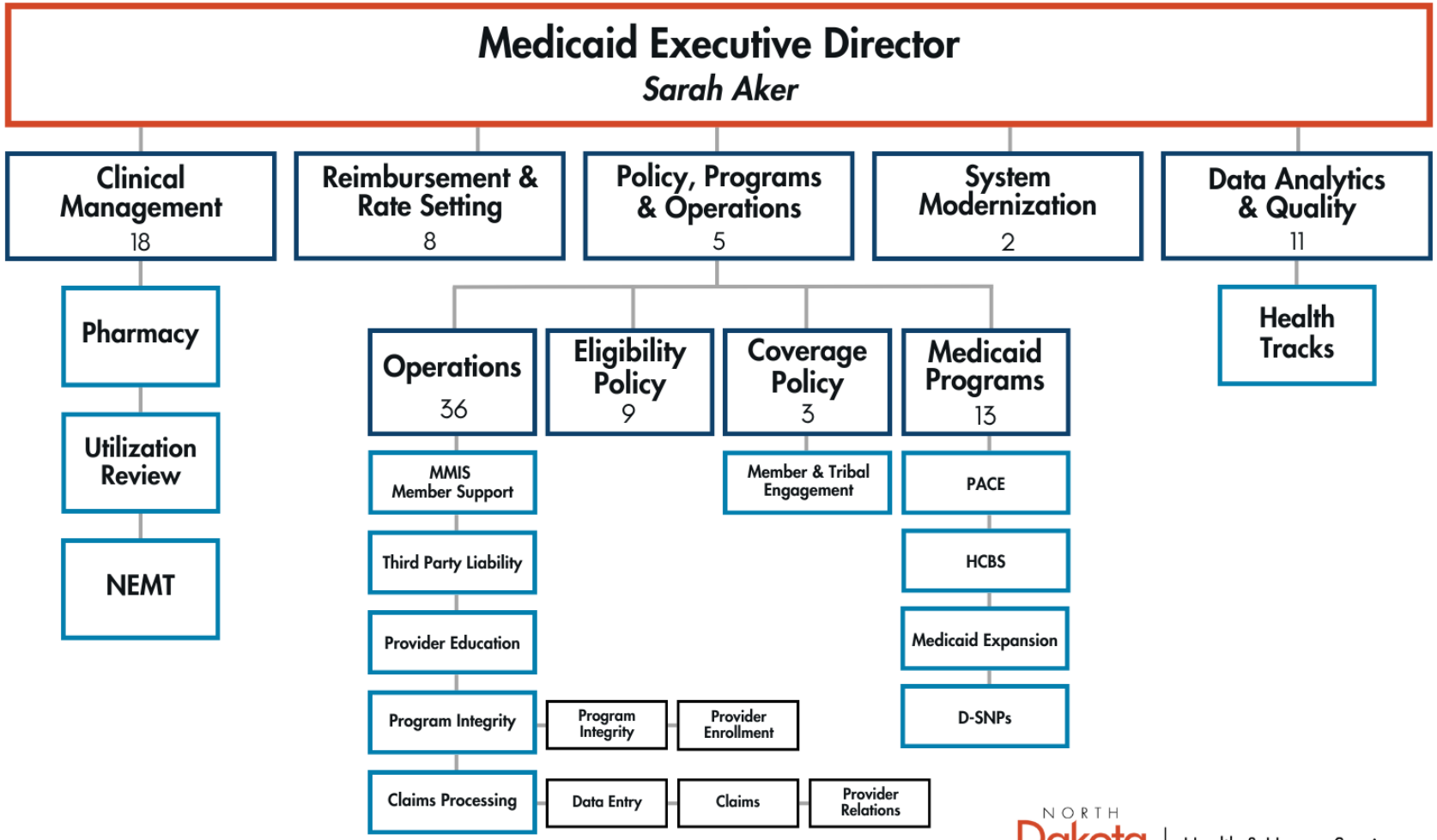
# Medical Services Division

## Team Structure and Function

| Medical Services Division | | | |
|---|---|---|---|
| Position #s Assigned/ Funding Exists | Positions Filled | # of Vacancies | # of Temporary Staff |
| *106* | *95.85* | *10** | *12** |

*As of 12/01/2024

| | |
|---|---|
| Average Age | *48* |
| Avg Years of Service | *11* |
| Retirement Risk | *12%* |
| Turnover 2021 | *1%* |
| Turnover 2022 | *6%* |
| Turnover 2023 | *11%* |
| Turnover 2024 | *7%* |

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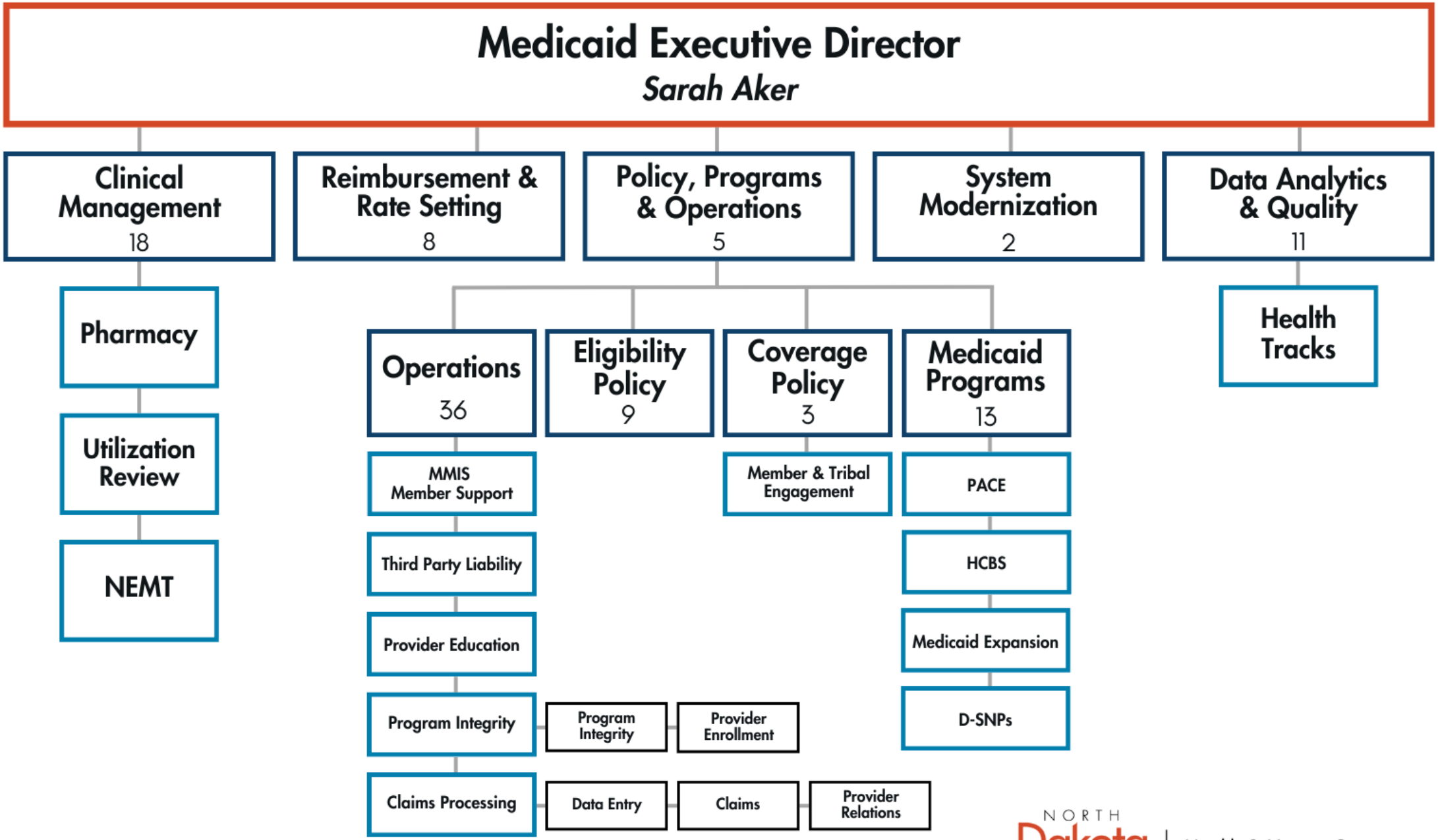


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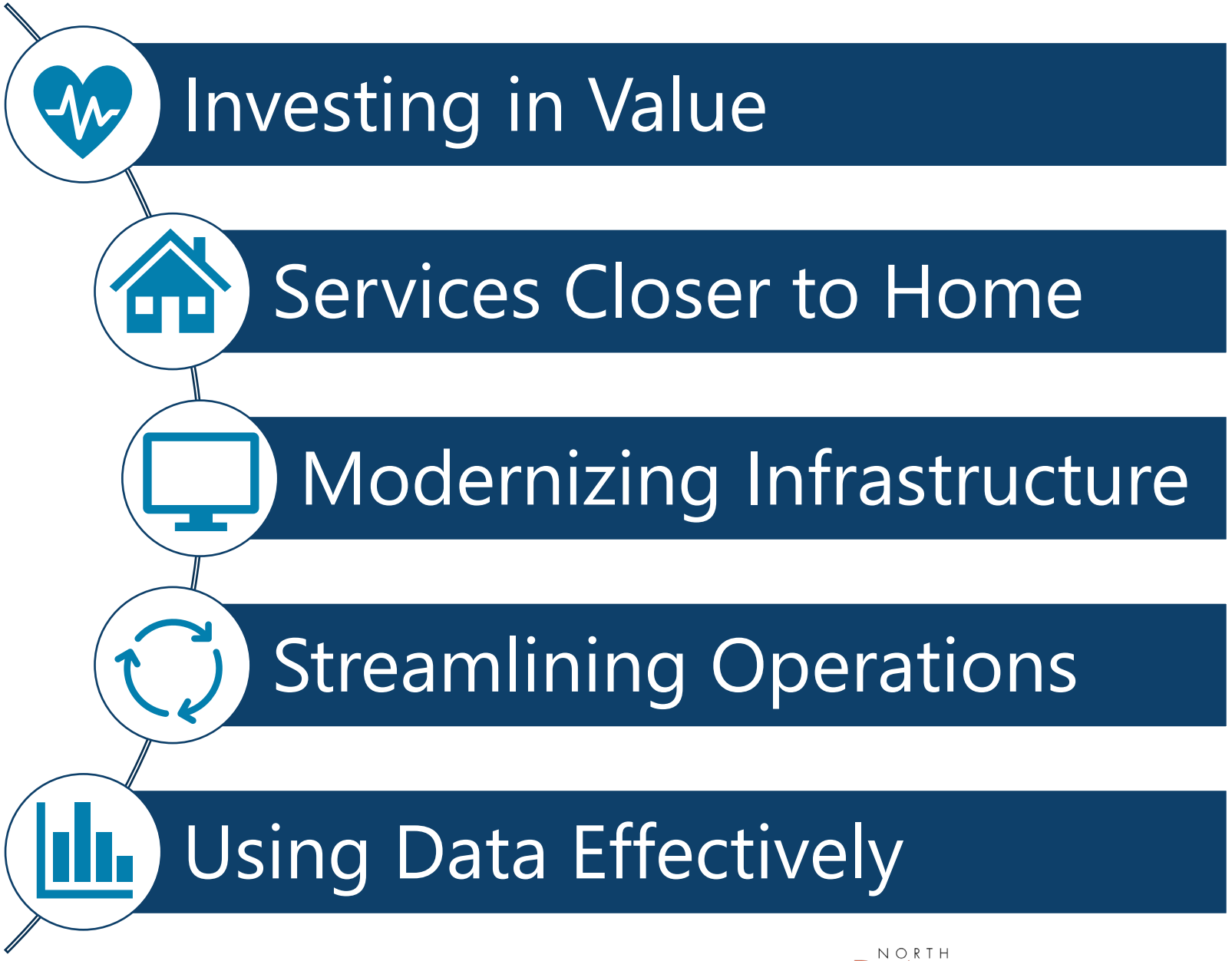
# Our Key Priorities

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# Goals for the Next Biennium

- Bending the Cost Curve
- Delivering Whole Person Care
- Promoting Sustainability & Value
- Improving the Member & Provider Experience

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# Improving the Lives of North Dakotans

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# Eligibles & Unwinding

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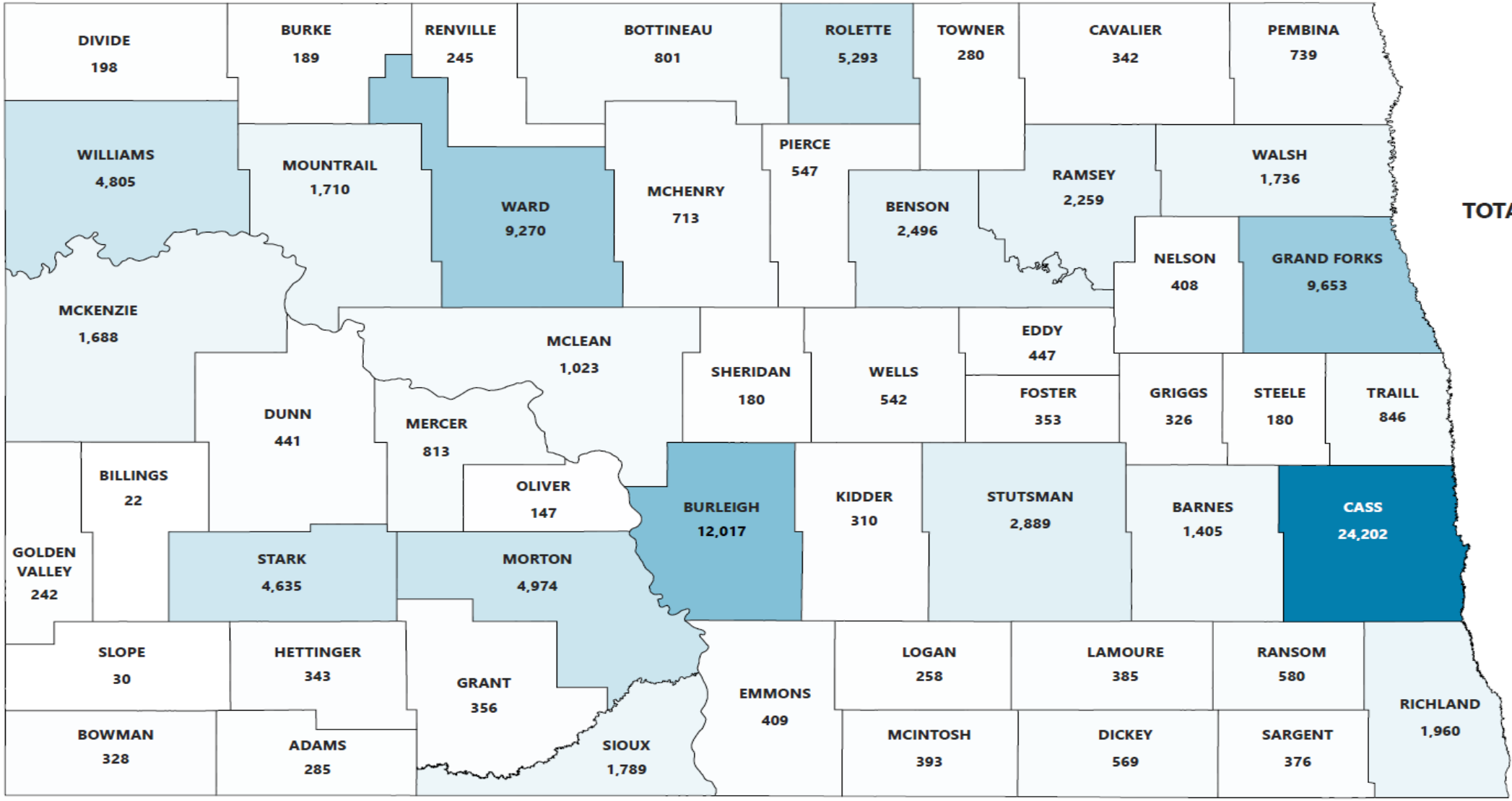
Last updated: 01/04/2024

# MEDICAID ELIGIBLES BY COUNTY

December 2024




**TOTAL ELIGIBLES**

**107,619**

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# Public Health Emergency Continuous Eligibility Requirement

The Families First Coronavirus Response Act (FFCRA) passed in March 2020 provided an additional 6.2% FMAP to states.

- To receive the enhanced FMAP, states had to meet certain Maintenance of Effort requirements including continuous coverage of all individuals enrolled on or after March 2020.
  - Members could only be disenrolled from a state's Medicaid program if they asked to be disenrolled, moved out of state, or died.
- In December 2022, Congress delinked the Medicaid continuous coverage requirement from the PHE, allowing states to resume Medicaid coverage terminations effective April 1, 2023.
- "Unwinding" is a term used to refer to the return to normal Medicaid eligibility rules.

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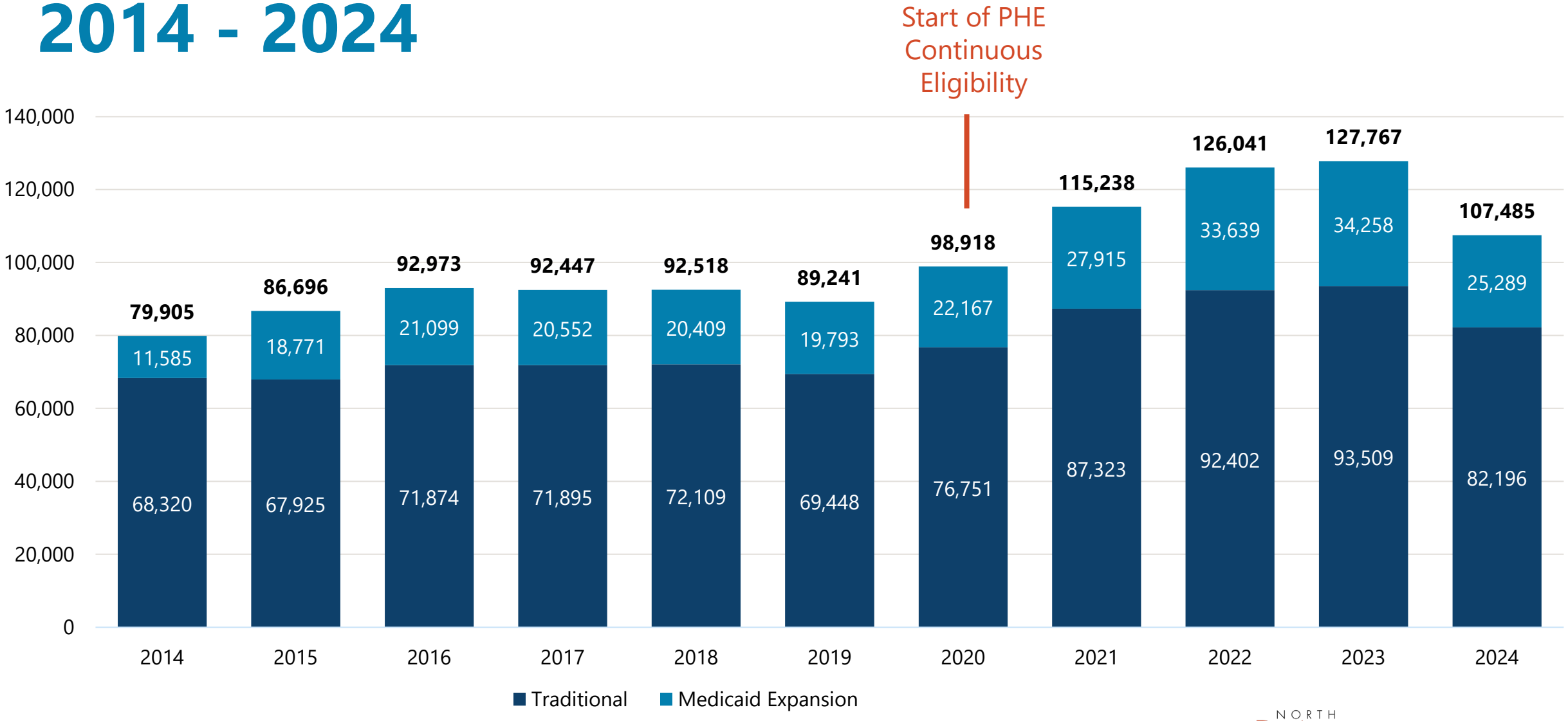
# ND Medicaid Average Monthly Enrollment 2014 - 2024

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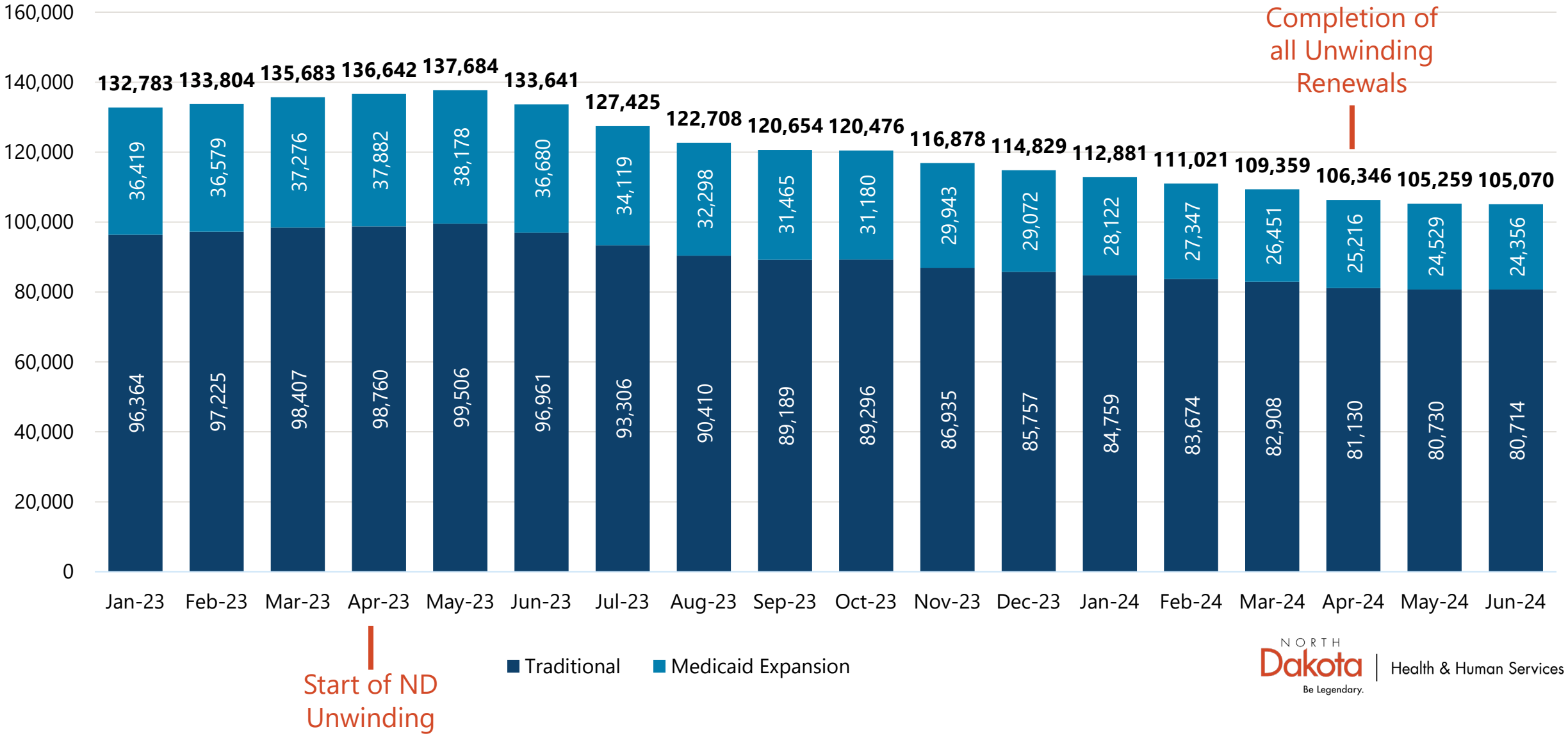
# Monthly Enrollment
# January 2023 – June 2024

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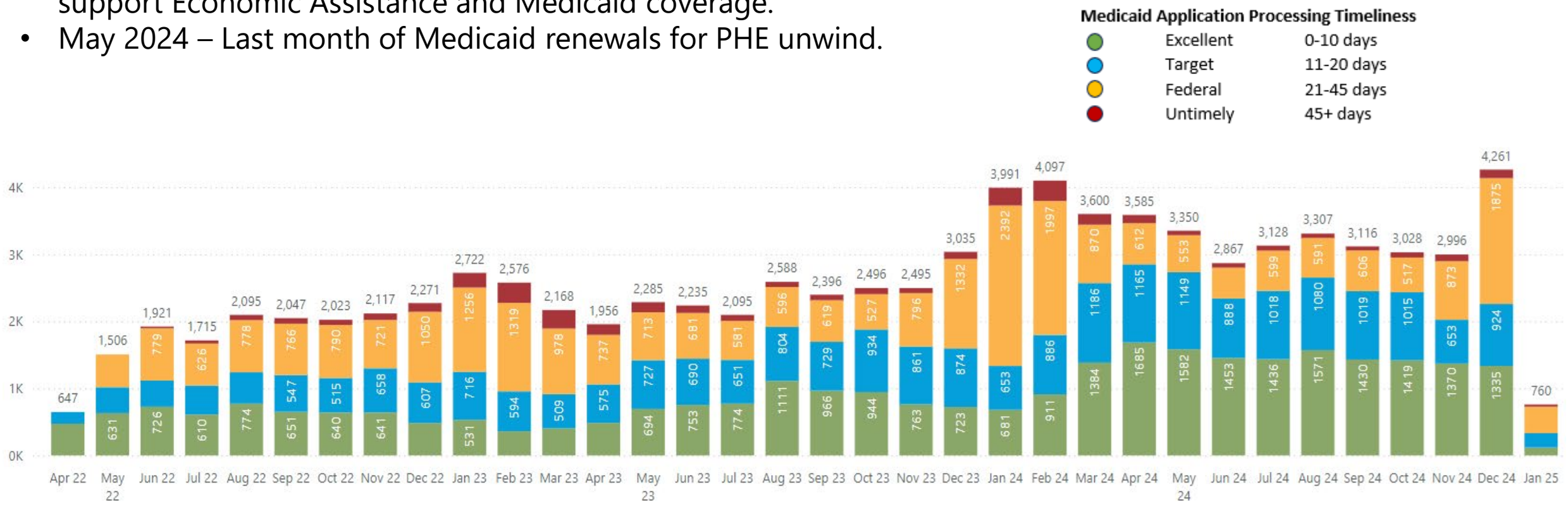
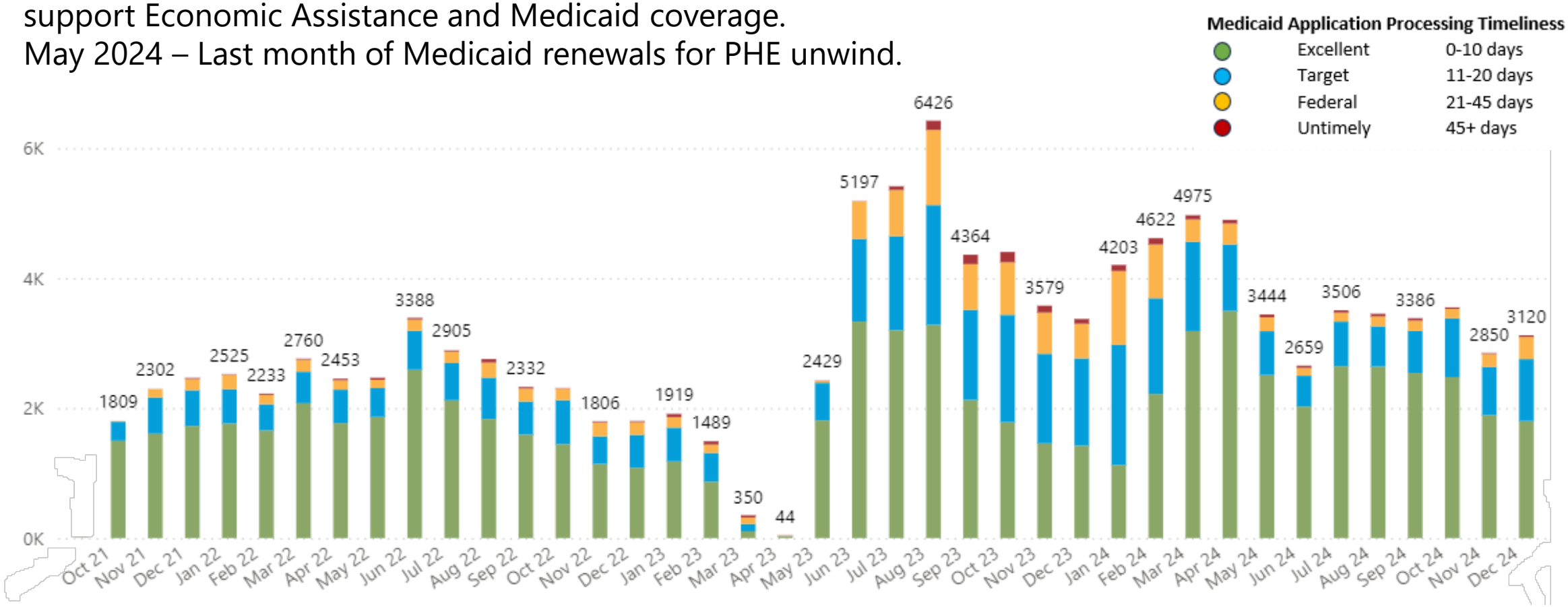
# Medicaid Application Processing

- February 2023 – HHS and HSZ's worked together to develop a regional service delivery model to support Economic Assistance and Medicaid coverage.
- May 2023 – First month participants were required to complete a Medicaid renewal, after the temporary Medicaid coverage extension due to the PHE.
- October 2023 – HHS and HSZ's moved from a regional to a statewide service delivery model to support Economic Assistance and Medicaid coverage.
- May 2024 – Last month of Medicaid renewals for PHE unwind.

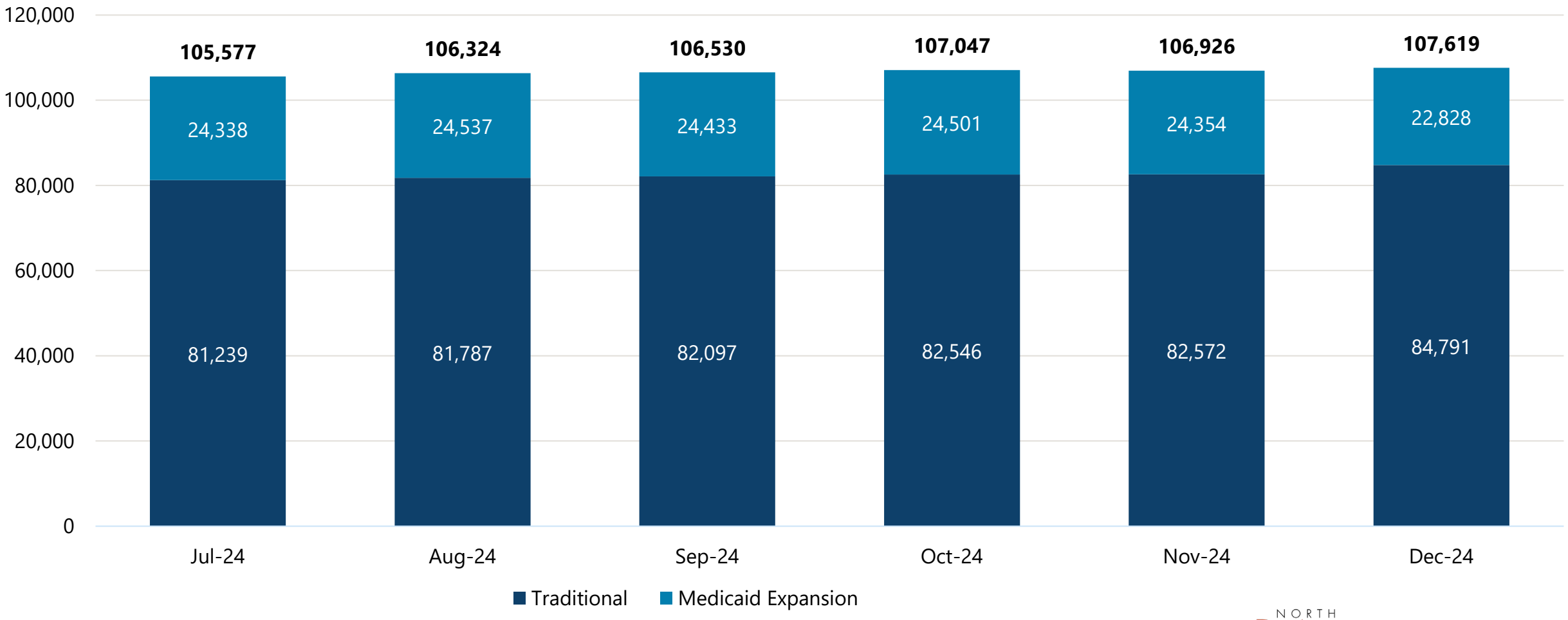


# Medicaid Review Processing

- February 2023 – HHS and HSZ's worked together to develop a regional service delivery model to support Economic Assistance and Medicaid coverage.
- May 2023 – First month participants were required to complete a Medicaid renewal, after the temporary Medicaid coverage extension due to the PHE.
- October 2023 – HHS and HSZ's moved from a regional to a statewide service delivery model to support Economic Assistance and Medicaid coverage.
- May 2024 – Last month of Medicaid renewals for PHE unwind.



# Monthly Enrollment
# July 2024 – December 2024

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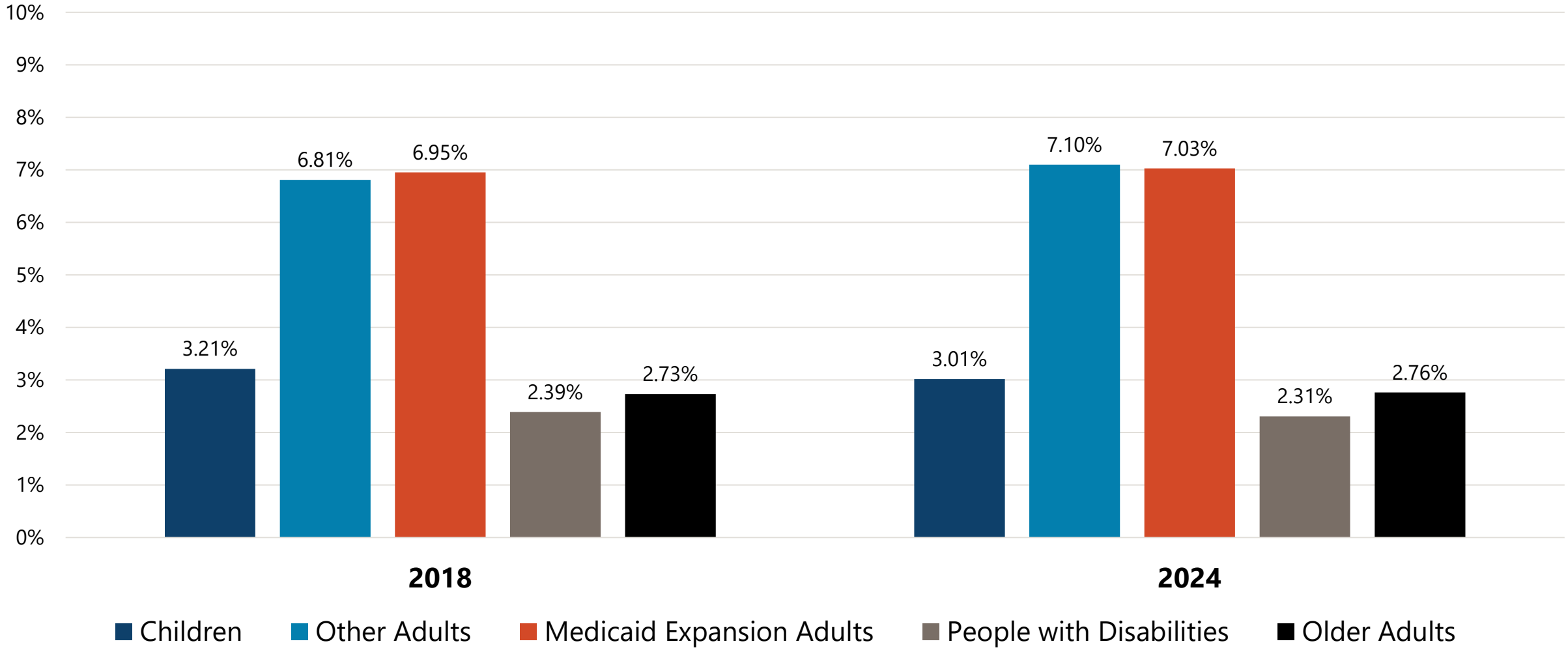
# Medicaid Churn: 2018 vs. 2024

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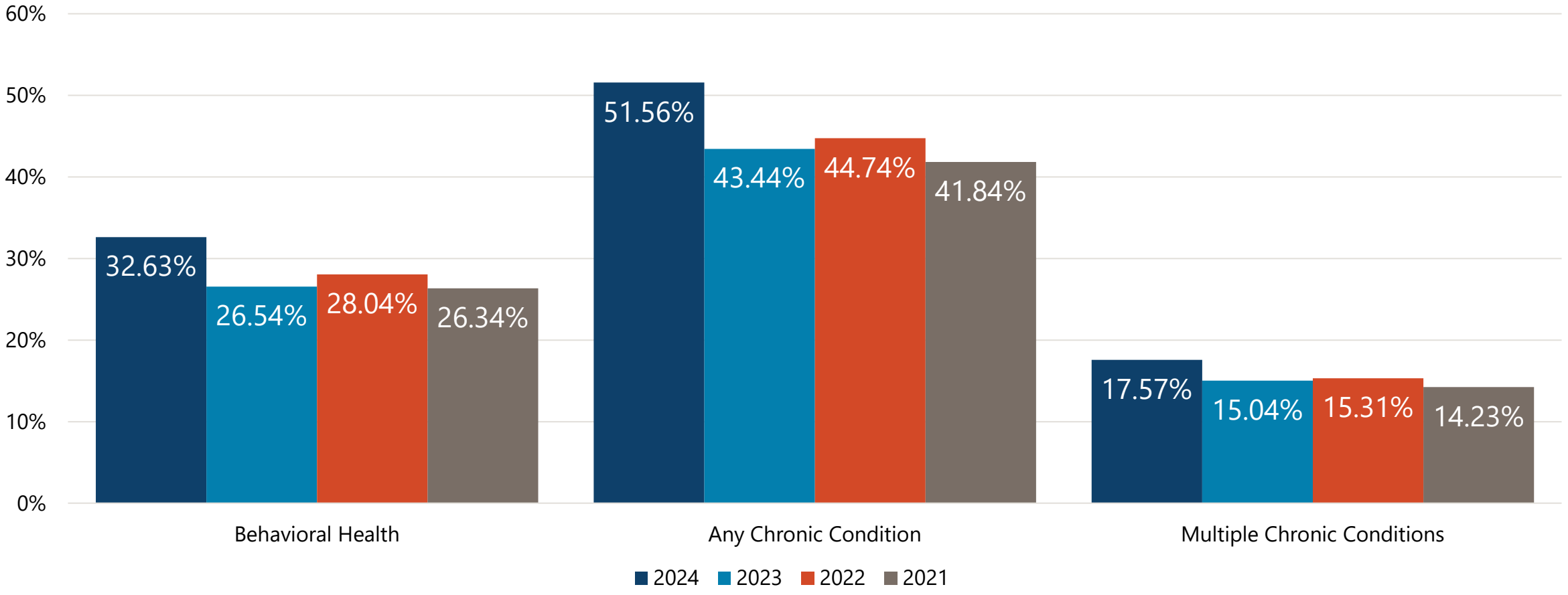
# Traditional Medicaid: Chronic Conditions
## Percent of Members with Diagnosis




Note: Chronic Conditions include Mental Health, Substance Use Disorder, Asthma, COPD, Diabetes, Heart Disease, Hypertension, Obesity, Pain Conditions

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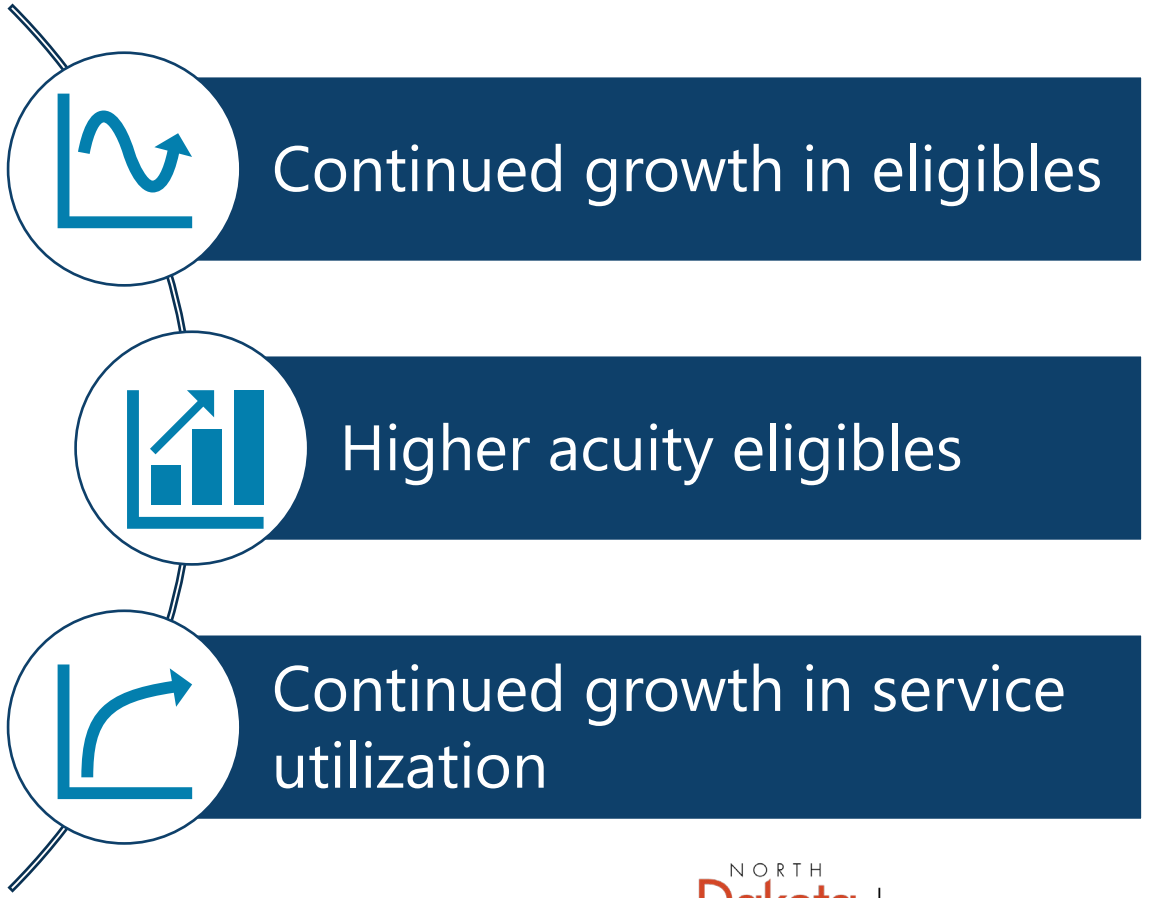
# Unwinding Impact on ND Medicaid Budget

- Lower Enrollment
- Higher Utilizers

## Eligibility Assumptions for 2025 – 2027 Biennium Base Budget

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# Medicaid & Incarceration

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# Federal Fund Restrictions for Inmates

**Federal Medicaid funds may not be used to pay for services for people while they are inmates of a public institution.**

- Incarceration does **not** make a person ineligible. People who are held involuntarily in a correctional facility may be eligible for and enrolled in Medicaid.
  - ND Medicaid suspends Medicaid eligibility while an individual is incarcerated.
- Medicaid can make medical payments for incarcerated individuals when they are inpatients in a medical institution for 24 hours or more.
- There are some limited exceptions that allow the use of federal Medicaid funds for youth and young adults who are incarcerated.

# Youth and Young Adults in Carceral Settings
## Section 5121 of the Consolidated Appropriations Act, 2023

| | Section 5121 |
|---|---|
| **Who is included?** | Medicaid members under age 21 and former foster care youth* through age 26. |
| **What Medicaid services are included?** | Limited screenings, diagnostic services and case management. |
| **When are the services covered?** | *Post-adjudication*, 30 days prior to and following release. |

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*Youth who age out of foster care at age 18 may receive Medicaid coverage through age 26.

# Youth and Young Adults in Carceral Settings

## Section 5121 of the Consolidated Appropriations Act, 2023

State Medicaid programs are required to:

1. Exchange data with all settings where the eligible population could be – state-run facilities, county jails and tribal jails.
2. Work with facilities to help people enroll in Medicaid if they are not already enrolled.
3. Work with facilities to provide access to covered services for the eligible group.

States must create an internal operational plan that shows how they will achieve compliance with estimated timeframes.

# Federal Grant

## State Grants to Support Continuity of Care for Medicaid Members Following Incarceration

- *Total Award:* $5M (all federal, no state match required. ND received maximum award)
- *Grant Period:* January 2025 to December 2028
- *Goal:* Bidirectional data exchange with all DOCR facilities and county/tribal jails by the end of 2028

**Related Bill:**
House Bill 1549 | Relating to [...] criminal justice data collection

# Next Steps

Focus on IT and automation

Create more tools, guidance and resources for correctional facilities

Partner across HHS – Medical Services, Economic Assistance, Zones and Human Service Centers – to ensure that correctional facilities are well-equipped to help people apply for and renew their Medicaid and become connected to services and support upon release.

# Medicaid Financing

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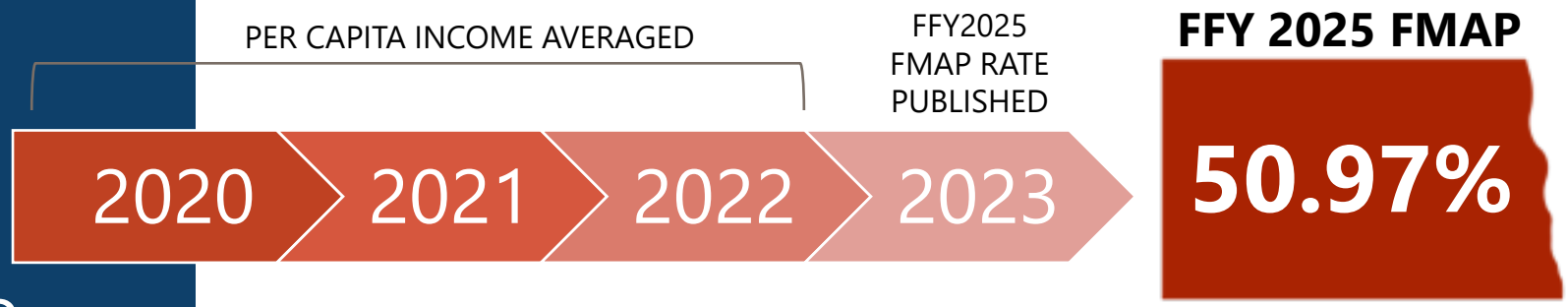
# What is the FMAP?

The federal government's share of a state's Medicaid expenditures is called the Federal Medical Assistance Percentage (FMAP).

States must contribute the remaining portion to qualify for federal funding.

The FMAP changes each federal fiscal year (October 1 – September 30) and is based on a funding formula related to a state's per capita income relative to the national average over a 3 year period.

$$FMAP = 1 - 0.45 \times \left(\frac{State\ Per\ Capita\ Income^2}{US\ Per\ Capita\ Income^2}\right)$$

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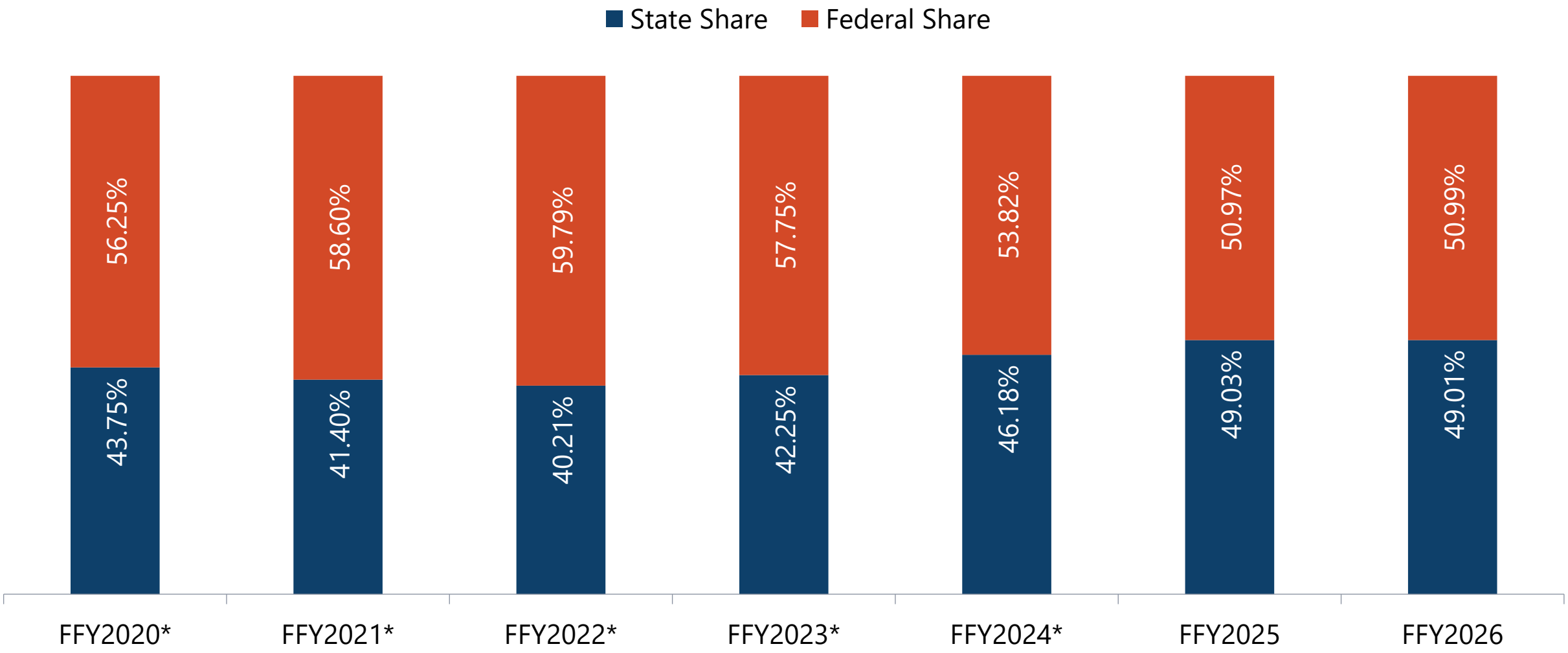
# FMAP




*The FMAP for FFY 2020 – 2023 includes a 6.2% increase due to the CARES Act during the Public Health Emergency. The FMAP was stepped down during the Unwinding period in FFY2023 and FFY2024

# FMAP

Most services are funded with the state's regular FMAP. Certain services, populations, systems and administrative functions are funded with a different percentage:

- Children's Health Insurance Program (CHIP) Members
- Medicaid Expansion Members
- Services Received through Indian Health Service or a Tribal 638 Provider
- Administration
- Professional Medical Staff
- Certified Systems

# Medicaid as a Funding Source

Medicaid federal regulation authorizes federal funding for administrative activities "as found necessary by the Secretary for the proper and efficient administration of the state plan."

## Medicaid Administrative Claiming Examples:

- NDQuits
- School Based Administrative Claiming
- Nurse Aide Registry
- Waiver Case Management Staff

# Tribal Care Coordination

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# Tribal Care Coordination FMAP Background

In 2016, the Centers for Medicare and Medicaid Services (CMS) released State Health Official (SHO) letter #16-002 updating policy related to federal funding available for Medicaid eligible American Indians/Alaska Natives (AI/AN) for services "received through" an Indian Health Service (IHS) or Tribal facility, allowing care delivered under a care coordination agreement to qualify for 100% federal funding.

- Tribal Care Coordination legislation was passed in North Dakota in 2019 and amended in 2021.
- Section 50-24.1-40 of North Dakota Century Code requires 80% of savings generated by care coordination agreements to be directed to the Tribal Care Coordination Fund; the remaining 20% returns to the state general fund.

# Tribal Care Coordination Savings Example


51% Federal 49% State

Under a **<u>care coordination agreement</u>** between the referring tribal health care organization and the non-tribal health care provider, traditional Medicaid FMAP is converted to 100% Federal Funding.


100% Federal

$49 is generated in savings due to conversion to 100% federal funding.


$49 Total State Savings

Savings is distributed under a **<u>tribal health care coordination fund agreement</u>** between ND Health and Human Services (HHS) and a tribal government:

$39.20 (80%) is allocated to the Tribal Care Coordination Fund.

$9.80 (20%) returns to the State General Fund.

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# Direct Service & Self-Governance

| Direct Service | Self-Governance |
| --- | --- |
| Tribes that either in whole or in part, receive primary health care directly from the Indian Health Service (IHS). | Tribes that negotiate with IHS and assume funding and control over programs, services, functions or activities or portions thereof, that IHS would otherwise provide. |
| Tribal care coordination agreements between Great Plains Indian Health Service and non-tribal healthcare providers. Tribes must authorize Great Plains IHS to enter into care coordination agreements on their behalf by either adding language to the fund agreement or by separate tribal resolution. | Tribal care coordination agreements are between the tribe and non-tribal healthcare providers. |
| • Turtle Mountain Band of Chippewa Indians<br>• Sisseton-Wahpeton Oyate<br>• Standing Rock Sioux Tribe | • Spirit Lake Nation<br>• Mandan, Hidatsa and Arikara Nation (Three Affiliated Tribes) |

# Care Coordination & Tribal Health Care Coordination Fund Agreements

## Care Coordination Agreements

Agreement between non-tribal provider and referring Tribal health care organization. Allows the state to convert regular FMAP into 100% federal funding and generate savings.

- Sanford and Great Plains Indian Health Service (2018)
- St. Alexius and Great Plains Indian Health Service (2018)
- Sanford and Mandan, Hidatsa and Arikara Nation (2021)

## Tribal Health Care Coordination Agreement

Agreement between Tribe and ND HHS distributing 80% of savings into the Tribal Health Care Coordination Fund. Specifies the purposes that the funds can be used for, the requirement for annual reports and audit reports.

- Turtle Mountain Band of Chippewa Indians and ND HHS (2022)
- Mandan, Hidatsa and Arikara Nation and ND HHS (2024)
- Standing Rock Sioux Tribe and ND HHS (2024)

# Tribal Health Care Coordination Fund

- The first distributions will be for claims from October 2022 through September 2024.
- Reports from tribes will be due every year by August 30 starting in 2025.
- Audits will be due every two years beginning in 2026.

**Related Bills:**
House Bill 1252 | Relating to Tribal Health Care Coordination Fund
House Bill 1461 | Relating to Tribal Health Care Coordination Fund

Tribes can use funding from the Tribal Health Care Coordination Fund for:

- Ten Essential Services of Public Health as defined by the Centers of Disease Control & Prevention
    1. Assess and monitor population health status, factors that influence health, and community needs and assets
    2. Investigate, diagnose, and address health problems and hazards affecting the population
    3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
    4. Strengthen, support, and mobilize communities and partnerships to improve health
    5. Create, champion, and implement policies, plans, and laws that impact health
    6. Utilize legal and regulatory actions designed to improve and protect the public's health
    7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
    8. Build and support a diverse and skilled public health workforce
    9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
    10. Build and maintain a strong organizational infrastructure for public health
- Development or enhancement of Community Health Representative (CHR) programs or services.

Note: No more than 50% of funds may be used for capital construction through June 30, 2025. Beginning July 1, 2025, no more than 35% of funds may be used for capital construction.

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# Tribal Health Care Coordination Fund Claims through September 30, 2024

| Tribal Nation | Mandan, Hidatsa and Arikara Nation | Turtle Mountain Band of Chippewa Indians | Standing Rock Sioux Tribe | Total |
|---|---|---|---|---|
| State Savings Generated through 9/30/2024 | $176,731.09 | $45,900.29 | $378,503.28 | $601,134.66 |
| Tribal Health Care Fund (80%) | $141,384.87 | $36,720.23 | $302,802.62 | $480,907.72 |
| State General Fund (20%) | $35,346.22 | $9,180.06 | $75,700.66 | $120,226.94 |

Notes:

1. Claiming for state savings is restricted to the time frame that the Centers for Medicare and Medicaid Services (CMS) allows for the financial reporting to be adjusted on the CMS-64 Report.
2. ND Medicaid is working with providers to analyze provider records of care coordination claims compared to those in the ND Medicaid data set.

# Costs & Outcomes

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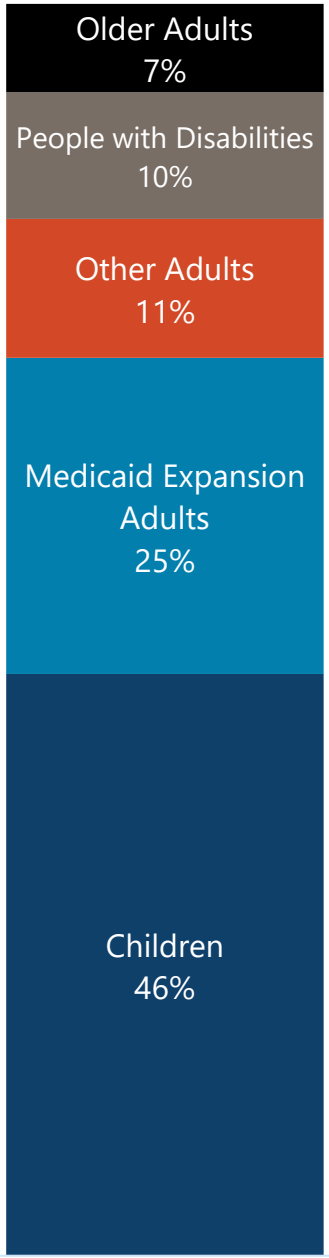
# How do we measure results in Medicaid?

Expenditures & Outcomes

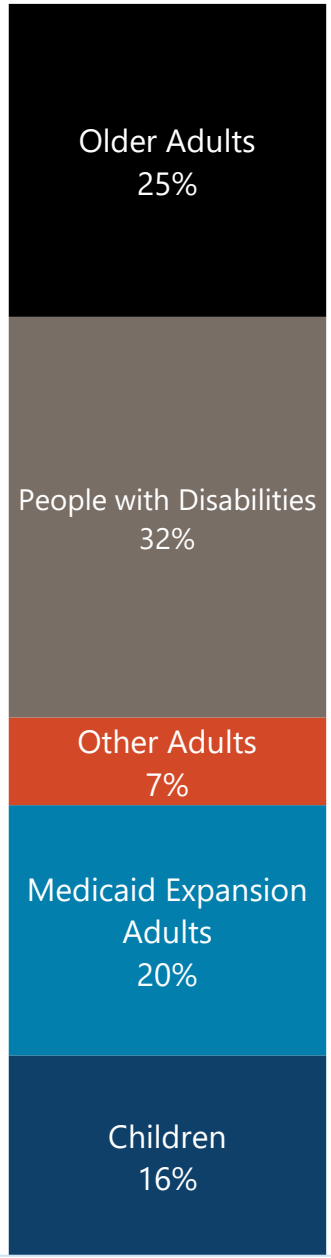
The Center for Medicare and Medicaid Services (CMS) collects and publishes data related to both expenditures and outcomes on the Medicaid & CHIP Scorecard.

- Expenditure data comes from TMSIS and CMS-64 Reports.
  - Expenditures in Medicaid are influenced by both rates and utilization.
- Outcome measures include nationally standardized metrics outlined in the Core Set and other reports.
- Data lags current performance.
  - Most recent data available is for CY 2022 and Core Set Year 2023 (Services in CY 2022).

# North Dakota Medicaid Enrollment and Expenditures SFY 2024

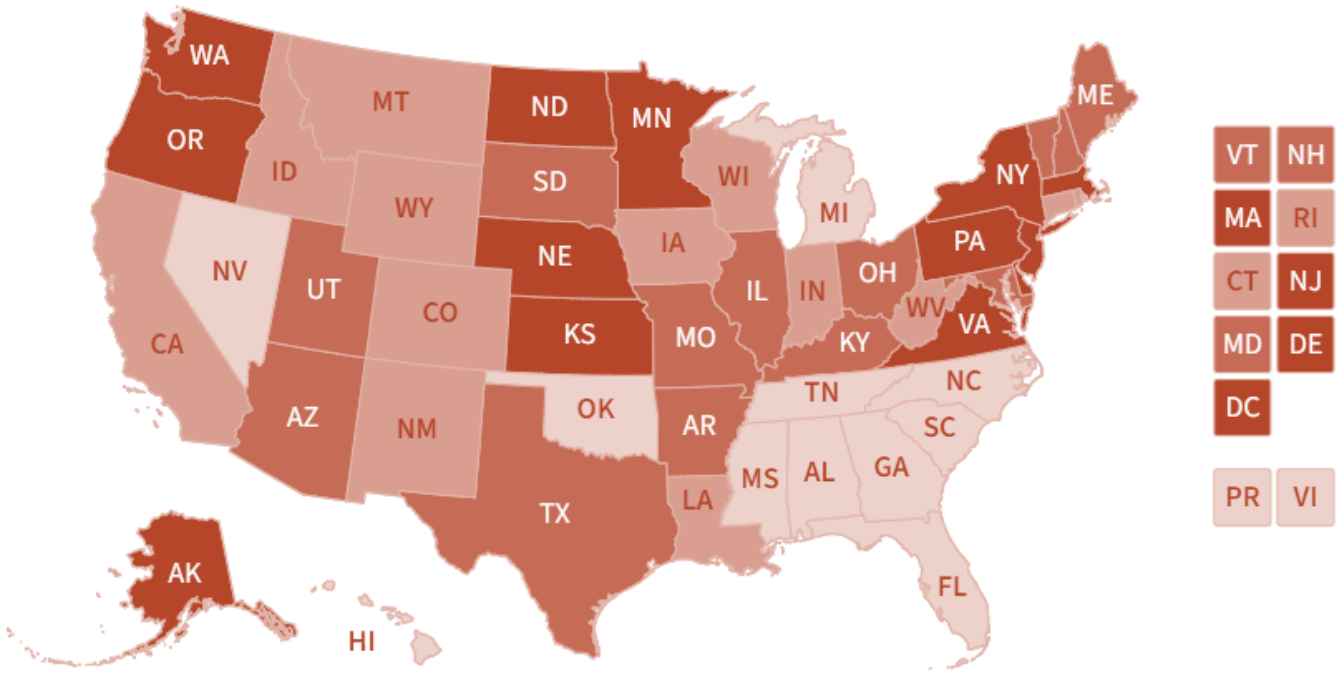



Enrollment




Expenditures

# Per Capita Expenditures: CY 2022




- North Dakota ranked **2nd** in the nation for highest total per capita expenditures.
  - North Dakota ranked **1st for Medicaid Expansion per capita** expenditures
  - ND Medicaid ranked **1st for Aged per capita** expenditures.
  - ND Medicaid ranked 7th for People with Disabilities expenditures.

| | Total | Children | Traditional Adults | Medicaid Expansion | Aged | People with Disabilities |
|---|---|---|---|---|---|---|
| **North Dakota** | **$13,097** | **$4,003** | **$6,207** | **$14,120** | **$36,020** | **$35,311** |
| National Median | $9,108 | $3,822 | $6,207 | $7,818 | $19,079 | $25,639 |
| Difference | $3,989 | $181 | $0 | $6,302 | $16,941 | $9,672 |

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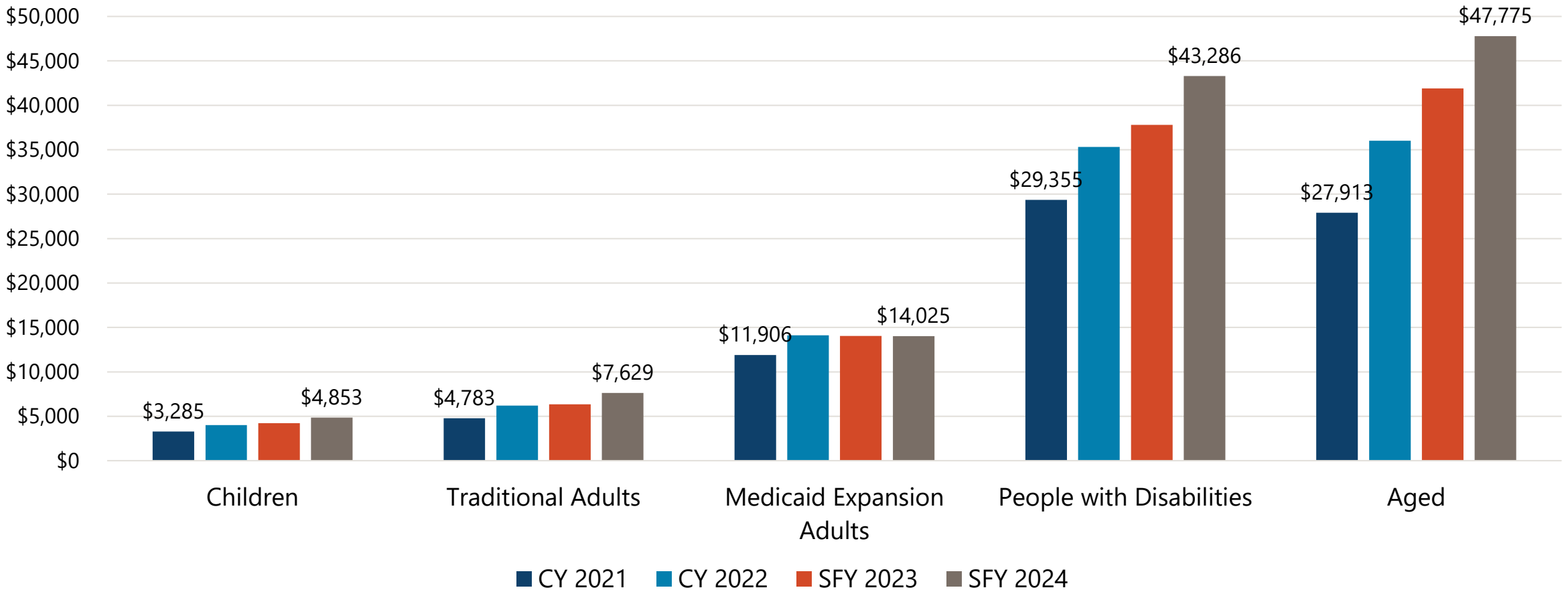
Medicaid and CHIP Scorecard - Medicaid Per Capita Expenditures

# Per Capita Expenditures




Note: CY 2021 and CY 2022 Data obtained from Medicaid and CHIP Scorecard - Medicaid Per Capita Expenditures. SFY 2023 and SFY 2024 numbers calculated from ND TMSIS data.

# Top 25 High Cost Claims vs. Top 25 High Cost People

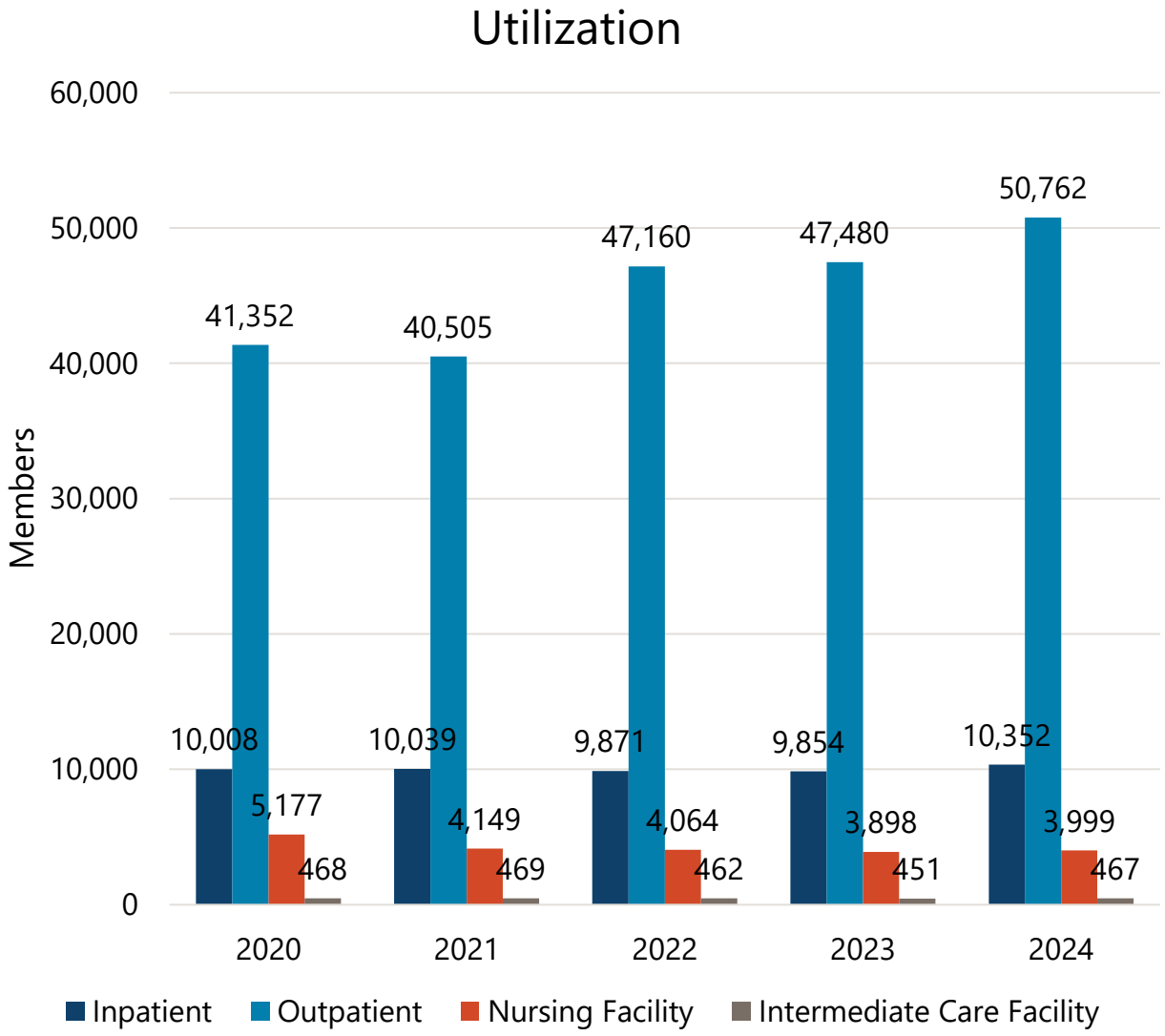
## Top 25 Claims

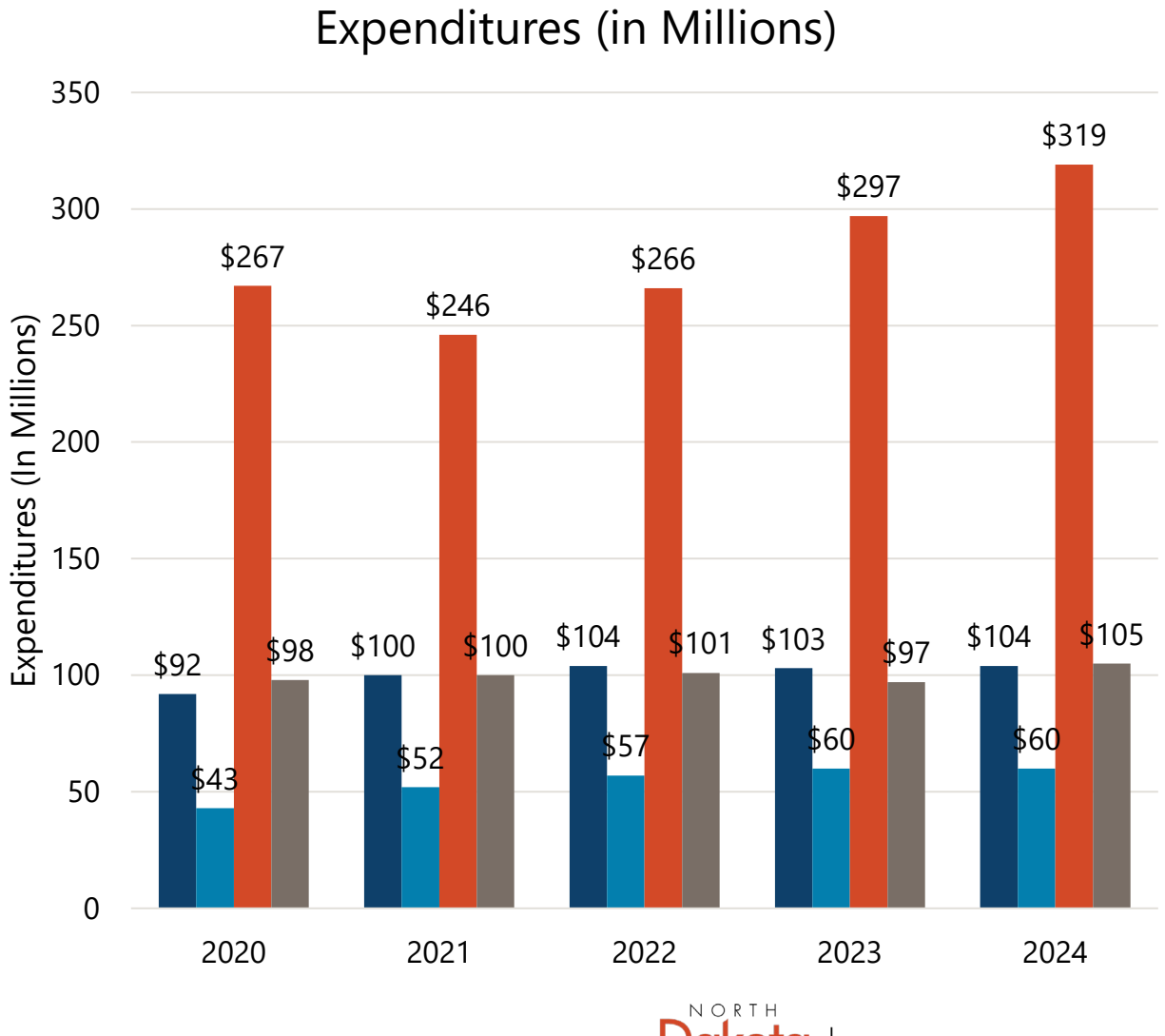
- Average Amount: $309,949
- 64% were for infants
- 60% related to cardiovascular disorders or disease
- Other diseases included: Cancer, End Stage Renal Disease (ERSD), and other rare conditions

## Top 25 People

- Average Amount: $801,645
- 8% were for infants
- 24% related to cardiovascular disorders or disease
- 40% related to traumatic brain injury or other developmental or intellectual disabilities
- Other diseases included respiratory disorders, cancer, and kidney disease.

# Utilization and Expenditures

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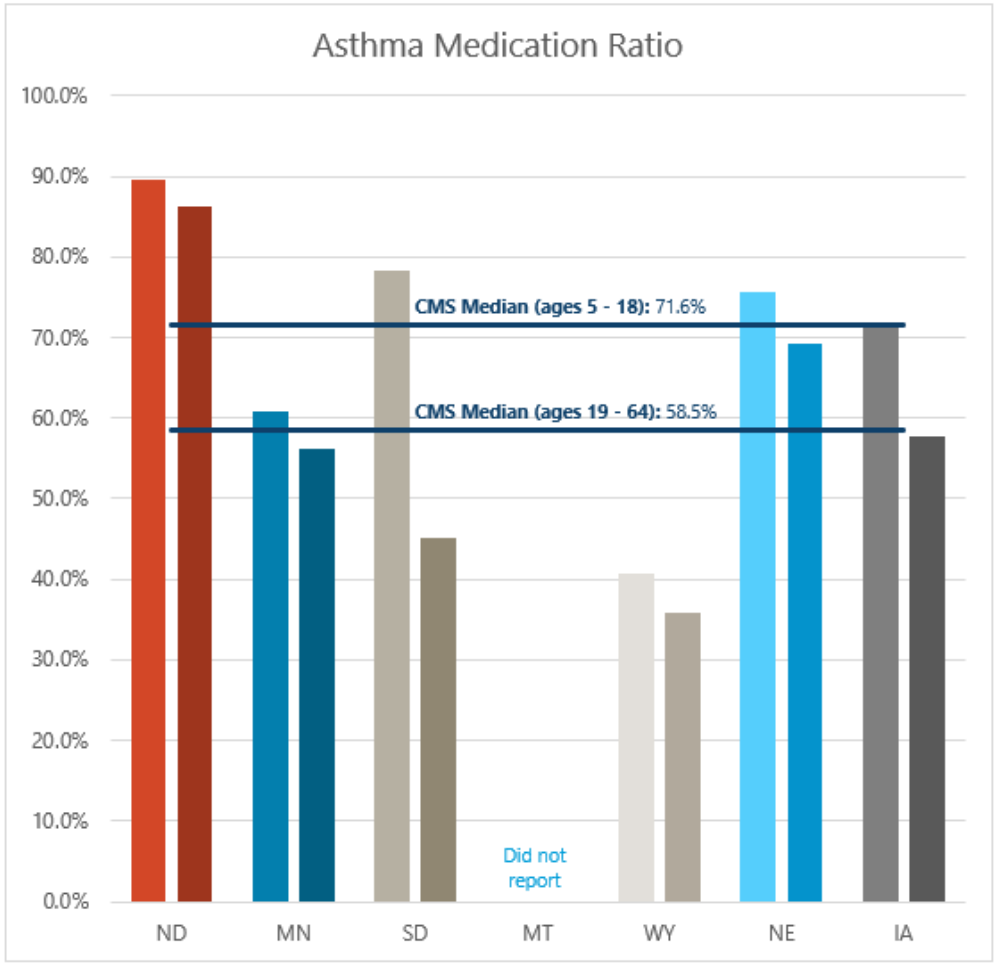
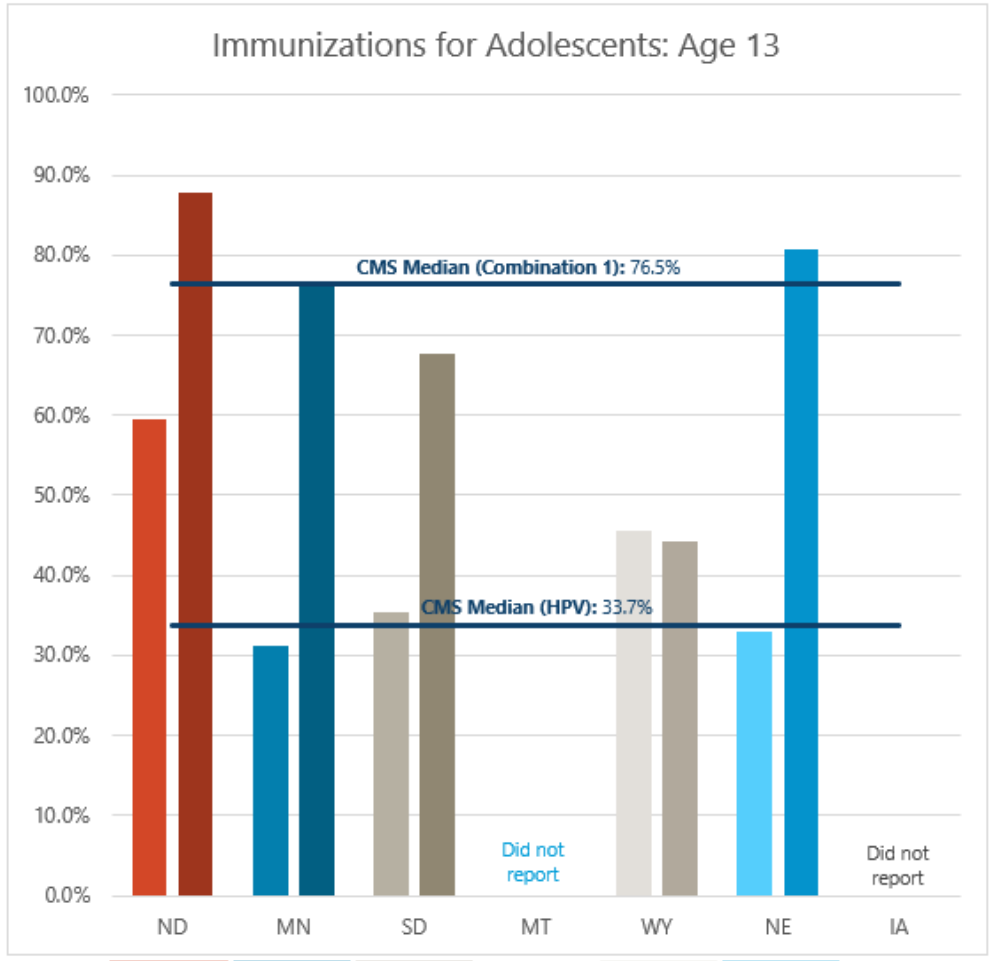
# Outcomes: Medicaid and CHIP Scorecard

- ND Medicaid reported 100 metrics across the Child and Adult Core Set for FFY 2023.
  - ND Medicaid rated above the National Median in 35 measures (35%).
    - ND is in the top quartile for 16 measures.
  - ND Medicaid rated below the National Median in 57 measures (57%).
    - ND is in the bottom quartile for 34 measures.
  - Due to small denominator sizes, 8 measures have their data suppressed

# Top Quartile Outcomes: FFY 2023




| | ND | MN | SD | MT | WY | NE | IA |
|---|---|---|---|---|---|---|---|
| Ages 5 - 18 | 89.5% | 60.8% | 78.2% | | 40.8% | 75.6% | 71.9% |
| Ages 19 - 64 | 86.3% | 56.1% | 45.2% | | 35.8% | 69.3% | 57.7% |




| | ND | MN | SD | MT | WY | NE | IA |
|---|---|---|---|---|---|---|---|
| HPV | 59.5% | 31.1% | 35.4% | | 45.5% | 33.0% | |
| Combination 1 | 87.9% | 76.5% | 67.6% | | 44.3% | 80.7% | |

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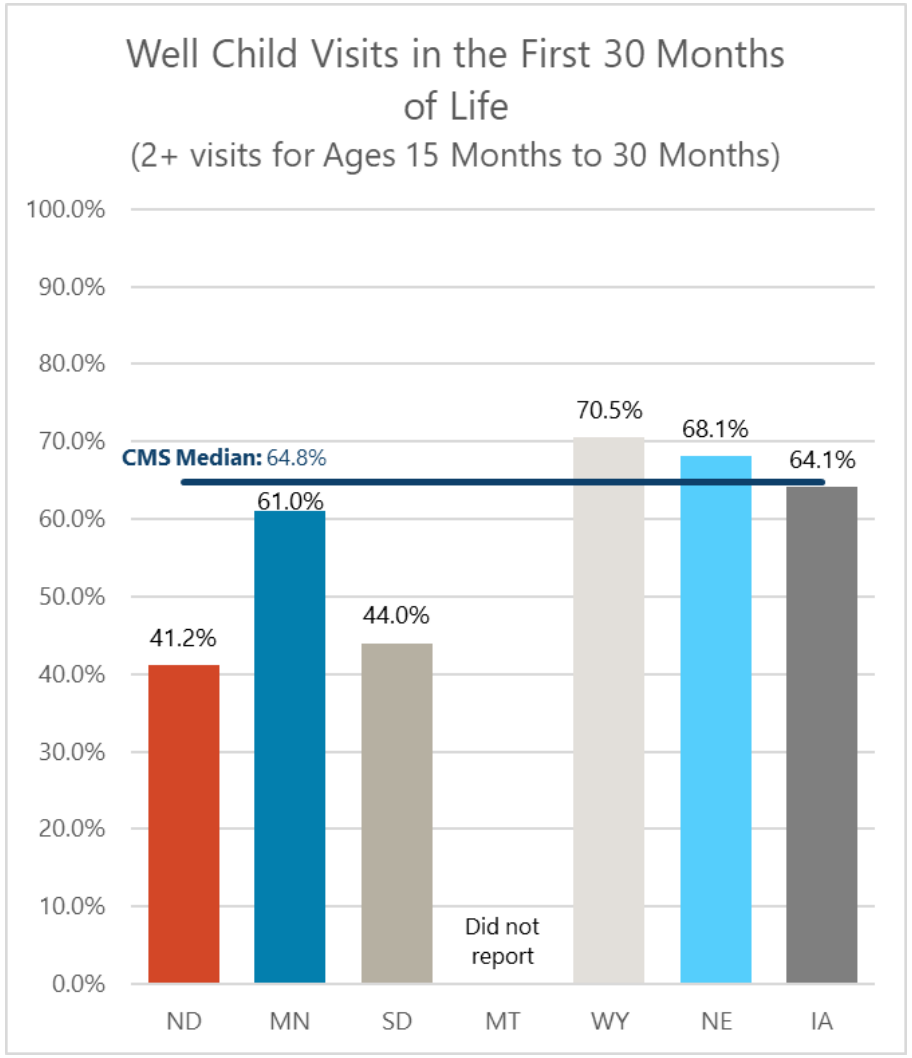
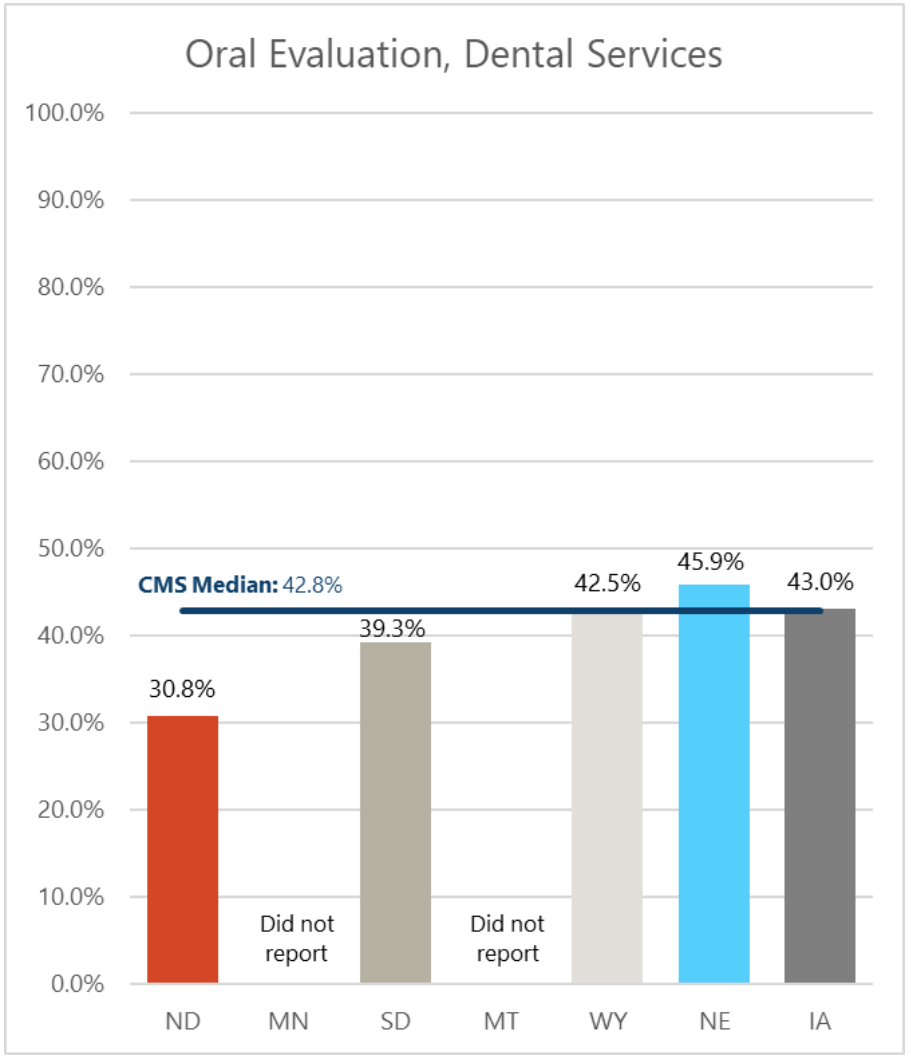
# Bottom Quartile Outcomes: FFY 2023

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# Value Based Programs

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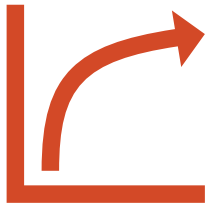
# Why Value Based Care?

Accountability for Enhanced Care Delivery

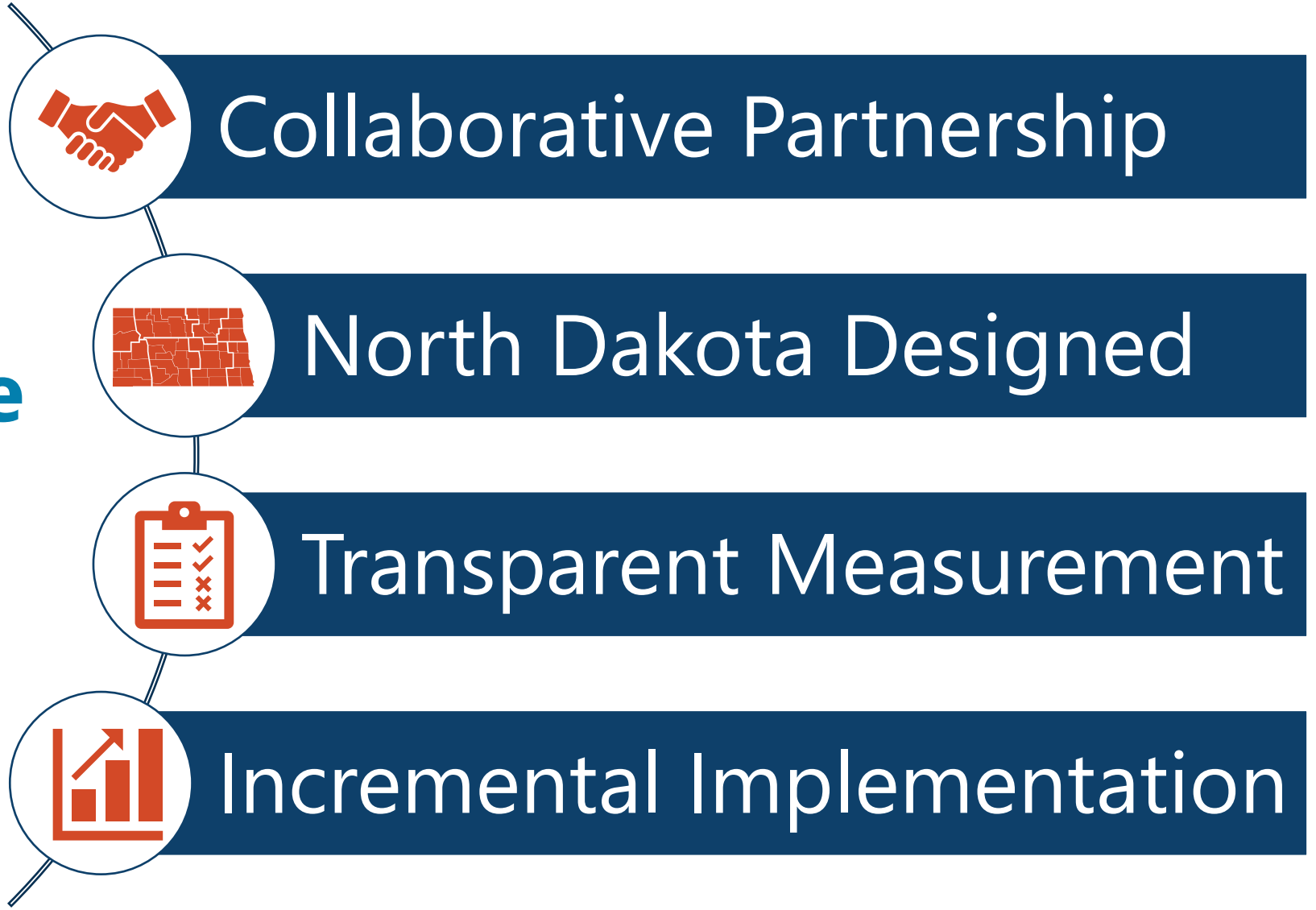
Improved Patient Experiences & Outcomes

Stable & Predictable Funding for Providers



Lower Long Term Costs Achieved by Shifting the Cost Curve

# North Dakota Medicaid Value Based Care Approach

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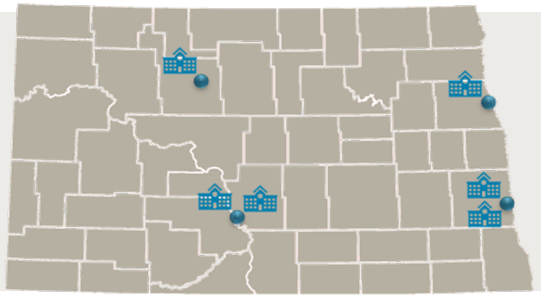
# Health System Value-Based Purchasing

**Program Start Date:** July 1st, 2023

6 Prospective Payment System (PPS) Health Systems are mandatory participants in the model

The PPS Hospital System VBP Program puts a portion of hospital payments at risk for performance on a suite of quality measures for their ND Medicaid patient population. PPS Hospital Systems will see no loss of funding if they meet specific success criteria.



## 2024
### Pay for Reporting

1. Submit Quality Improvement Plans through VBP Reporting Tool
2. VBP Quality Improvement Outcomes Meeting
3. Supplemental Data Submission

## 2025

**Pay for Reporting**

+

**Pay for Performance**
(Initial Measure Set)

## 2026
### Pay for Performance

| Initial Measure Set |
|---|
| Well-Child Visits First 15 Months of Life |
| Child & Adolescent Well-Care Visit |
| Breast Cancer Screening |
| Postpartum Care: Prenatal & Postpartum Care |
| Screening for Depression & Documented Follow-up Plan |
| Ambulatory Care Emergency Department (ED) Visits |
| Plan All-Cause Readmissions |
| Topical Fluoride for Children |

| Expanded Measure Set |
|---|
| Colorectal Cancer Screening |
| Controlling High Blood Pressure |
| Maternal Health Services Optional Measures: (systems must select 1)<br>1. Prenatal Care: Prenatal Care & Postpartum Care<br>2. Contraceptive Care: Postpartum Women<br>3. Structural Measure: Perinatal Collaborative Participation |
| Behavioral Health Services Optional Measures: (systems must select 1)<br>1. Follow-up After Emergency Department Visit for Alcohol & Other Drugs Abuse or Dependence<br>2. Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment |

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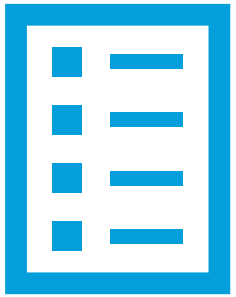
# 2024 Pay for Reporting Components



**Quality Improvement Plan Submission**

February 2024

All 6 PPS Hospital Systems submitted QIPs by the last day in February.

**VBP Quality Improvement Outcomes Meeting**

Oct - Nov 2024

6 out of 6 PPS Hospital Systems have completed their Outcomes Meetings .

**Supplemental Data Submission**

January 2025

6 out of 6 PPS Hospital Systems submitted supplemental data.

If the system satisfies the pay-for-reporting requirements, the system retains 100% of the at-risk funding.

If the system does not satisfy all of the reporting requirements, the system must pay the State 100% of the at-risk funds

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# Health System Value-Based Purchasing Outcomes

| | | State Goal | System A | System B | System C | System D | System E | System F | Combined System Rate |
|---|---|---|---|---|---|---|---|---|---|
| * | Ambulatory Care: Emergency Department Utilization (AMB-CH) | 31.90 | 27.95 | 28.82 | 39.49 | 40.90 | 36.77 | 31.27 | 32.80 |
| | Breast Cancer Screening (BCS-AD) | 52.20% | 24.64% | 23.60% | 33.22% | 25.78% | 45.61% | 24.41% | 29.00% |
| | Child & Adolescent Well-Care Visits (WCV-CH) | 48.07% | 31.33% | 31.25% | 26.50% | 23.92% | 35.39% | 31.81% | 30.79% |
| * | Plan All-Cause Readmissions (PCR-AD) | 0.9850 | 0.7372 | 0.8939 | 0.7519 | 0.5563 | 0.4736 | 0.8055 | 0.7377 |
| | Postpartum Care: Prenatal and Postpartum Care (PPC) | 78.10% | 74.31% | 40.49% | 35.55% | 51.85% | 61.22% | 72.84% | 57.61% |
| | Screening for Depression & Documented Follow-up Plan (CDF) | 72.60% | 6.95% | 0.26% | 0.19% | 5.66% | 51.35% | 5.80% | 12.16% |
| | Topical Fluoride for Children (TFL-CH) | 19.30% | 3.61% | 4.67% | 2.79% | 2.39% | 4.90% | 4.11% | 3.86% |
| | Well-Child Visit First 15 Months (W30-CH) | 66.76% | 42.28% | 51.74% | 50.53% | 41.38% | 56.52% | 46.54% | 48.07% |
| | Well-Child Visit 15 – 30 Months of Life (W30-CH) | 58.38% | 58.33% | 66.15% | 59.57% | 40.74% | 66.67% | 55.83% | 59.20% |

**Performance Timeframe:** January 2024 – August 2024 (8-month performance snapshot)
2024 final performance will be produced in May 2025 which allows the systems 12 months to close care gaps

Meeting State Goal | Improvement from CY 2023

** Lower Performance is better*

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# Nursing Facility Incentive Program

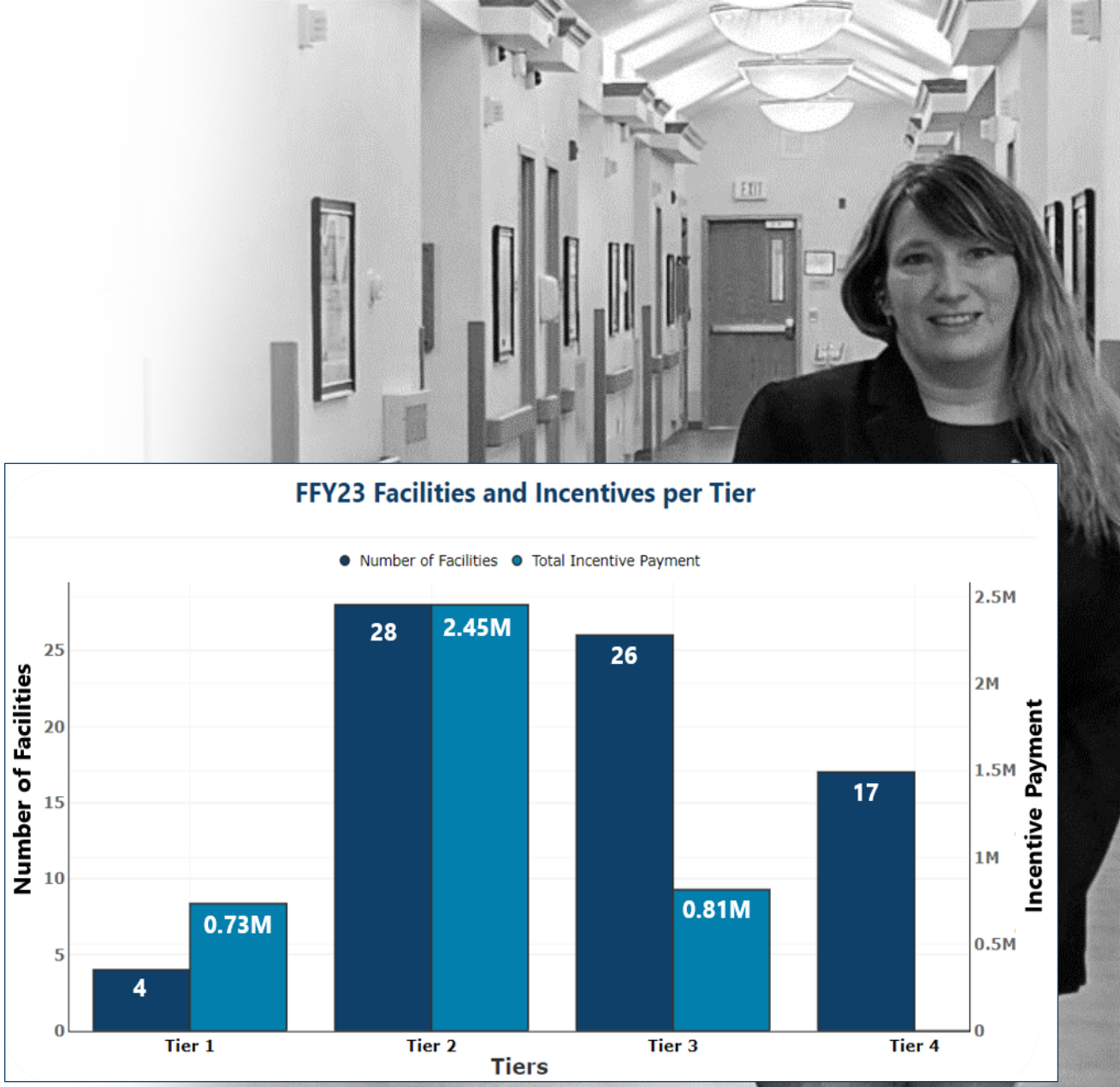
**Improve resident outcomes through an incentive payment based on specific quality measures.**

- Incentive program; no payments are at risk.
- All Medicare/Medicaid certified facilities that have been open 10 months will participate.

- Incentive fund distribution is done annually in June.
- Annual payments based on Quality Measure performance:
  - Tier 1: 100% of incentive payment
  - Tier 2: 85% of incentive payment
  - Tier 3: 60% of incentive payment
  - Tier 4: Not eligible for an incentive payment
- Nursing Facility Quality Measures:
  - Patient Care Measures
    - Long-Stay Urinary Tract Infections
    - Long-Stay Antipsychotic use
    - Long-Stay Pressure Ulcers
  - Facility Process Measures
    - Long-Stay Hospitalizations
    - ACHA/NCAL National Quality Award (Baldrige Framework)

# Initial Outcomes

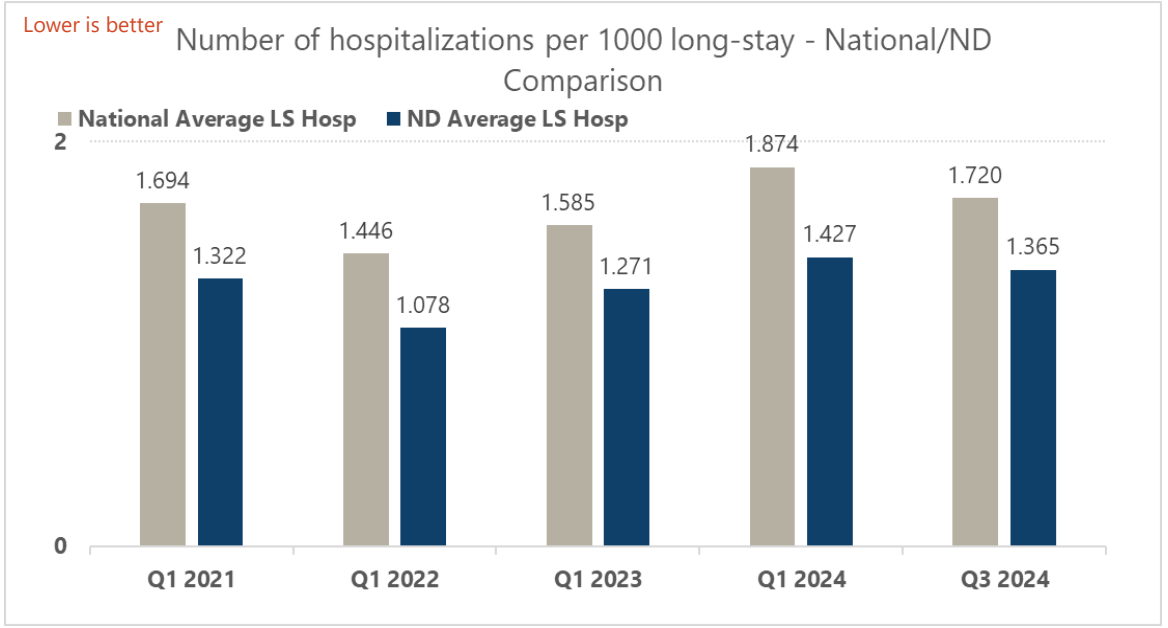
- $4 million dollars distributed in June 2024
- 58 out of 75 Nursing Facilities received incentives to improve quality of care for residents
- Examples of reported use of funds include
  - New mattresses for entire facility
  - Staff bonuses
  - Building renovation
  - Staff training




Carrie Zazeski, Administrator, Elm Crest Manor, New Salem

# Nursing Facility Incentive Program Initial Outcomes

Lower is better

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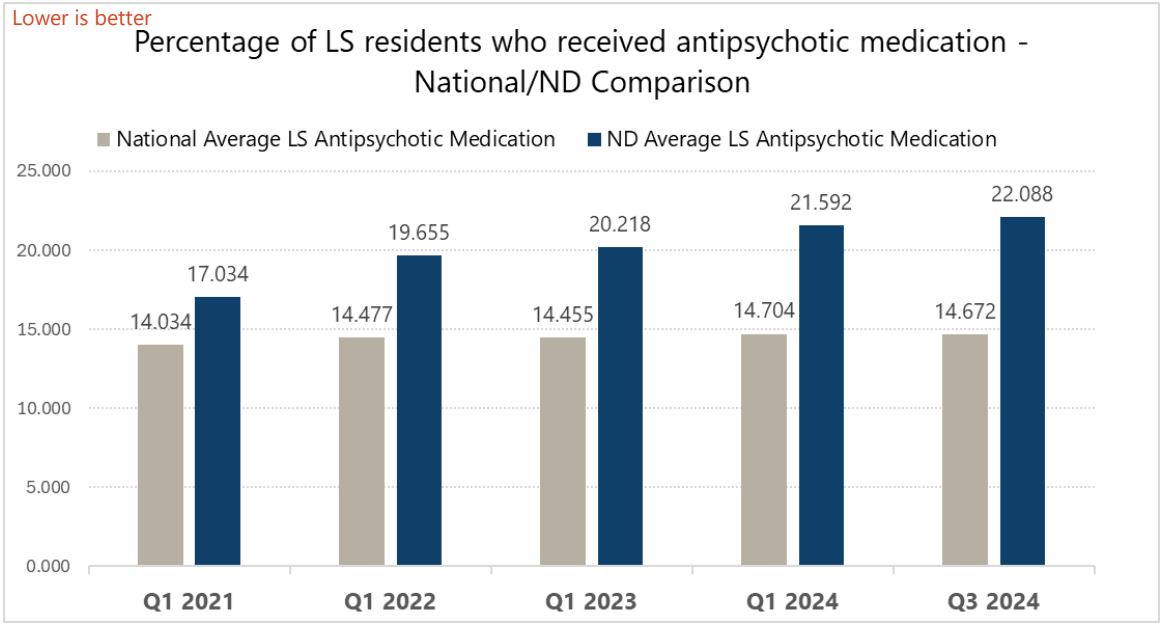


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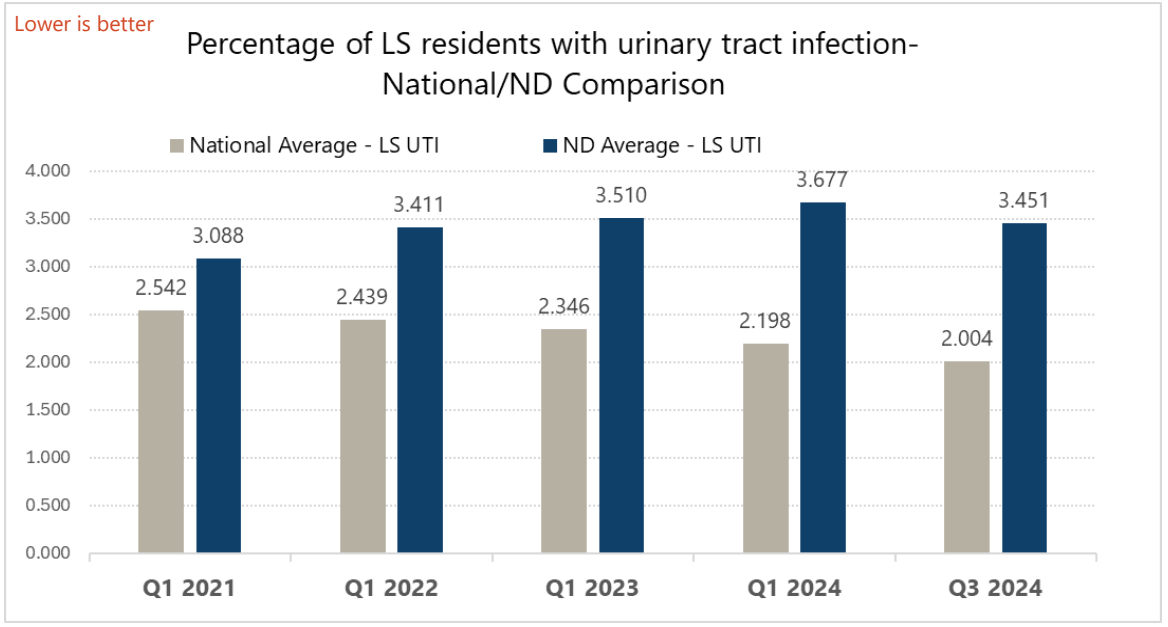


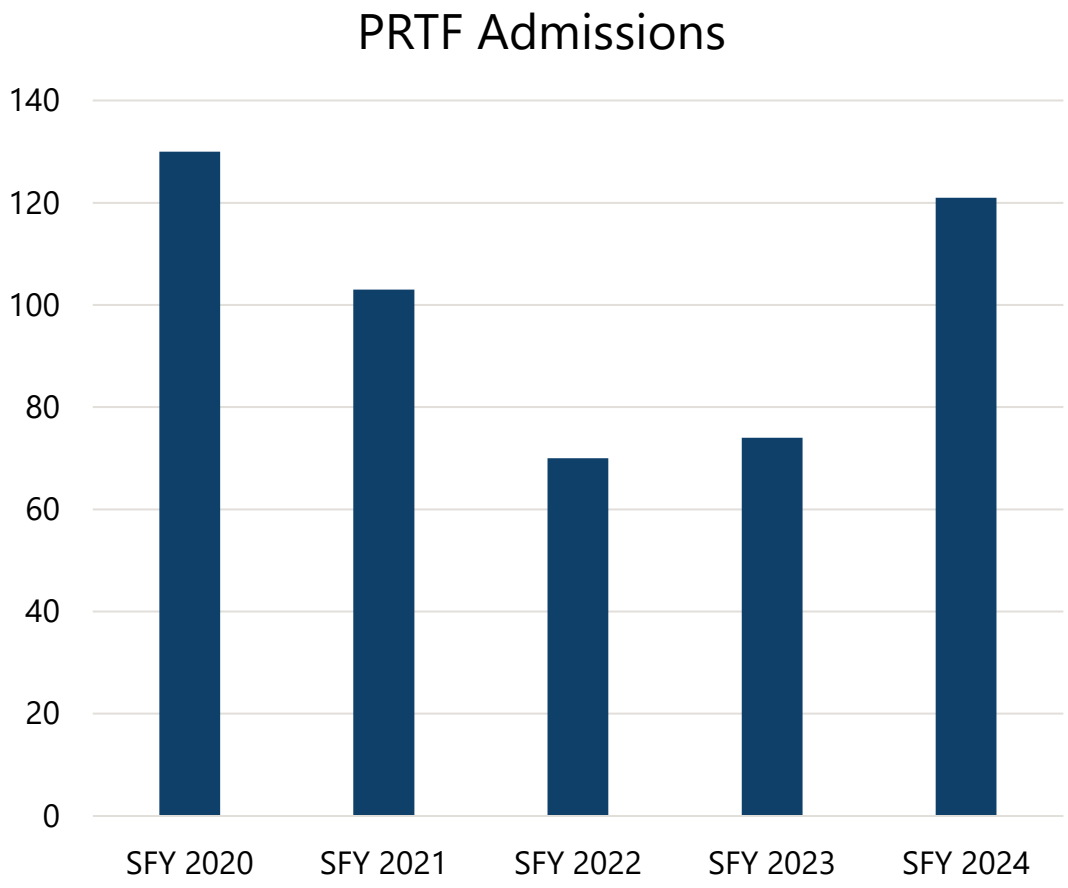
# What's next in Value Based Care?

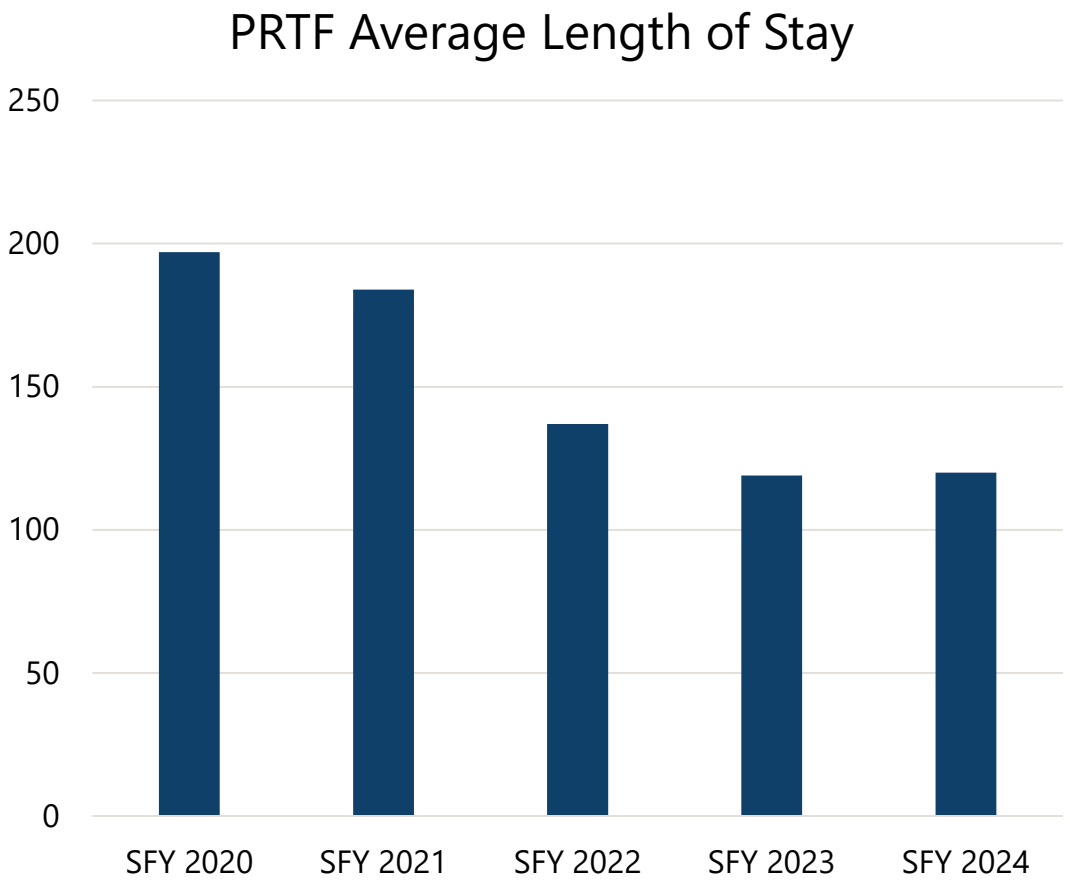
## Refinement and Expansion of Current Programs

## Exploration of New Provider Groups

- High-Cost Services
- Opportunity to Impact Care Outcomes and Improve Services
- Ability to Incentivize Innovation
- Need to Stabilize Funding

# Psychiatric Residential Treatment Facilities

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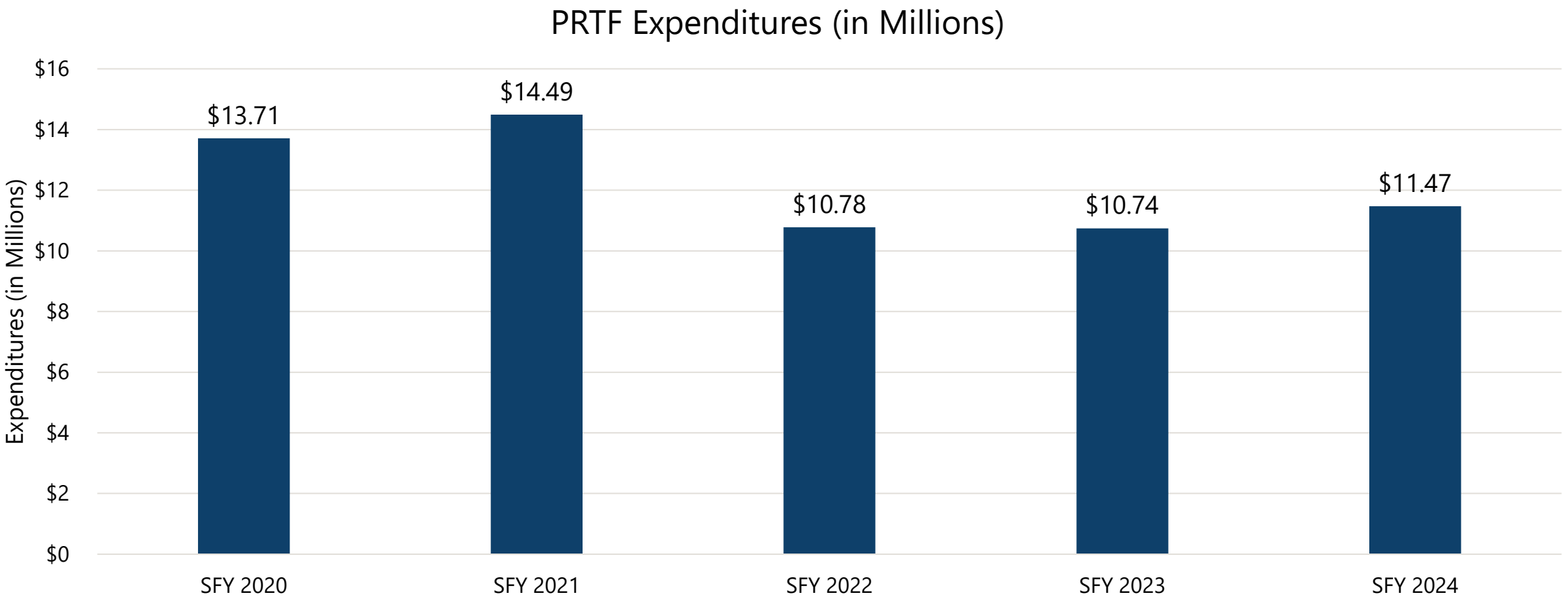
# Psychiatric Residential Treatment Facility Expenditures



# Value Based Care
## Ongoing

| Total | $2,000,000 |
|---|---|
| General | $1,000,000 |
| Federal | $1,000,000 |

Expand care focused on value to additional provider groups and continue to refine current programs to ensure populations are supported with person-centered care and support.

Included in Long Term Care Budget

**Refinement and Expansion of Current Programs**

- Continue to grow and refine current value-based programs.
- Review attributed populations and supports available to individuals with complex health care needs.
- Strengthen care coordination to ensure service delivery provides comprehensive, person-centered care focused on ensuring access and appropriate follow-up supports across multiple delivery systems.

**Exploration of New Provider Groups**

- Expand health system value-based program to rural delivery system to include critical access hospitals and associated primary care providers. Ensure rural VBP design builds on the current program to improve healthcare quality, accessibility, and sustainability in rural areas.
- Explore a value-based purchasing model with PRTFs and QRTP providers to drive towards enhanced services and outcomes for youth while ensuring stability of safety net service delivery for children with behavioral health needs in North Dakota.

**Funding will support:**

- Subject Matter Expertise
- Value Based Program Provider Workgroup Facilitator
- Service Infrastructure Development

# Rates & Reimbursement

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# How does ND Medicaid pay for services?

| **Traditional Medicaid: Fee For Service (FFS)** | **Medicaid Expansion: Managed Care Organization (MCO)** |
|---|---|
| State pays providers directly for each covered service received by a Medicaid member. | State pays a monthly fee called a capitation payment to the managed care organization (MCO). |
| Only services received by members are paid. | Monthly fee is paid to MCO regardless of member use of services. |

# Rate Methodology Guiding Principles Traditional Medicaid

- Predictable
- Consistent
- Transparent
- Data Driven
- Population Focused
- Quality & Outcomes Oriented
- Incentivizes Innovation, Efficiency & Community Based Care

# Rate Methodologies in Fee For Service Medicaid

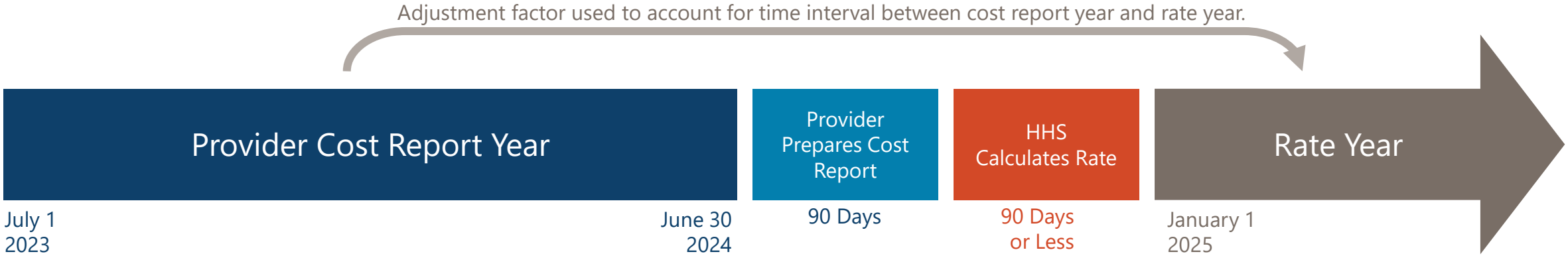
- **Cost Based Per Diem** – Uses cost reports as the basis for setting individual facility per diem payments. Per diem payments may be adjusted to account for patient acuity.
- **Classification System** – Defines an episode (ex. inpatient admission or outpatient visit) and assigns a classification based on services provided. May be used in conjunction with cost reports to assign facility specific base rates.
- **Relative Value Units** – Defines the resource intensity of a service. Used in conjunction with a conversion factor.
- **Fees –** List of reimbursements correlated to a nationally defined code set.
- **Percent of Charge –** Uses a defined percentage to reimburse based on billed charges.
- **Cost Settlement –** Compares provider costs to payments made by ND Medicaid.

# What is a cost report?

A cost report is a financial document submitted by health care providers and outline the expenses incurred in delivering patient care and include data on operating costs, salaries, supplies, and other expenditures. Cost report data is used to set provider reimbursement rates.

- Cost reports cover a defined time period and are used to detail provider costs during that timeframe.
- Costs are generally broken into a few distinct categories:
  - Direct Care
  - Indirect Care
  - Property
  - Other

# How are cost reports used to set rates?




The rate methodology for the service uses cost report data to calculate provider rates.

- An adjustment factor is used to inflate costs forward from the cost report year to the rate year.
- Some costs are not allowable (ex. lobbying) for use in calculating reimbursement rates.
- Cost categories have limits to ensure that costs are reasonable and efficient.
- Provider cost reports and underlying data may be audited to ensure that costs were appropriately reported and allocated.
- The department must prepare/calculate rates for multiple providers within the same 90 day timeframe.

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# Upper Payment Limit

- Medicaid payments are required to be "consistent with efficiency, economy, and quality of care."
- CMS requires states to demonstrate compliance that payments for certain providers do not exceed an upper payment limit (UPL).
- The UPL is a reasonable estimate of the amount that would have been paid for the same service under Medicare payment principles.

**Required Upper Payment Limit Demonstrations in North Dakota:**

- Inpatient Hospital Services
- Outpatient Hospital Services
- Nursing Facility Services
- Institutions for Mental Disease (IMD)
- Clinic Services
- Intermediate Care Facility for the Individuals with Intellectual Disabilities (ICF/IID)
- Psychiatric Residential Treatment Facility (PRTF)

**Federal Financial Participation Limit:**

- Durable Medical Equipment

# Fee for Service: Inpatient Hospital Reimbursement

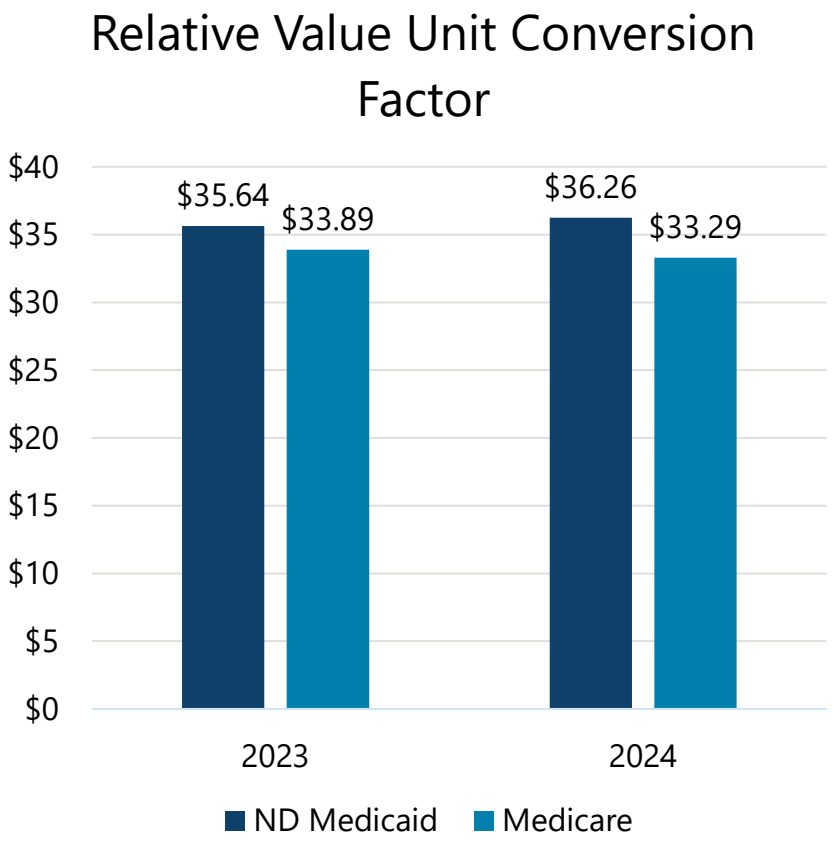
- Prospective Payment System (PPS) Hospitals – DRG per stay
- Critical Access Hospitals – Interim per diem with cost settlement when Medicare cost report is finalized
- Psychiatric Hospitals – Per diem
- Rehab Hospitals – Per diem
- Long Term Care Acute Hospitals – Percentage of charges
- Out-of-State Hospitals – Percentage of charges

# Fee for Service: Outpatient Hospital Reimbursement

- Prospective Payment System (PPS) Hospitals – Enhanced Ambulatory Payment Groups (EAPG) per visit
- Critical Access Hospitals – Interim percentage of charges with cost settlement when Medicare cost report is finalized
- Psychiatric Hospitals – Percentage of charges
- Rehab Hospitals – Percentage of charges
- Long Term Care Acute Hospitals – Percentage of charges
- Out-of-State Hospitals – Percentage of charges

# Fee for Service: Professional Services and Clinics

- Professional services
  - Relative Value Unit (RVU) and Conversion Factor used for most practitioner services
  - Fee (dental, transportation)
  - Center for Medicare and Medicaid Services (CMS) rates (labs, vaccines)
- RHCs and FQHCS
  - Encounter rate, one payment for all services the provider delivers on that day
  - FQHCs can be reimbursed for a medical visit, behavioral health visit and a dental visits on the same day



# Provider Inflation
## Ongoing

| Total | $16,215,764 |
|---|---|
| General | $6,949,693 |
| Federal | $9,266,071 |

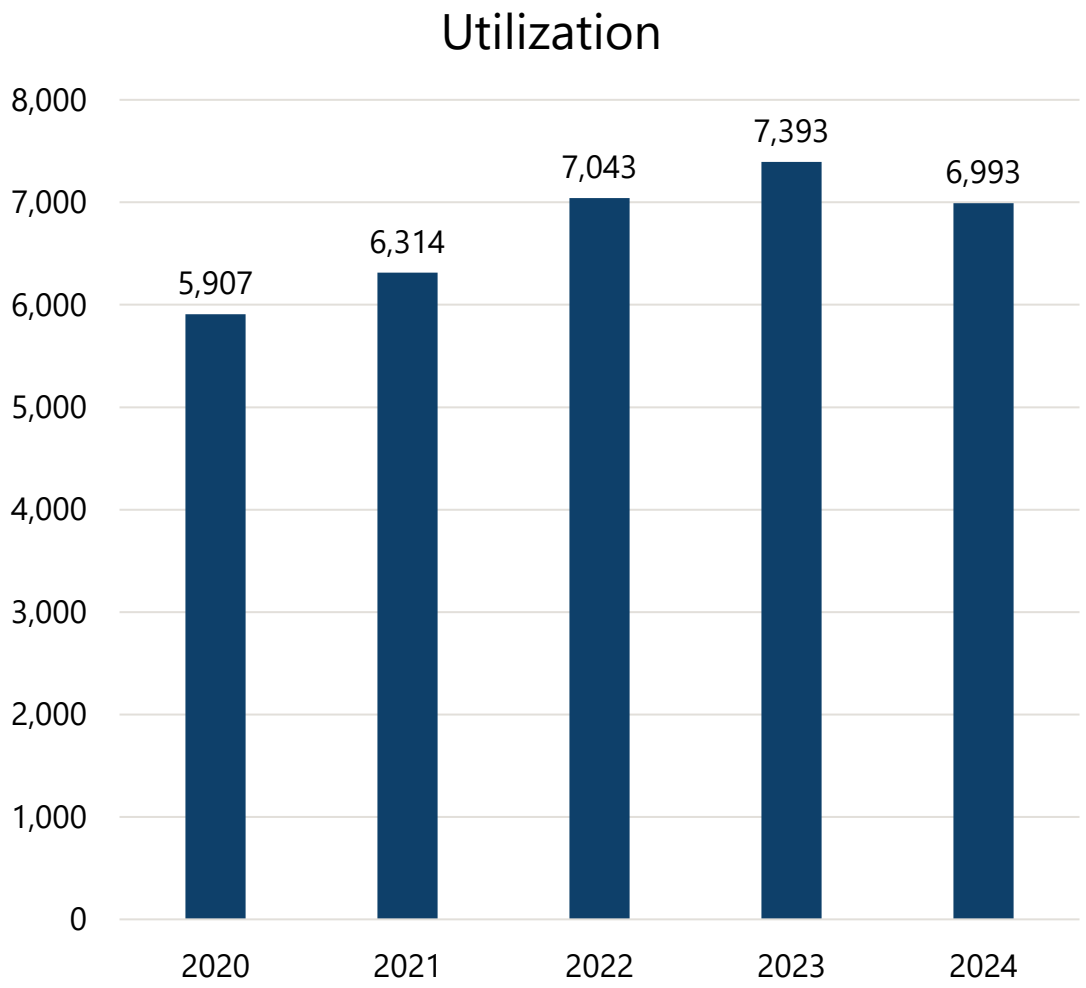
Increase includes the following inflation of provider rates for the 2025-2027 biennium:

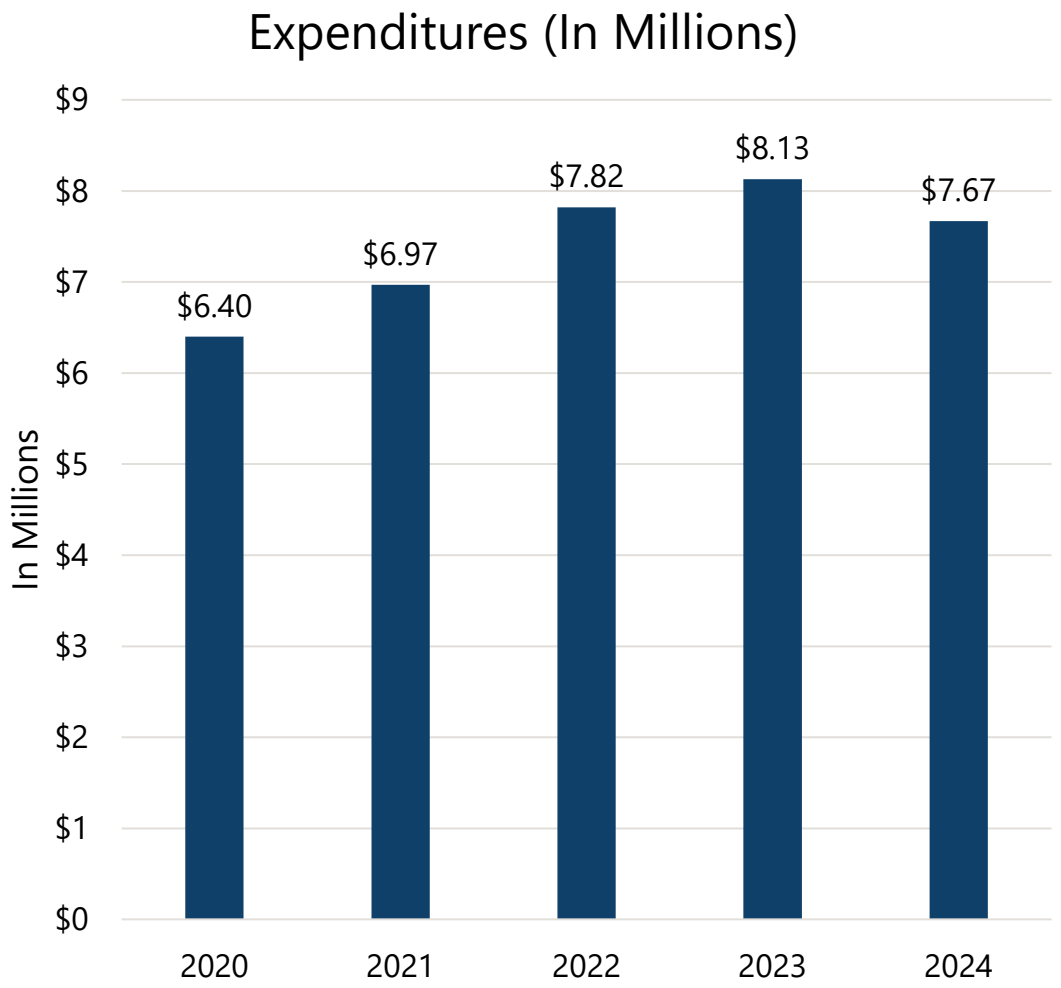
- SFY 2026: 1.5%
- SFY 2027: 1.5%

- Provider inflation is applied to provider rates in accordance with the rate methodology for the service.
  - Most provider rates paid from a fee schedule are updated each July 1.
  - Inflation is used as the adjustment factor to inflate costs forward from provider cost reports for most cost-based providers.
    - Some providers use a standardized index in place of inflation.

| Appropriated Inflation, SFY 2019 - 2024 | | | | | |
|---|---|---|---|---|---|
| 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| 2.0% | 2.5% | 2.0% | 0.25% | 3.0% | 3.0% |

# Ambulance Utilization & Expenditures

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# Ambulance Targeted Rate Increase

## Ongoing

| | |
|---|---|
| **Total** | **$**4,379,540 |
| General | $2,189,770 |
| Federal | $2,189,770 |

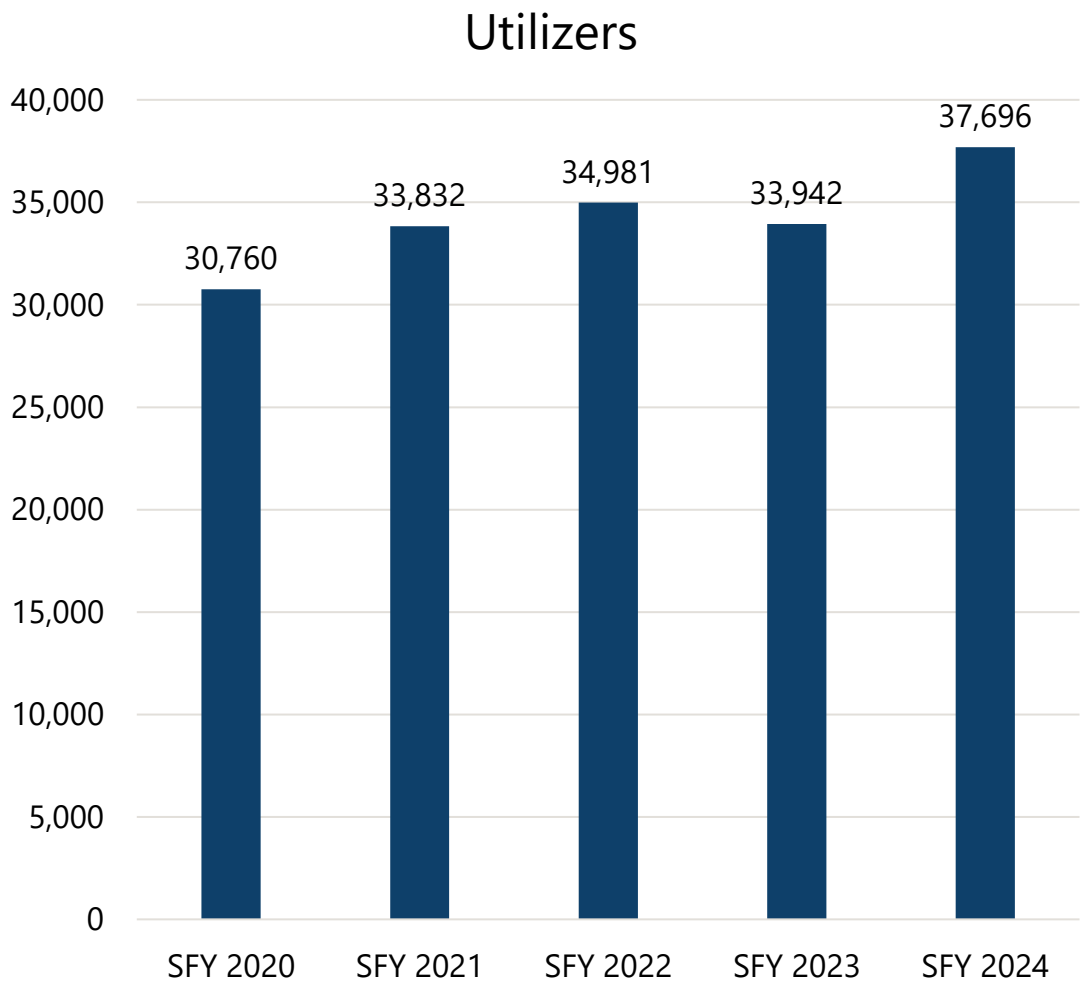
Increase rebases ambulance rates to the Lowest Quartile Medicare Rural Base Rate.

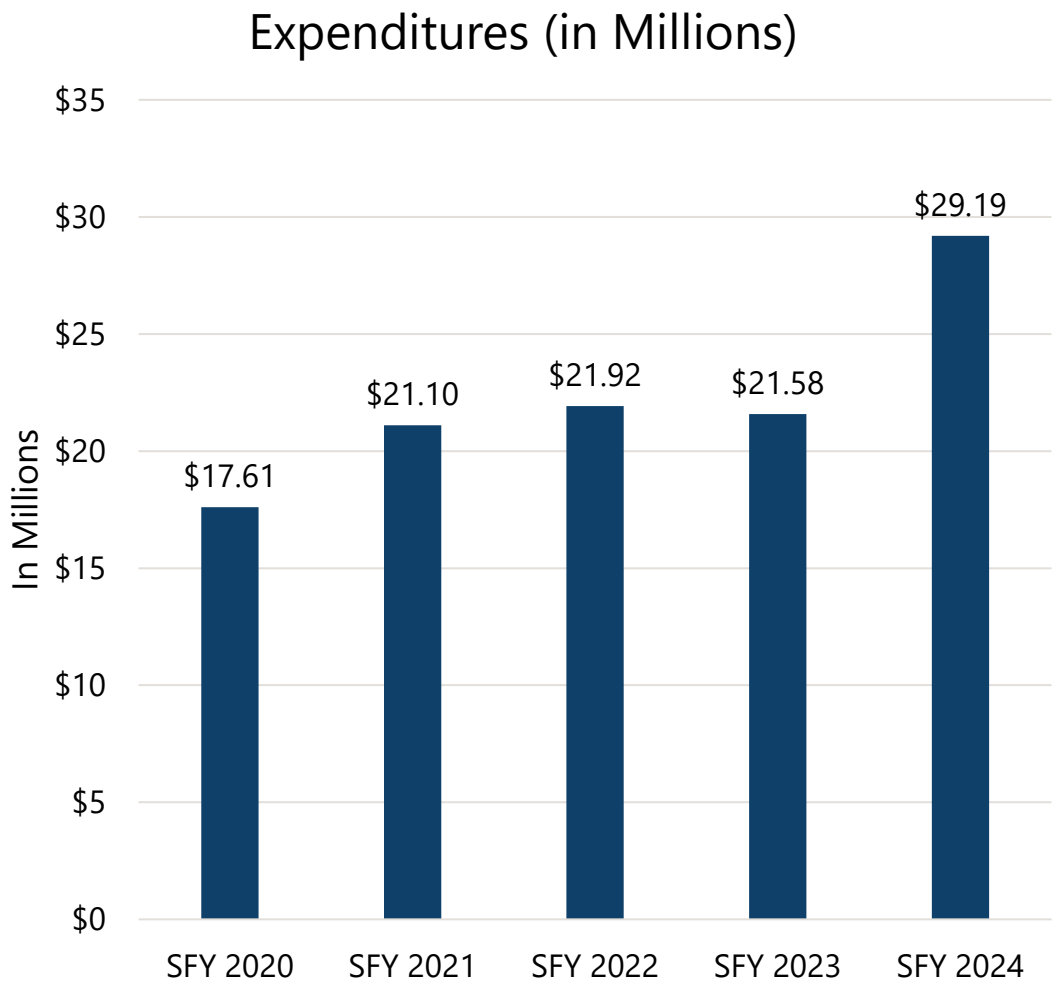
| A0427: Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 Base Rate | | | | | |
|---|---|---|---|---|---|
| North Dakota Medicaid | Medicare Rural – Lowest Quartile | Minnesota Medicaid | Montana Medicaid | South Dakota Medicaid | Wyoming Medicaid |
| $602.19 | $669.35 | $530.06 | $280.94 | $479.85 | $291.24 |

| A0429: Ambulance Service, Basic Life Support, Emergency Transport Base Rate | | | | | |
|---|---|---|---|---|---|
| North Dakota Medicaid | Medicare Rural – Lowest Quartile | Minnesota Medicaid | Montana Medicaid | South Dakota Medicaid | Wyoming Medicaid |
| $507.10 | $563.67 | $446.36 | $236.58 | $404.08 | $245.26 |

**Related Bills:**
House Bill 1322 | Relating to Ambulance Service Provider Reimbursement
*Note: HB 1322 does not apply to Medicaid.*

# Dental Utilization & Expenditures

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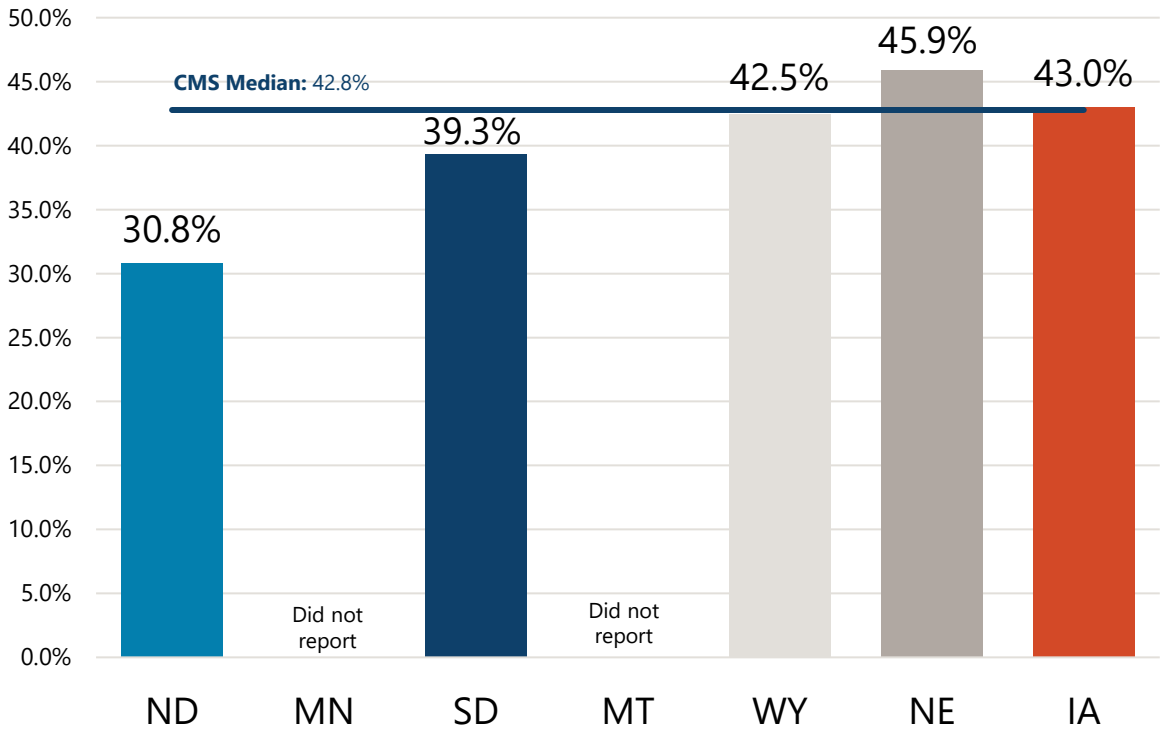
# Dental Outcomes & Rates

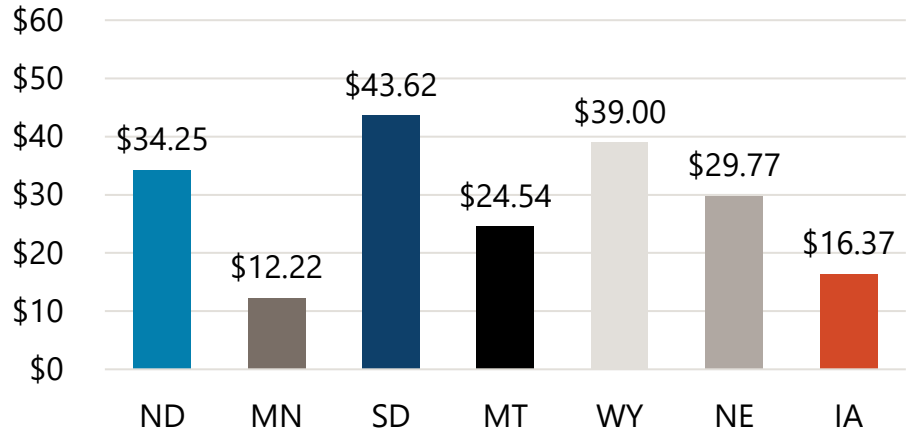
ND Medicaid Dental Rates were last rebased in 2009. Dental rates have increased approximately 42% since last rebase.

**Oral Evaluation, Dental Services, FFY 2023**

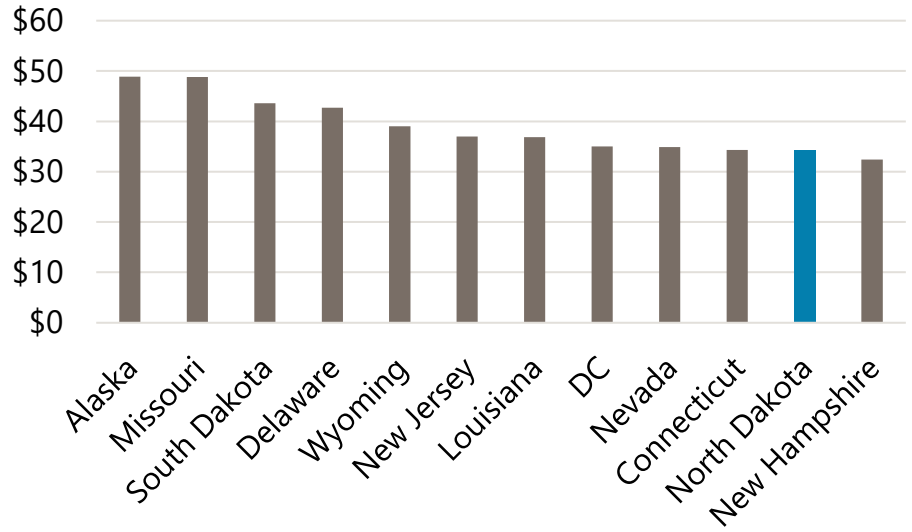



**Related Bills:**
House Bill 1567 | Relating to Dental and Oral Health Care Status among Medicaid Recipients and Workforce Support to Improve Access for Low-Income Children
Senate Bill 1322 | Relating to Covered Services for Medical Assistance

**Medicaid Reimbursement Rate: D0120 Periodic Oral Evaluation, SFY2025**




**NORTH DAKOTA RANKS 3RD IN THE REGION**




**NORTH DAKOTA RANKS 11TH IN THE NATION**

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# Managed Care & Medicaid Expansion

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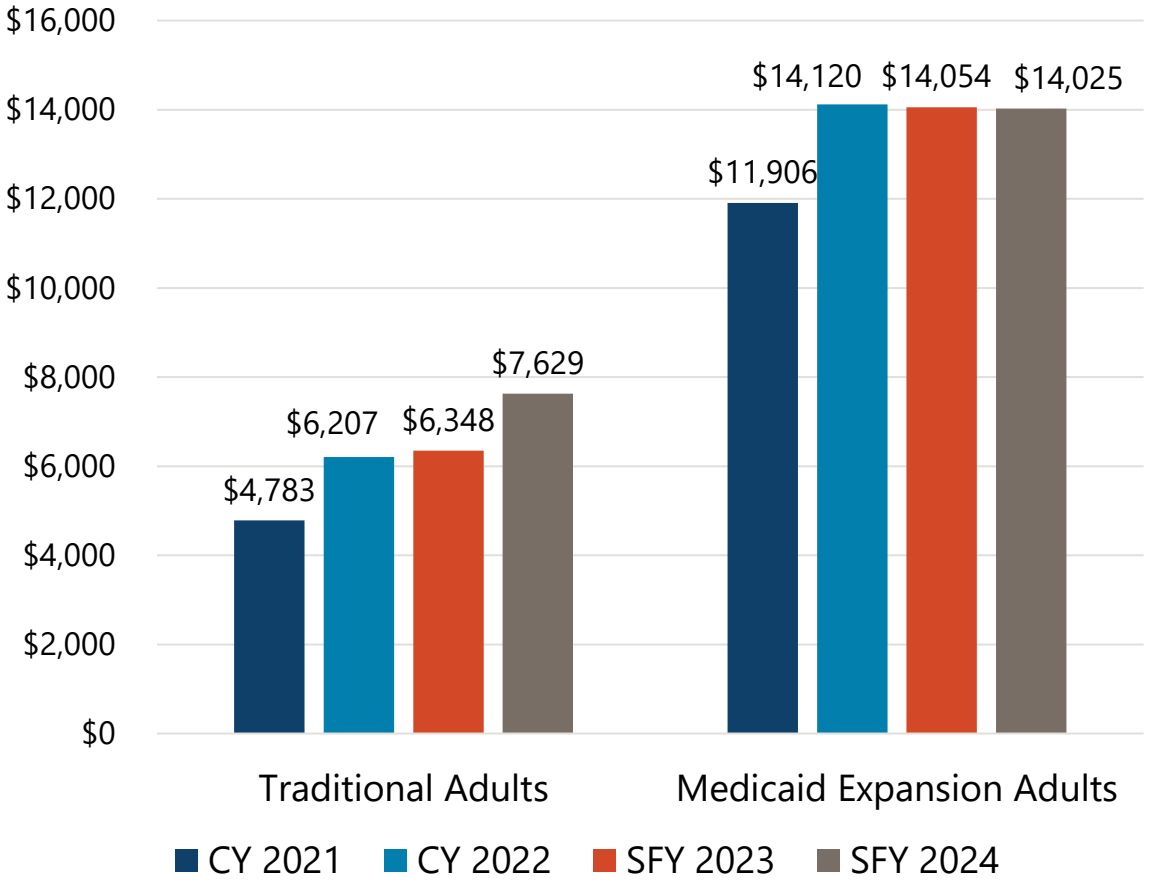
# Per Capita Expenditures:
# Medicaid Expansion & Traditional Adults




- ND Medicaid ranked **1st for Medicaid Expansion per capita** expenditures.
- ND Medicaid ranked 25th **for Traditional Adult** expenditures.

Note: CY 2021 and CY 2022 Data obtained from Medicaid and CHIP Scorecard - Medicaid Per Capita Expenditures. SFY 2023 and SFY 2024 numbers calculated from ND TMSIS data.

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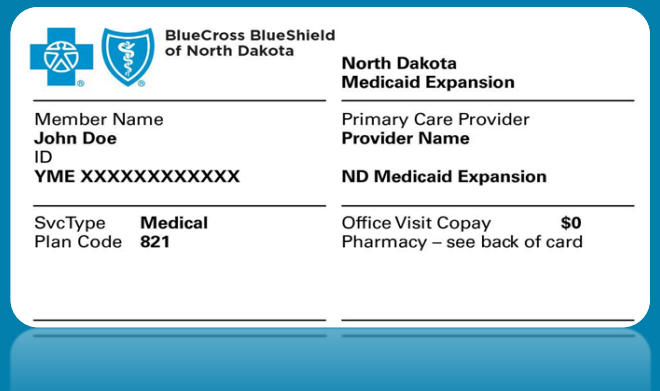
# Medicaid Expansion Coverage

North Dakota provides Medicaid Expansion through risk based Managed Care.

- Current Vendor: Blue Cross Blue Shield of North Dakota (BCBS ND)




- There are a few key differences between Medicaid Expansion and traditional Medicaid.
- Medicaid Expansion **does not** cover:
  - Skilled Nursing Facility Services[1]
  - Dental Services[2]
  - Vision Services[2]
  - Any waiver services
  - Long Term Care services

*[1] Only covers up to 30 days and only covers a skilled level of care*
*[2] Only covered for 19- and 20-year-olds*

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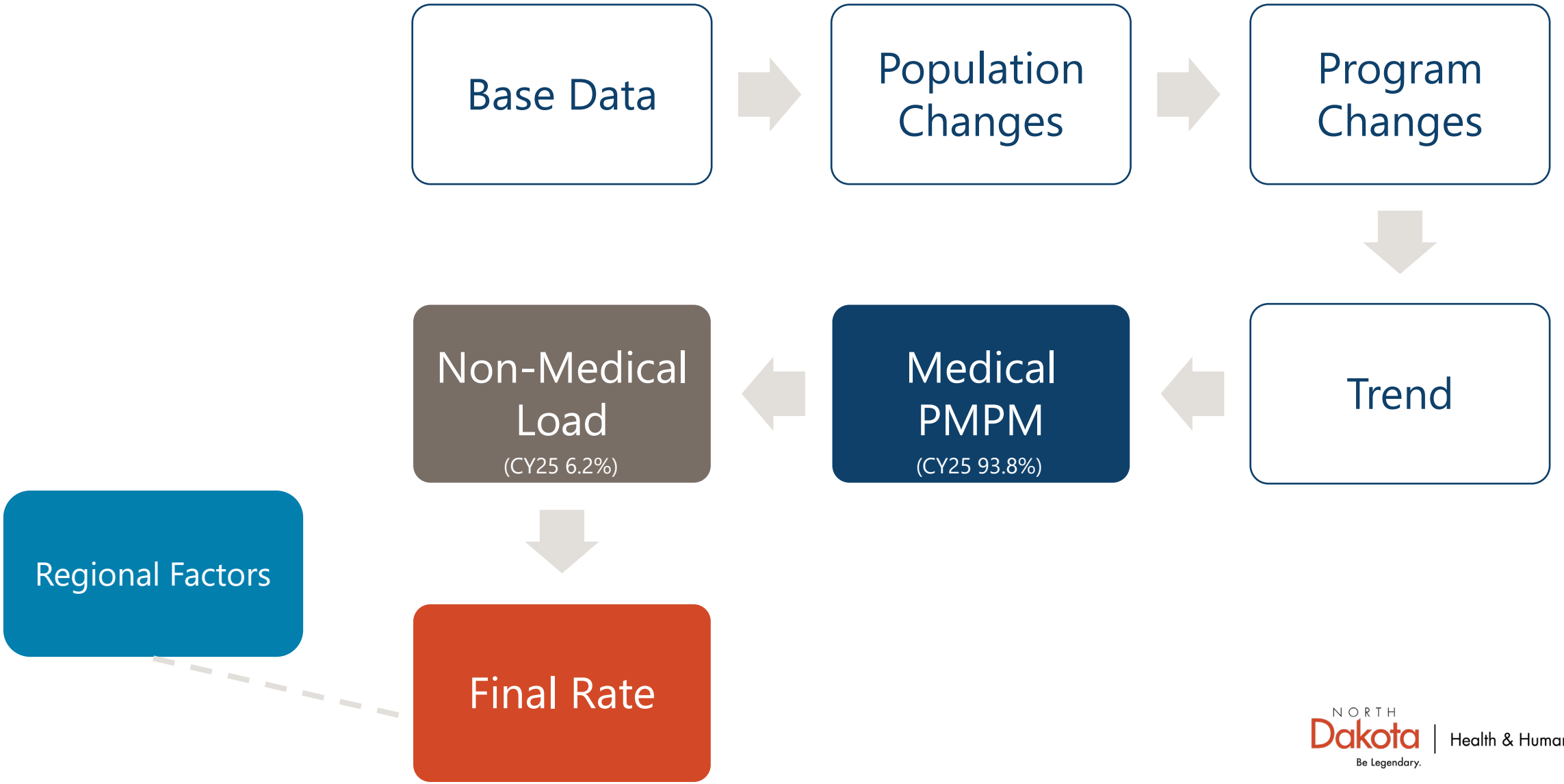
# Managed Care

- **Managed Care Plans use their own provider networks.** Providers must enroll in Blue Cross Blue Shield to provide care to Medicaid Expansion members.
- **Managed Care Plans use their own coverage criteria, authorization process, and limits.** Providers must follow Blue Cross Blue Shield policies for Medicaid Expansion members.
- **Managed Care Plans use their own reimbursement methodology and fee schedules.** Providers are paid according to Blue Cross Blue Shield's policy for Medicaid Expansion members.
- **North Dakota Medicaid has carved out pharmacy benefits for Medicaid Expansion members.** Pharmacy benefits are the same for Medicaid Expansion and traditional Medicaid.

# How does ND Medicaid pay for services?

| **Traditional Medicaid: Fee For Service (FFS)** | **Medicaid Expansion: Managed Care Organization (MCO)** |
|---|---|
| State pays providers directly for each covered service received by a Medicaid member. | State pays a monthly fee called a capitation payment to the managed care organization (MCO). |
| Only services received by members are paid. | Monthly fee is paid to MCO regardless of member use of services. |

# Capitation Rate Development Process

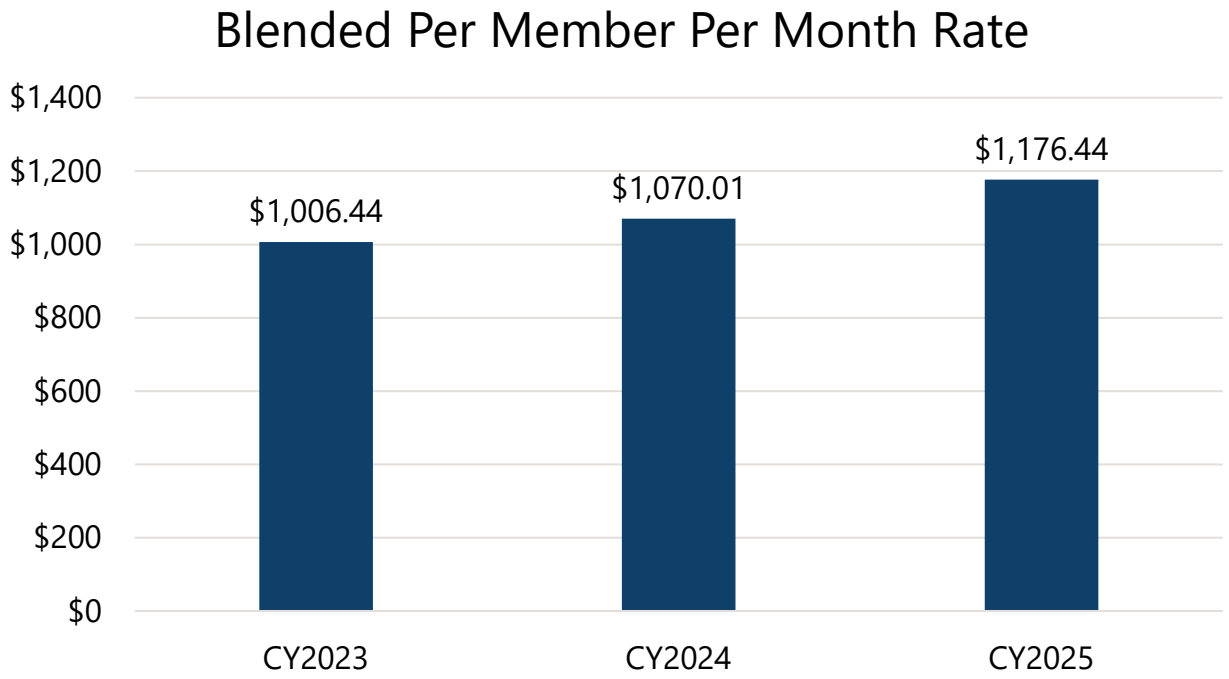


# 2025 Capitation Rates

CY2025 capitation rates are in development by our actuary in conjunction with HHS and BCBSND.

- CY2025 capitation rates implement Senate Bill 2012 provision to ensure that the capitation rate calculation assumes that MCO rates will not exceed 145% of Medicare reimbursement, except for services noted in Section 22.

- No decrease to the CY2025 Capitation Rates to comply with 145% of Medicare requirement.
  - Actuarial analysis showed BCBS was already at 144.5% in aggregate of Medicare.
- Overall, 9.1% increase in rates for CY2025.

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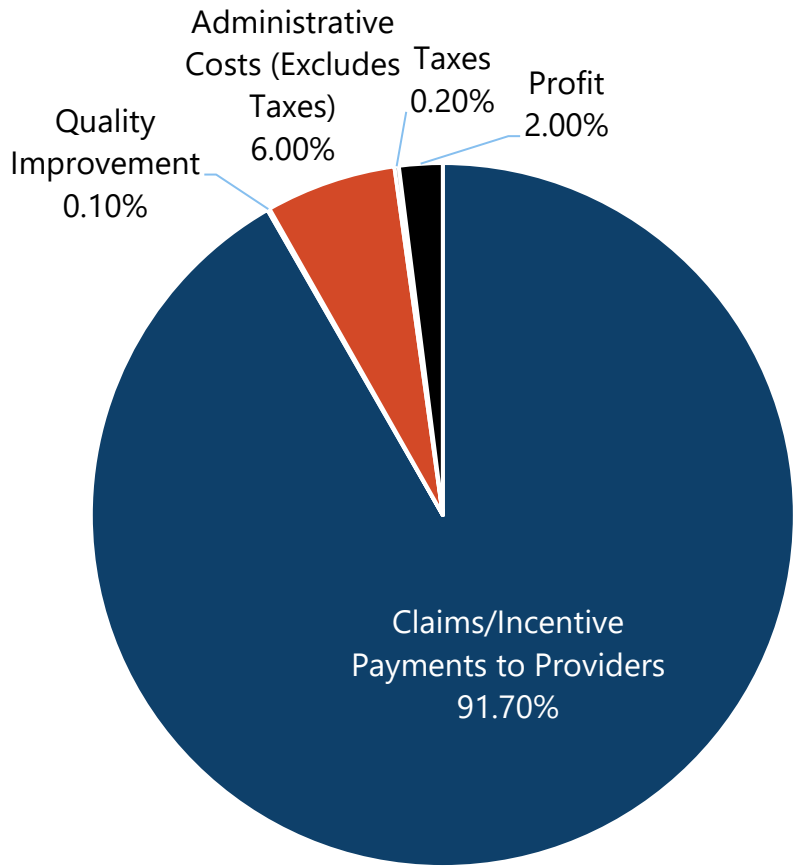
# Medical Loss Ratio (MLR) & Profit Cap

- Since reprocuring the Medicaid Expansion contract in 2022, ND Medicaid has used both a Medical Loss Ratio (MLR) and Profit Cap to protect the state.
  - Profit Cap: Overall limit on the amount of profit that can be retained by the plan.
  - Medical Loss Ratio: Requires a specific percentage of the total capitation is spent on services and quality improvement. Protects states from paying for excessive administrative expenses or profits.
- While providing overall protection to the state, a profit cap can be a disincentive to continued innovation and lowering administrative costs.
- For CY 2025, ND Medicaid will use a robust MLR as the key Managed Care risk mitigation strategy.

Allocation of Retained MCO Revenue



# Performance Withhold: 2023

- 2% of Capitation Payments were withheld from the monthly premium.
- MCO had opportunity to earn back funds based on meeting quality goals.

| Quality Rating | Earn Back Percent | Quality Performance |
|---|---|---|
| ◆ | 0% | MCO rate below NCQA Quality Compass National Average |
| ◆◆ | 50% | MCO rate equals or exceeds NCQA Quality Compass National Average, but is less than 75th percentile |
| ◆◆◆ | 75% | MCO rate equals or exceeds NCQA Quality Compass 75th percentile but does not meet 90th percentile |
| ◆◆◆◆ | 100% | MCO rate equals or exceeds NCQA Quality Compass 90th percentile |

| Measure | CY2023 Quality Rating |
|---|---|
| Initiation and Engagement of Substance Use Disorder (SUD) Treatment | ◆◆ |
| Follow up after ER Visit for SUD | ◆◆◆ |
| Follow up after ER Visit for Mental Illness | ◆ |
| Controlling High Blood Pressure | ◆ |
| Hemoglobin A1c Control for Patients with Diabetes | ◆ |
| Eye Exam for Patients with Diabetes | ◆ |
| Plan All Cause Readmissions | ◆ |
| Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate | ◆◆◆ |
| Diabetes Short Term Complications Admissions Rate | ◆ |

**22.93% Total Earn Back for CY 2023**

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# 2023 – 2025 Medicaid Expansion Budget Assumptions

ND Medicaid developed the budget recommendation for the 2023 – 2025 Biennium in Spring & Summer 2022.

- Assumed PHE Unwinding was to begin **January 2024**
- Assumed:
  - 1.25% increase for 10 months during continued MOE.
  - 0.87% ramp down for 14 months of unwinding the PHE.
- Assumption ended the biennium (June 2025) at approximately 25,000 eligibles
- Projected Turnback:

| Total | General | Federal |
|---|---|---|
| $157,548,409 | $15,723,314 | $141,825,096 |

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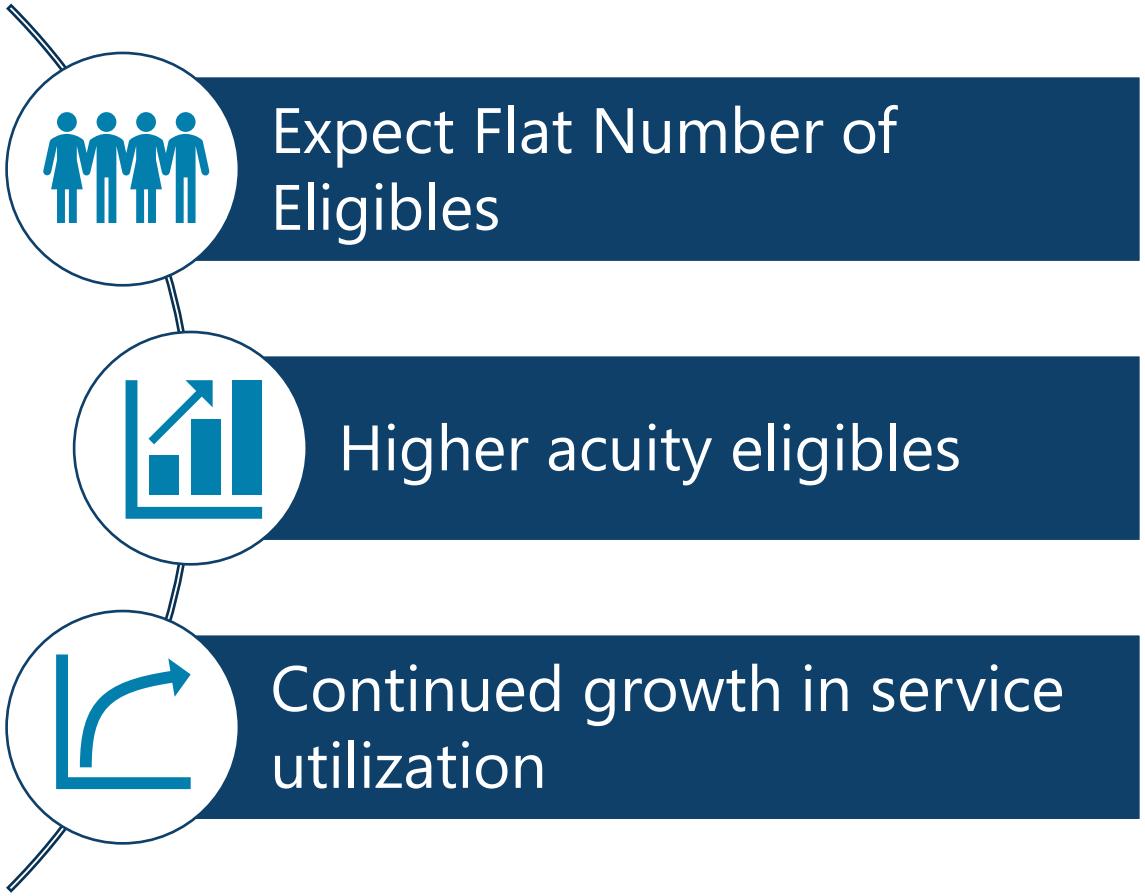
# 2025 – 2027 Medicaid Expansion Budget Assumptions




Medical Services budget assumes no increase to Medicaid Expansion provider rates.

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# Drugs

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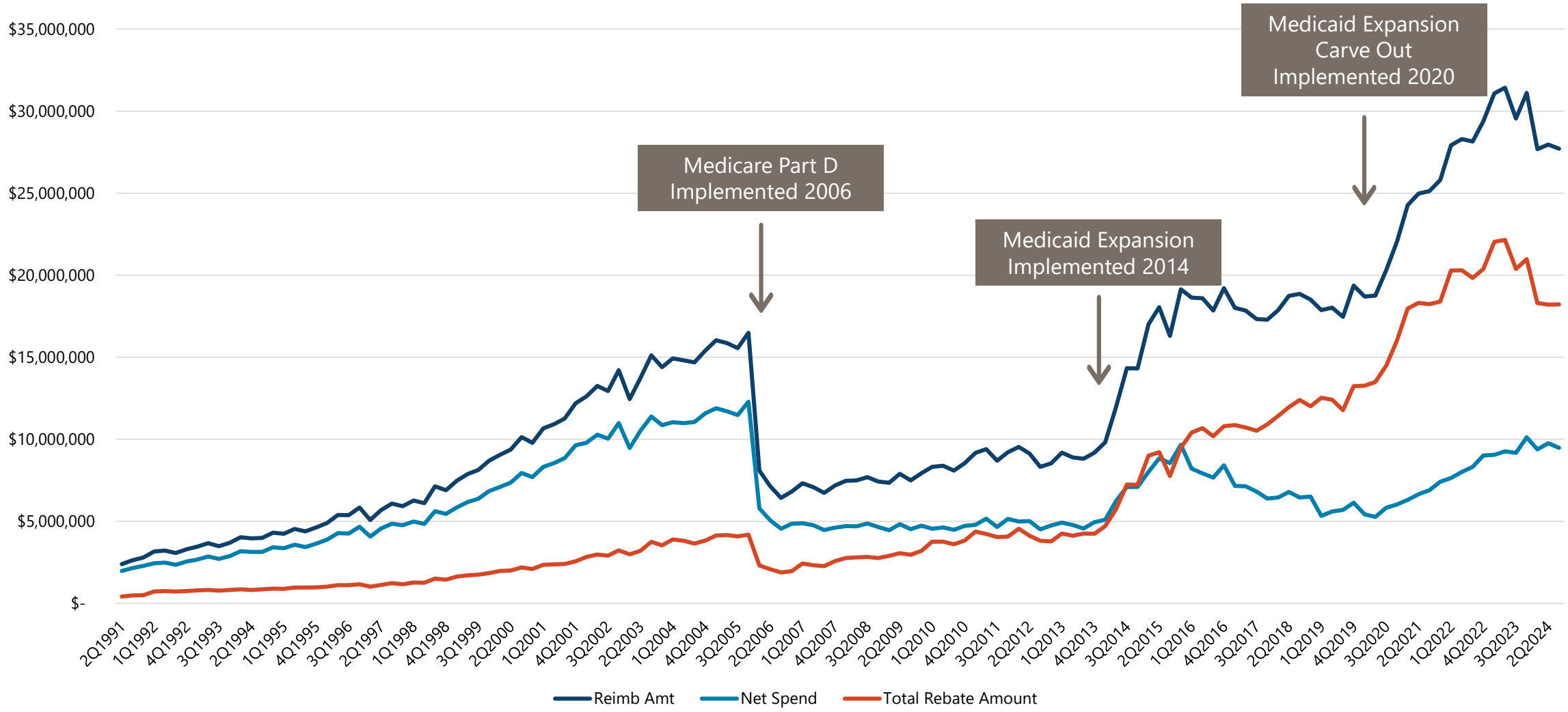
# Coverage

- **Prescription Only/Legend Drugs:** federal law requires Medicaid to cover all legend drugs of manufacturers who have signed a Medicaid Drug Rebate Agreement (MDRP)
  - Essentially all legend drugs are covered as most manufacturers participate in the MDRP
- **Over-the-Counter Drugs:** some are covered if they are part of the MDRP as outlined in the Pharmacy Provider Manual
- **Supplements/Vitamins:** some are covered as outlined in the Pharmacy Provider Manual
  - Medicaid works with the health division to cover some supplements required for treatment of diseases
- **Diabetic Supplies:** glucose test strips, meters, lancets, continuous glucose monitors, insulin syringes, tubeless insulin pumps, and pen needles as outlined in the Preferred Drug List (PDL)
- **Other:** inhaler spacers, injectable medication supplies (syringes, needles)

# Drug Use Review

- **Drug Use Review (DUR) Board:**
  - Mandated by federal and state law; board meets quarterly to provide recommendations on our pharmacy prior authorization (PA) program and our DUR program. Six physicians and six pharmacists are voting members of the DUR Board.
- **Prior Authorization (PA):**
  - Over 900 PAs received in December 2024
  - A Preferred Drug List (PDL) is a requirement for supplemental drug rebate agreements. ND has decided to use it for our entire PA program. The PDL outlines coverage parameters for many medications, including PA criteria.
- **DUR Program:** Mandated by federal law; includes prospective and retrospective education on therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect drug dosage, incorrect duration of drug treatment, drug-allergy, and clinical abuse/misuse edits
  - **Prospective DUR:** Prospective DUR requirements to ensure appropriate payment and provision of prescription drugs as well as drug counseling and patient profile requirements
  - **Retrospective DUR:** Roughly 400 cases reviewed two of every three months; once a quarter, a targeted mailing is done; letters are mailed to pharmacists and prescribers

# Overall Spend History (Includes Expansion)

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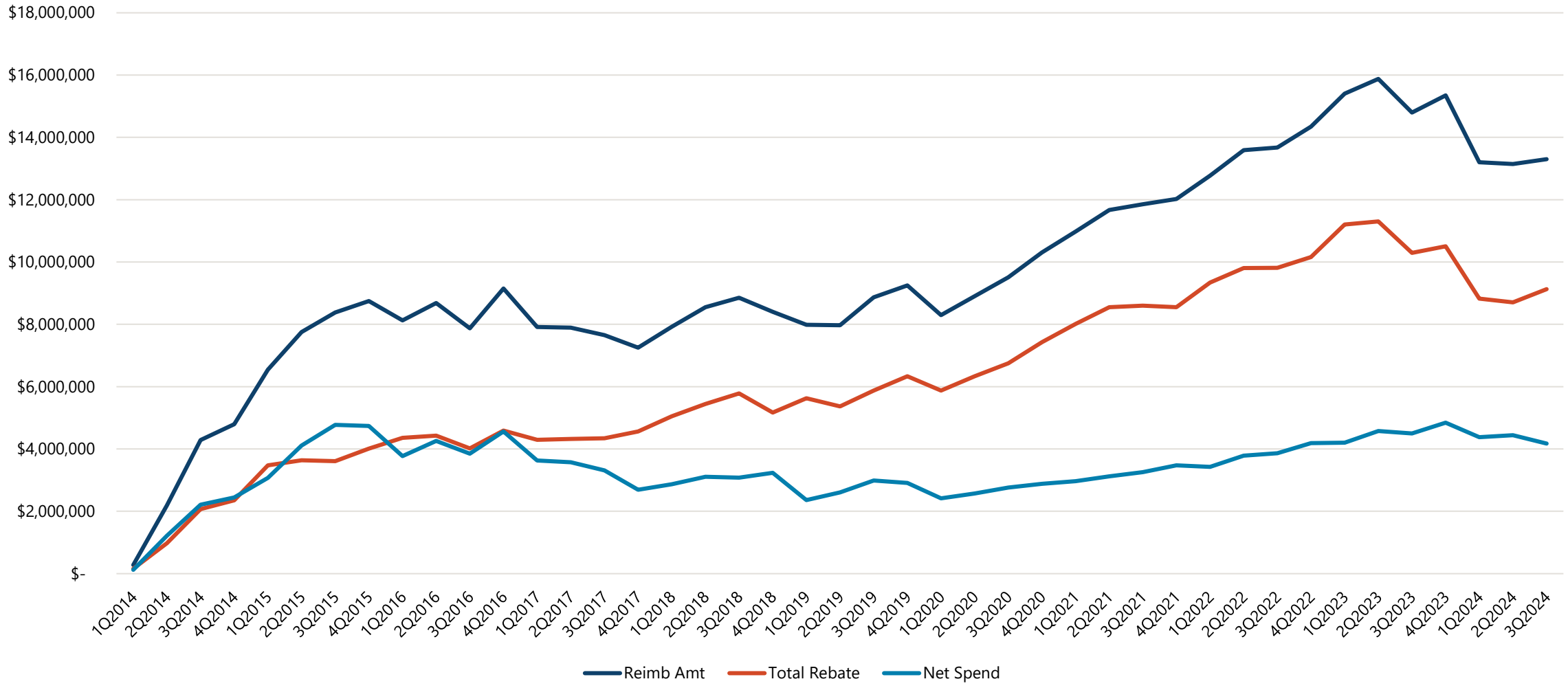
# Overall Expansion Spend History

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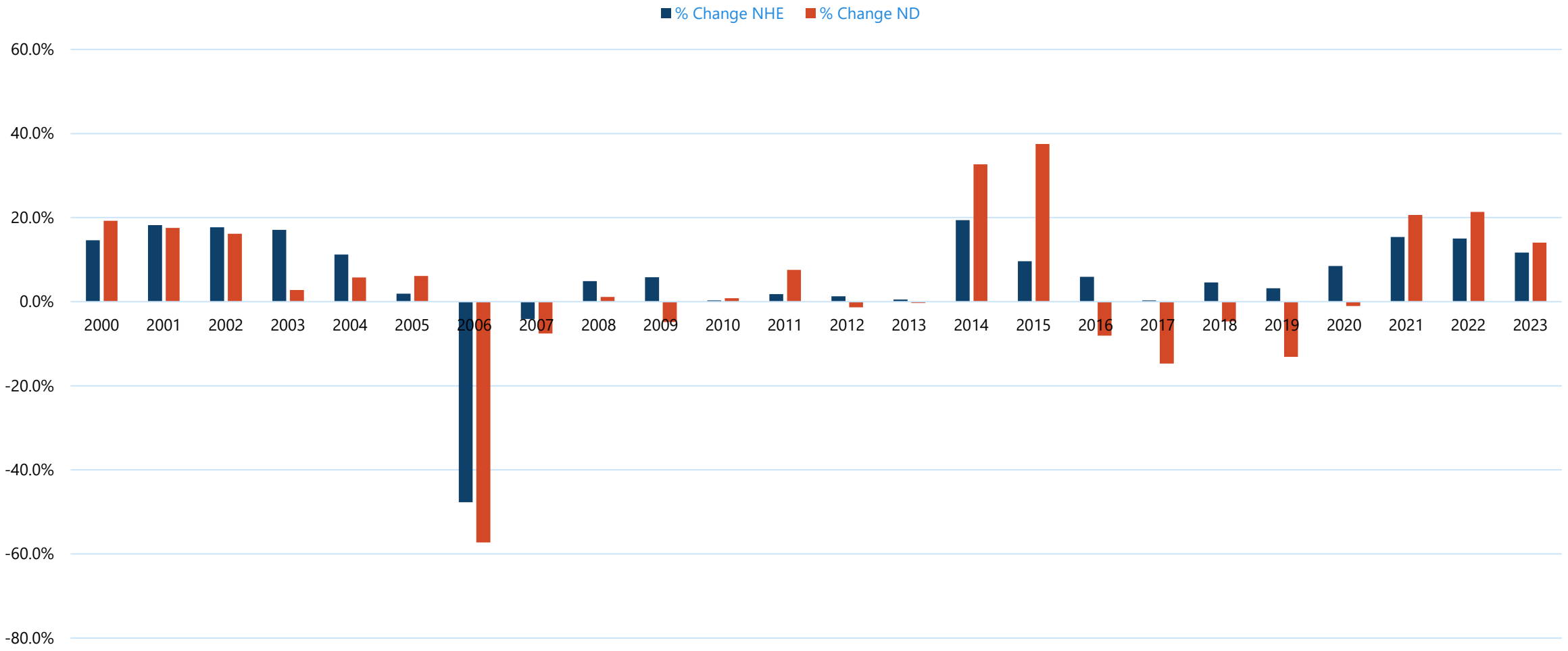
# Savings from Medicaid Expansion Prescription Drug Carve Out

- Expected Total Savings
  - Claims = $3.018 million (> $2.1 million projected in 2019 session)
  - Indian Health Service (IHS) = $7.2 million (*New savings)
  - Premiums = $3.4 million (*New savings)
  - Admin = $3.441 million (< $3.991 million projected in 2019 session due to Health Insurance Provider's Fee going away in 2021)

- Total = $17.059 million (> $6.091 million projected in 2019 session)

# ND Medicaid Growth vs. National Growth

## Medicaid Pharmacy

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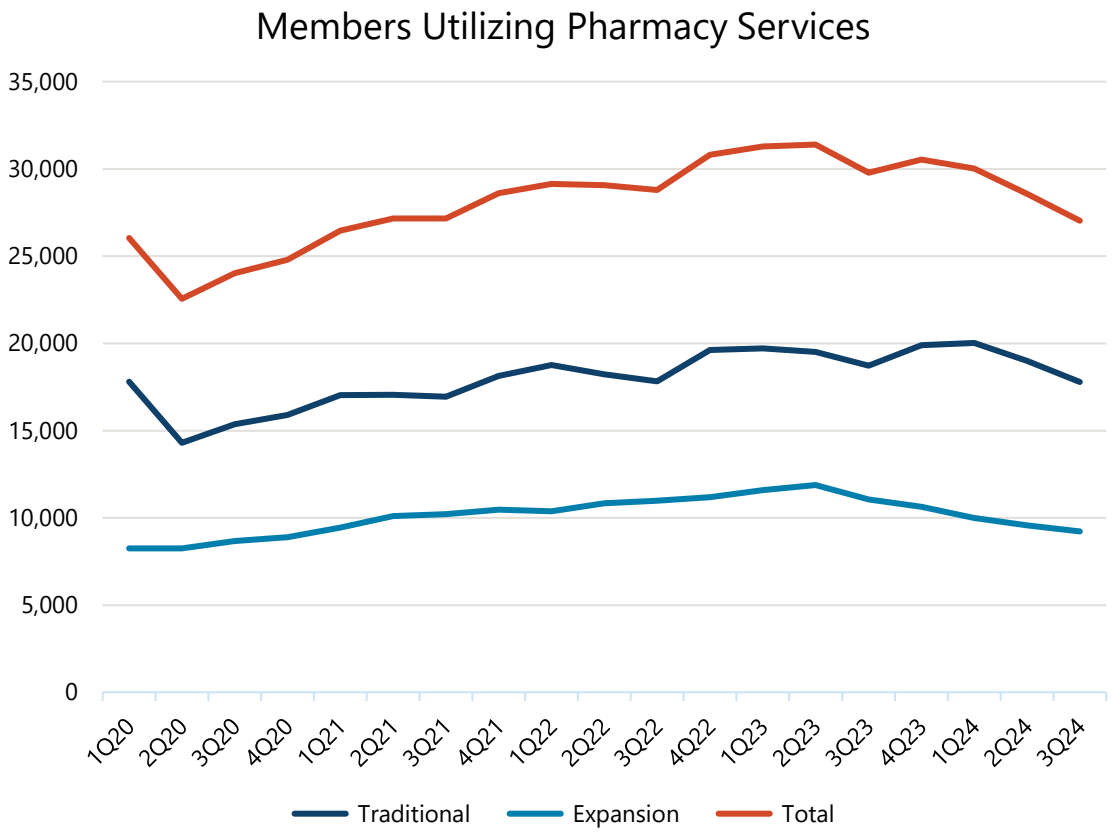
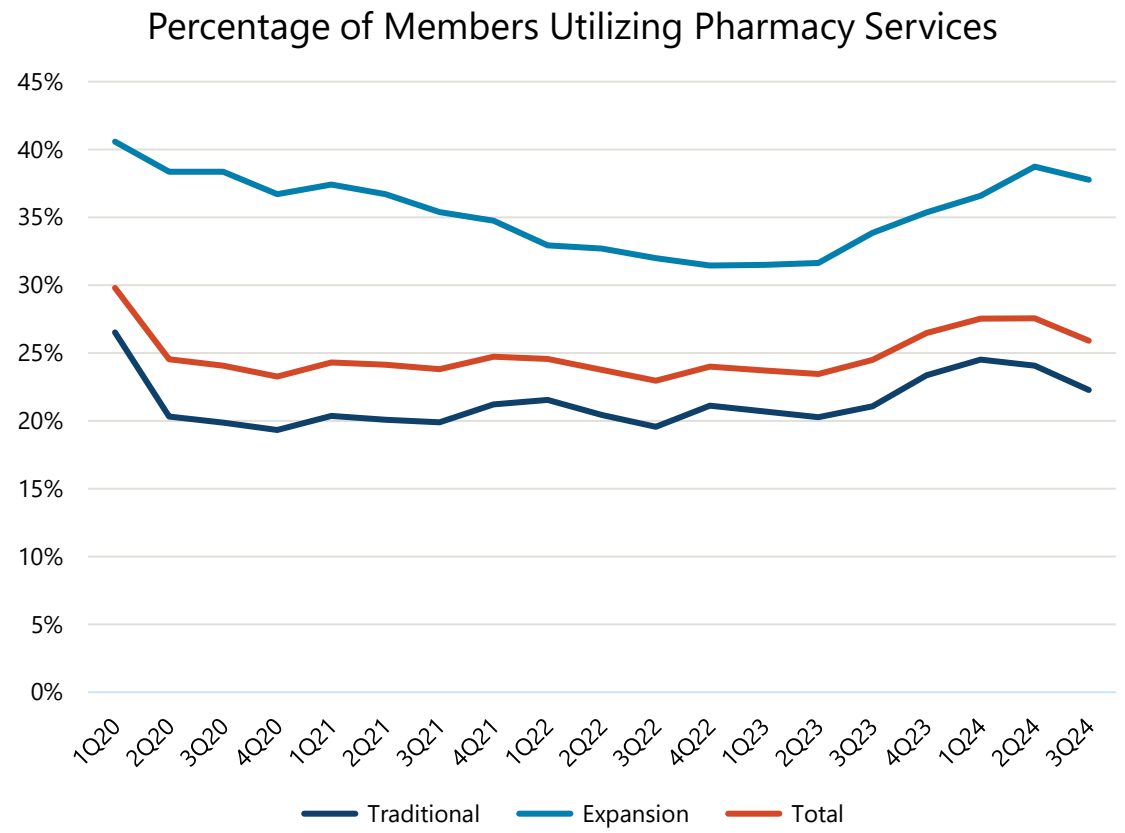
# Utilizers of Pharmacy Services

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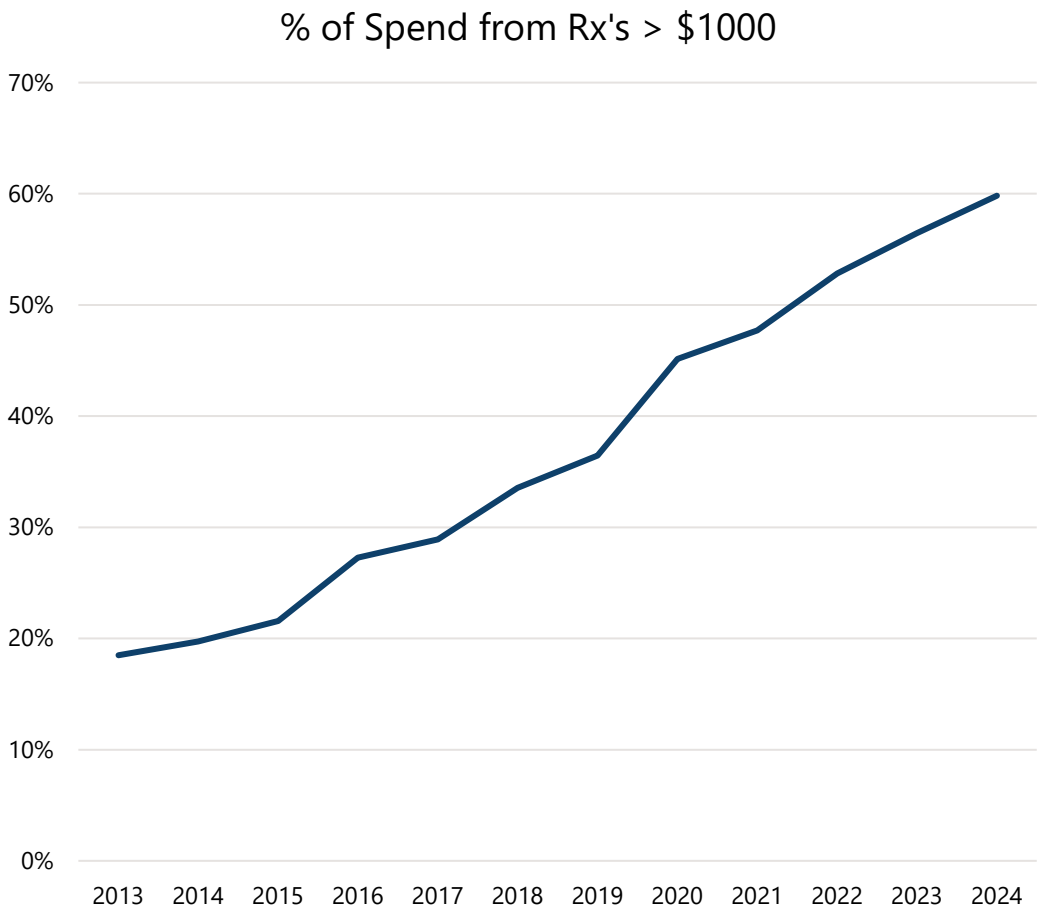
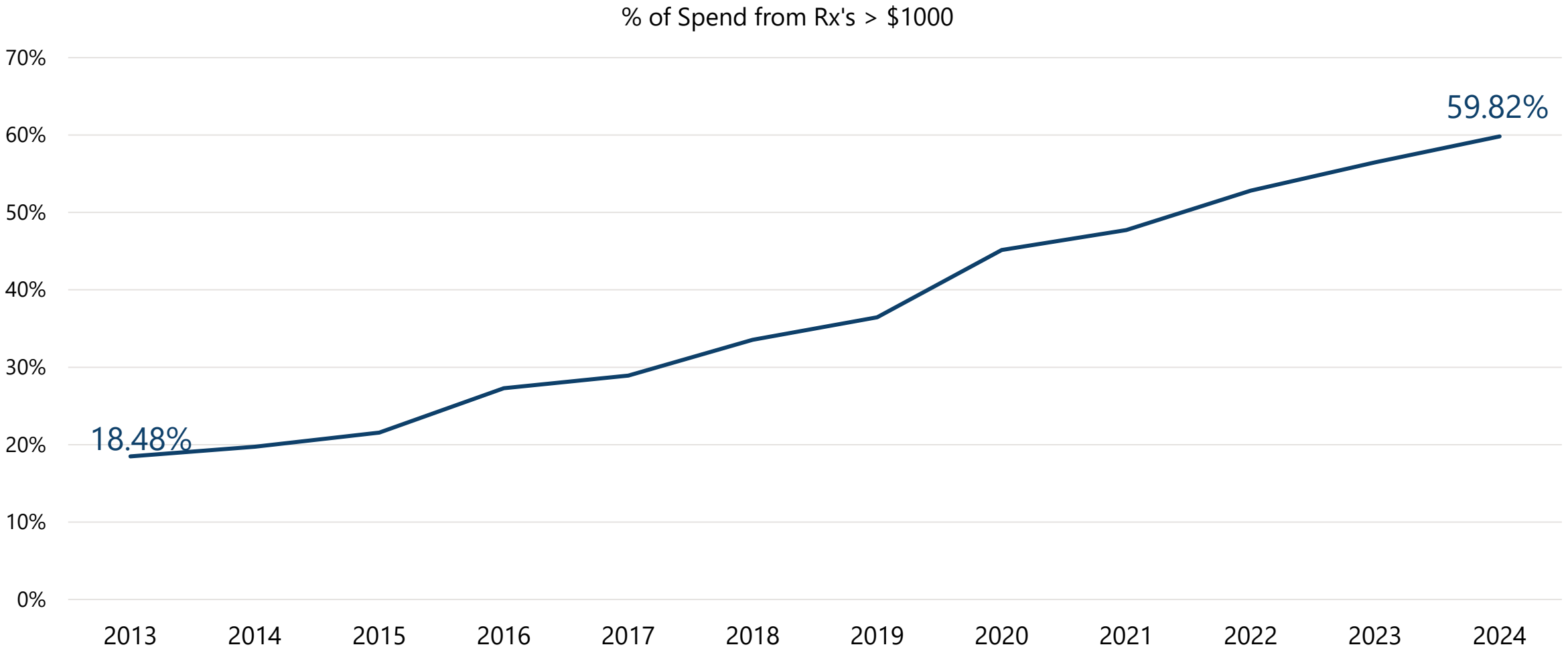
# Cost Drivers

- **6 Drug Classes:** 6 drug classes make up 36.3% of the drug budget (4Q23 to 3Q24):
  - Cystic Fibrosis, Immunomodulators, Migraine, Non-Insulin Diabetes, Pulmonary Hypertension, Tardive Dyskinesia
  - Spend for these classes increased by 138% between 1Q2020 and 3Q2024 to $10 million per quarter
  - During the same period, claims volume for drugs in these classes only increased by 14%
- **50 Hyper-Cost Drugs:** 50 hyper-cost drugs make up 33.7% of the drug budget (4Q23 to 3Q24):
  - Over $950,000 spent on 22 claims from 4Q23 to 3Q24 on just 3 drugs: Daybue, Gattex, and Oxervate



# High-Cost Drugs Continue to Climb

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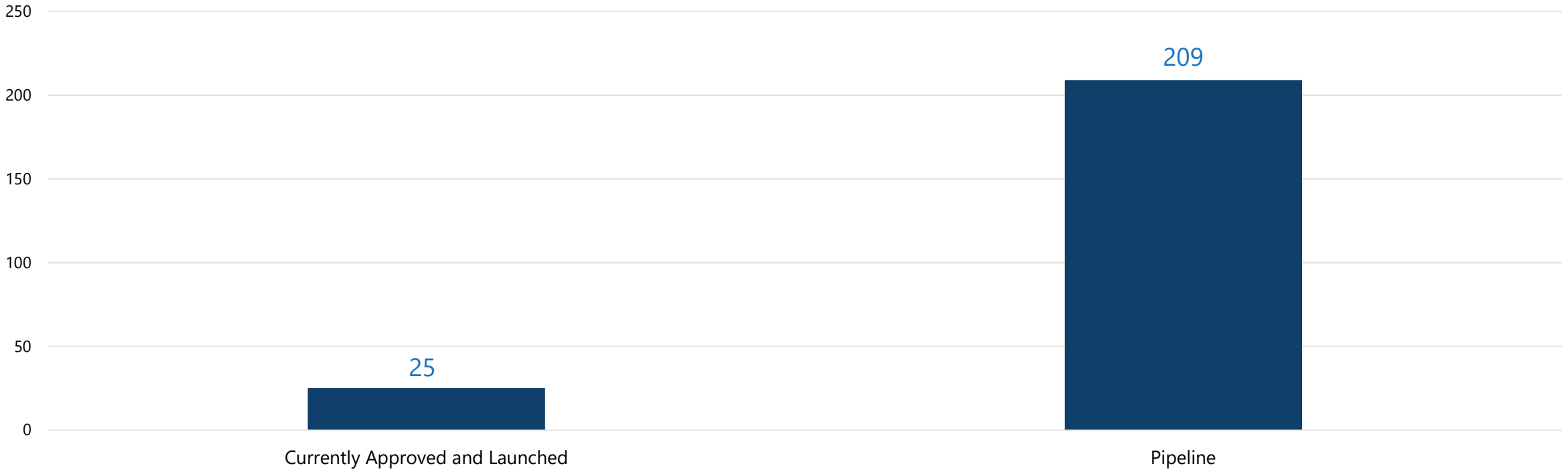
# Cell and Gene Therapies

- 25 total drugs: 11 of them cost > $2 million
- Many more coming

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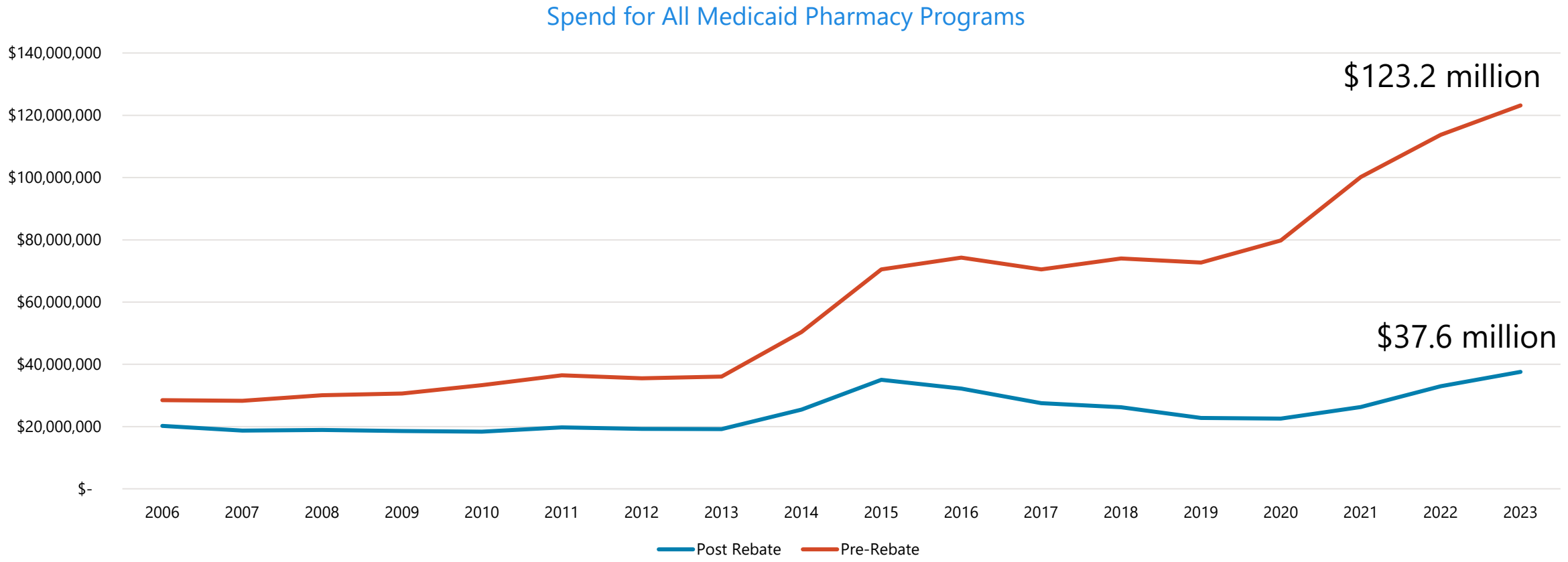
# Drug Rebates are Increasingly Important

- Pre-rebate spend growing much faster than post-rebate spend

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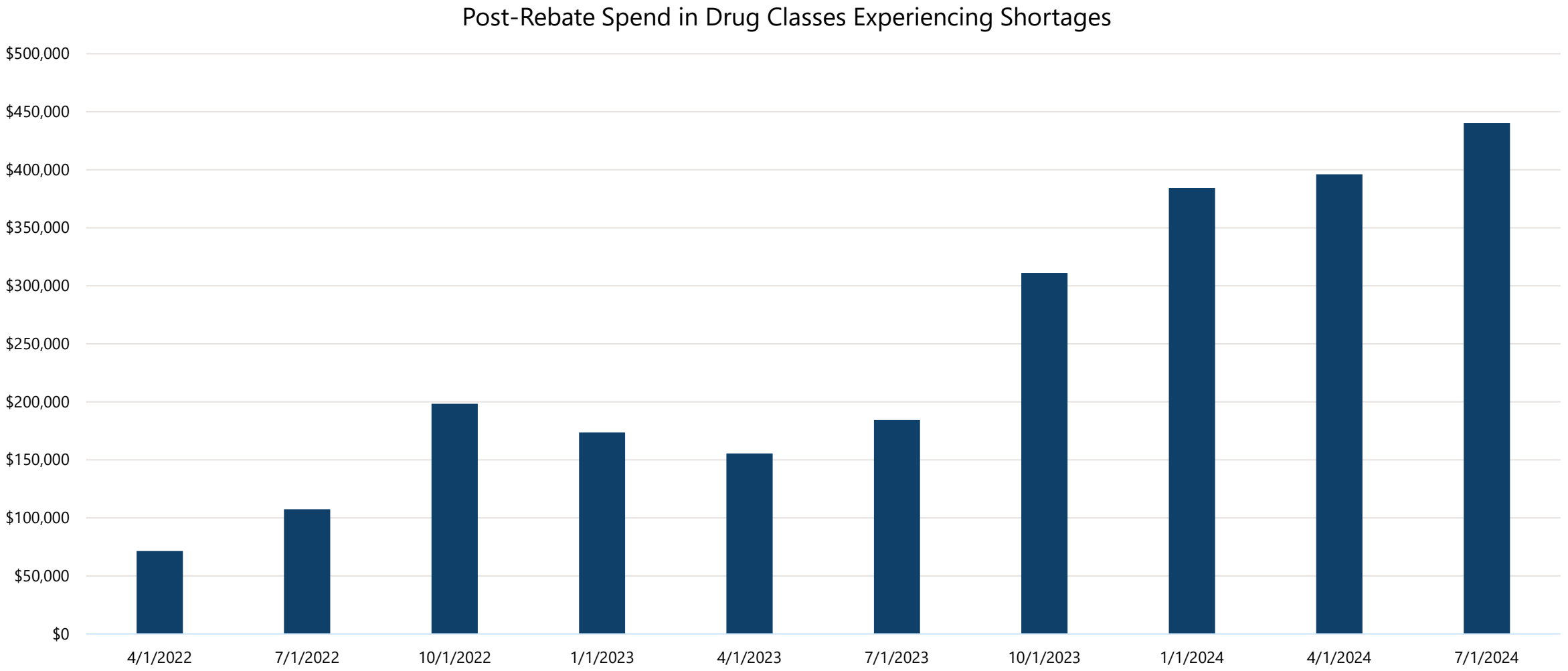
# Total Prescription Drug Rebates

- Collected $811 million in total drug rebates since 1991.
  - Since Part D carved out, $700 million saved. (2006)
  - Since Medicaid Expansion, $594 million saved. (2014)
  - Since COVID, $351 million. (2020)
- More than 1/3rd of total rebate savings since the beginning of the program were collected in the last 4 years.
- Net spend for prescription drugs is $848 million since 1991.
- Total payment to providers is $1.659 billion since 1991.

# Value Based Agreements - “Warranties”

- Currently 4 in place, 2 more offers
- Challenges:
  - Time consuming tracking of outcomes and negotiation of terms
  - Churn of eligibility limits length of warranty
  - Slow uptake by manufacturers:
    - Manufacturers won’t work with small states
    - Manufacturers won’t give offers to multi-state pools
    - Manufacturers are picking “one state to start with”

# Drug Shortages Increase Post-Rebate Spend

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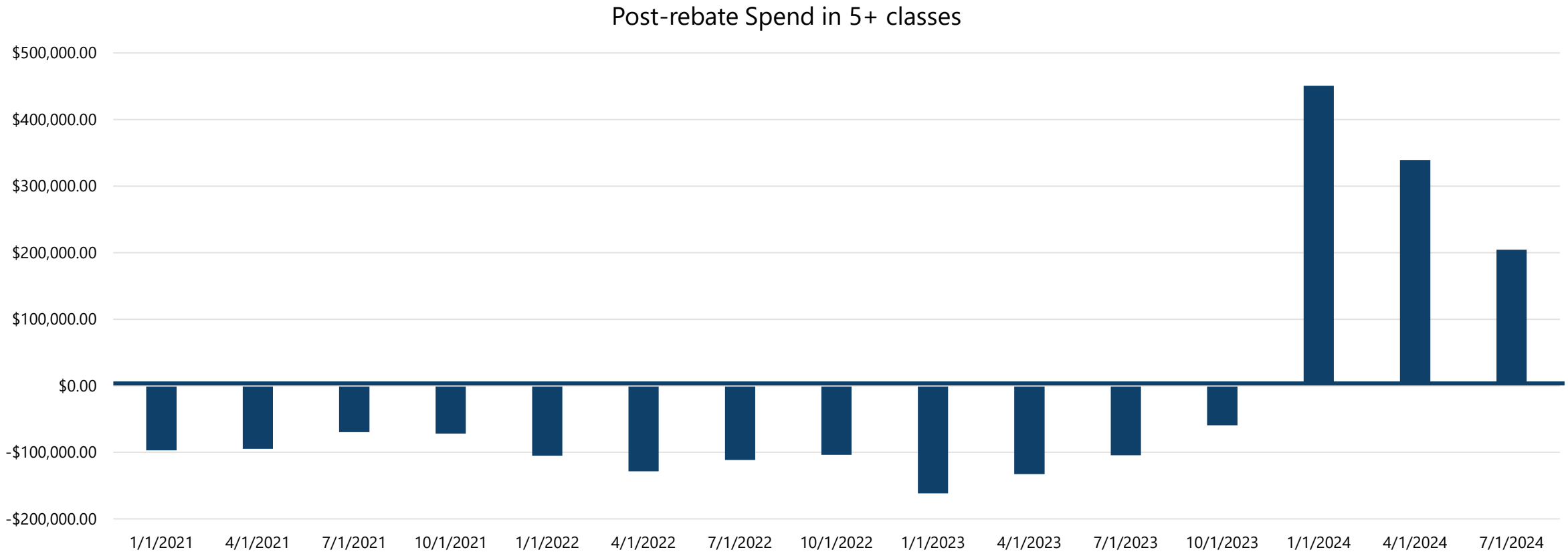
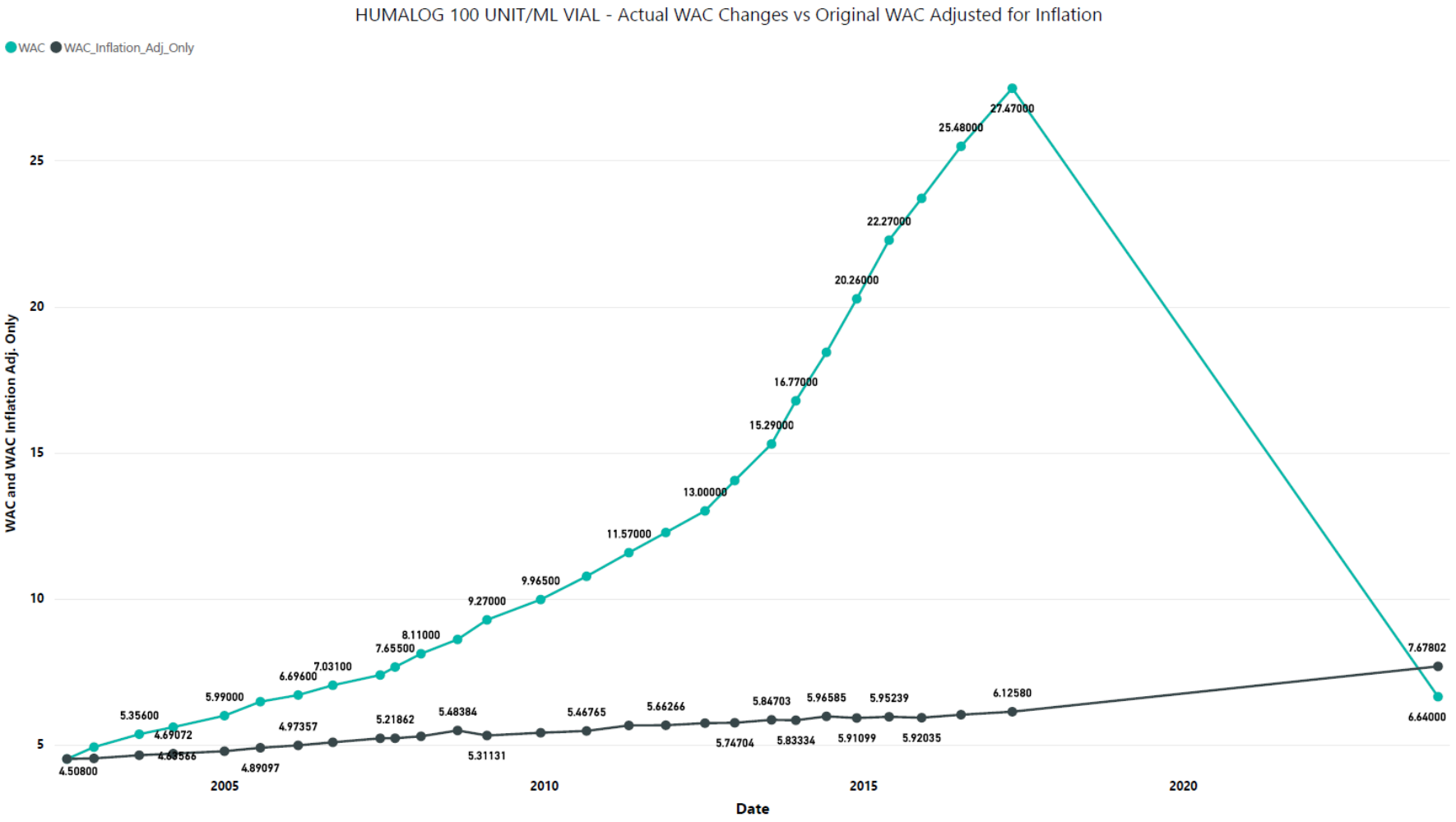
# Congressional Changes

- Average Manufacturer Price (AMP) cap removal caused increase in net spend



# Congressional Changes – AMP Visual

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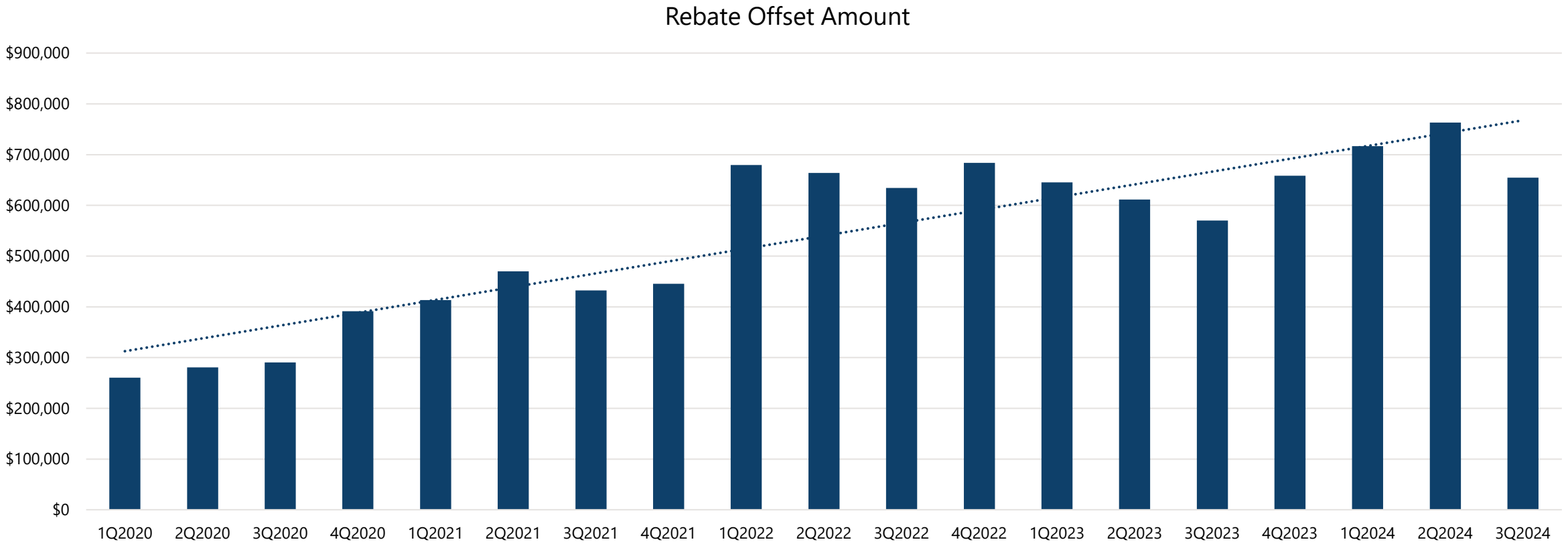
# Congressional Changes

- CMS Unit Rebate Offset Amount Increasing (portion of the rebate collection that is 100% federal share); Complicates Evaluation of Coverage

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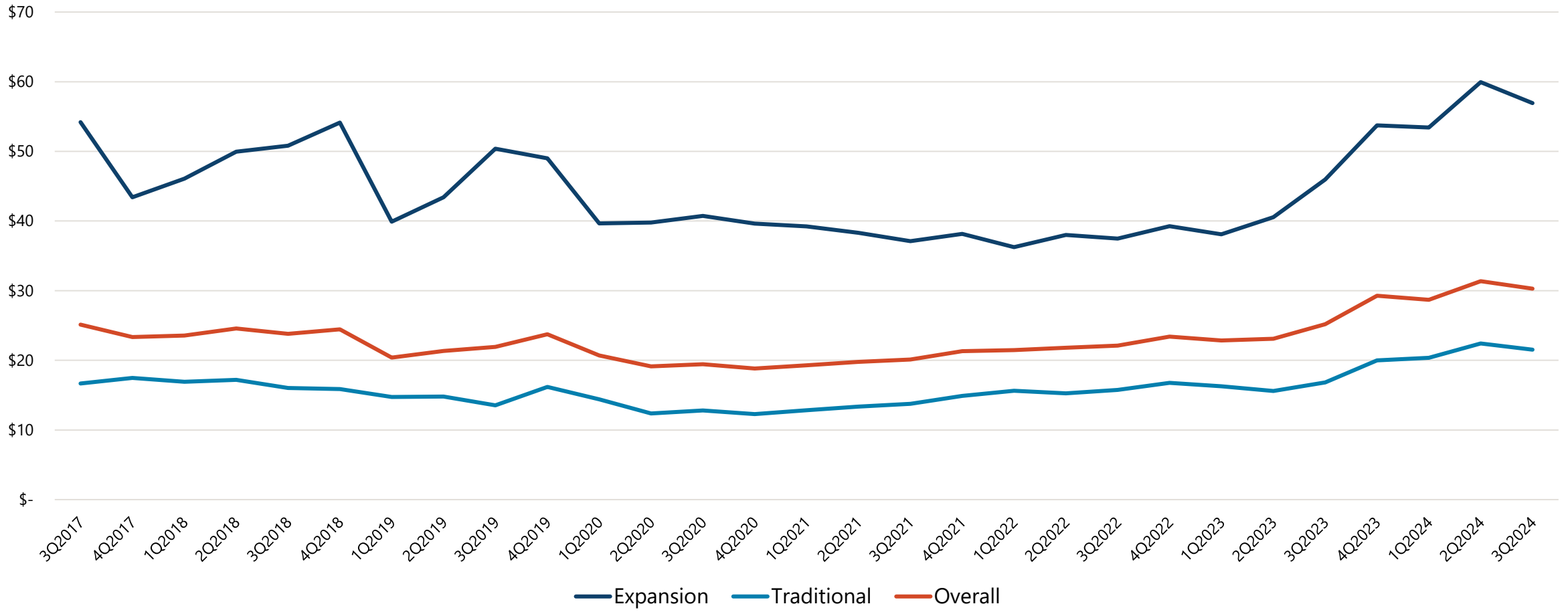
# Cost Per Member Per Month (PMPM) Climbing

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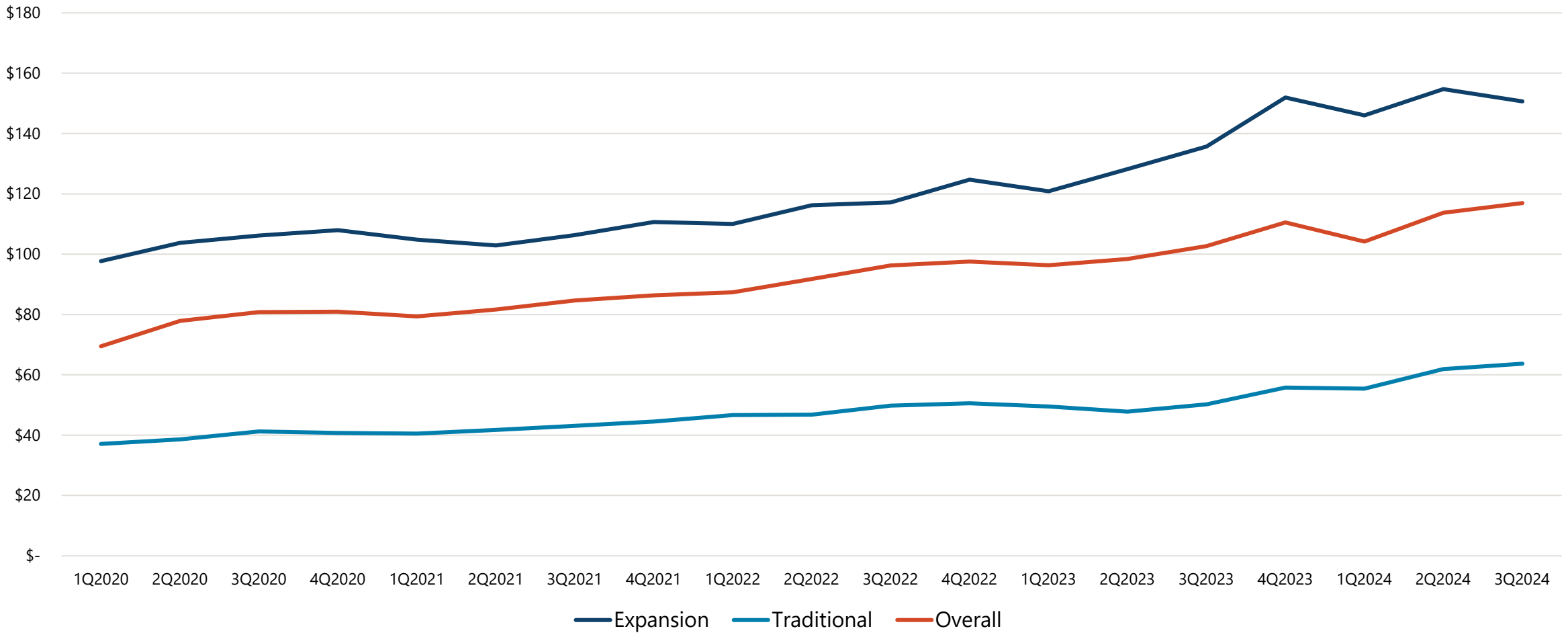
# Cost Per Utilizer Per Month (PUPM) Climbing

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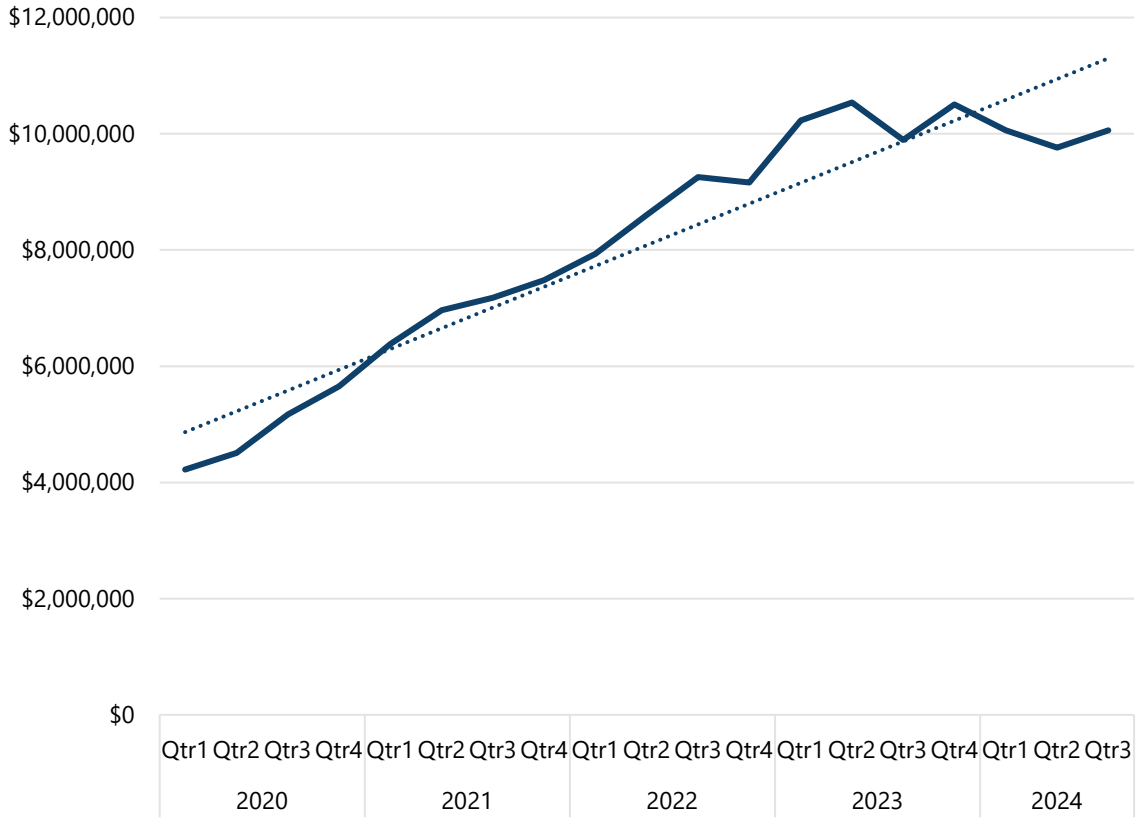
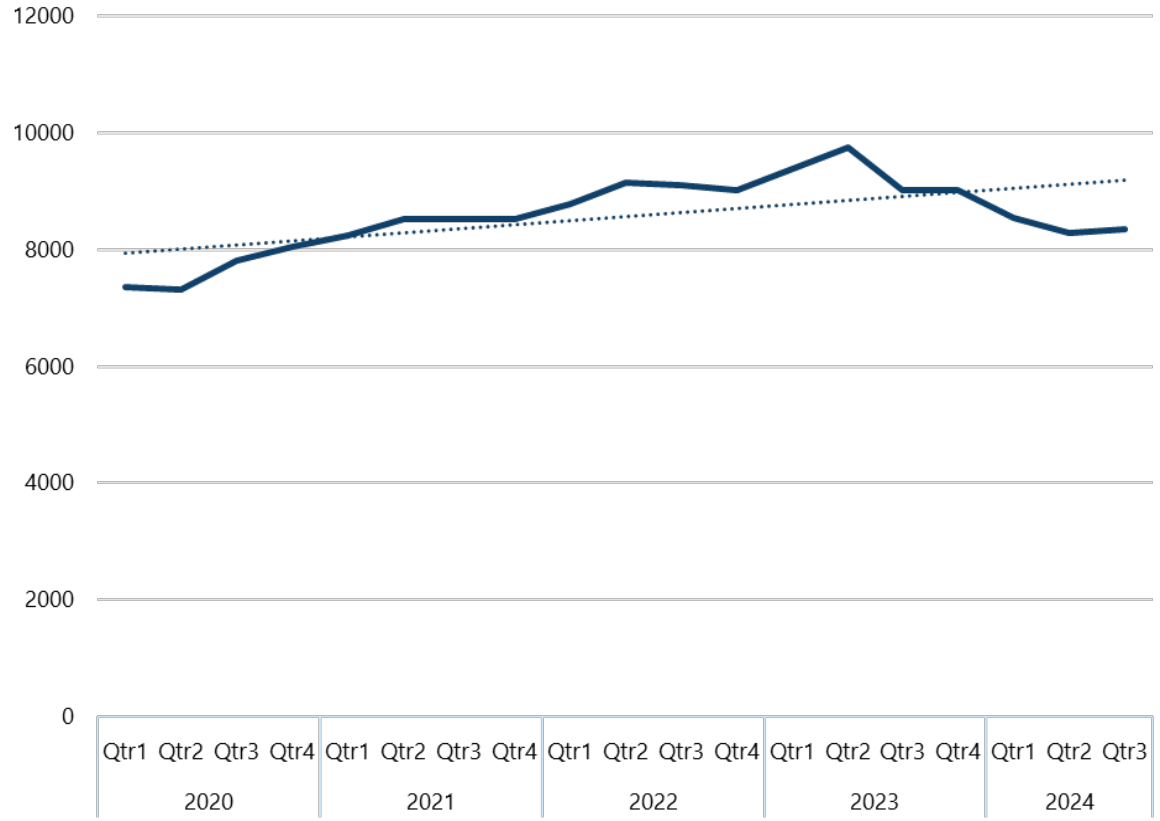
# Spend Increasing Faster Than Member Growth

- Cystic Fibrosis, Immunomodulators, Migraine, Non-Insulin Diabetes, Pulmonary Hypertension, Tardive Dyskinesia

Spend increased by 138% ($6 million per quarter)




Claims increased by 14%

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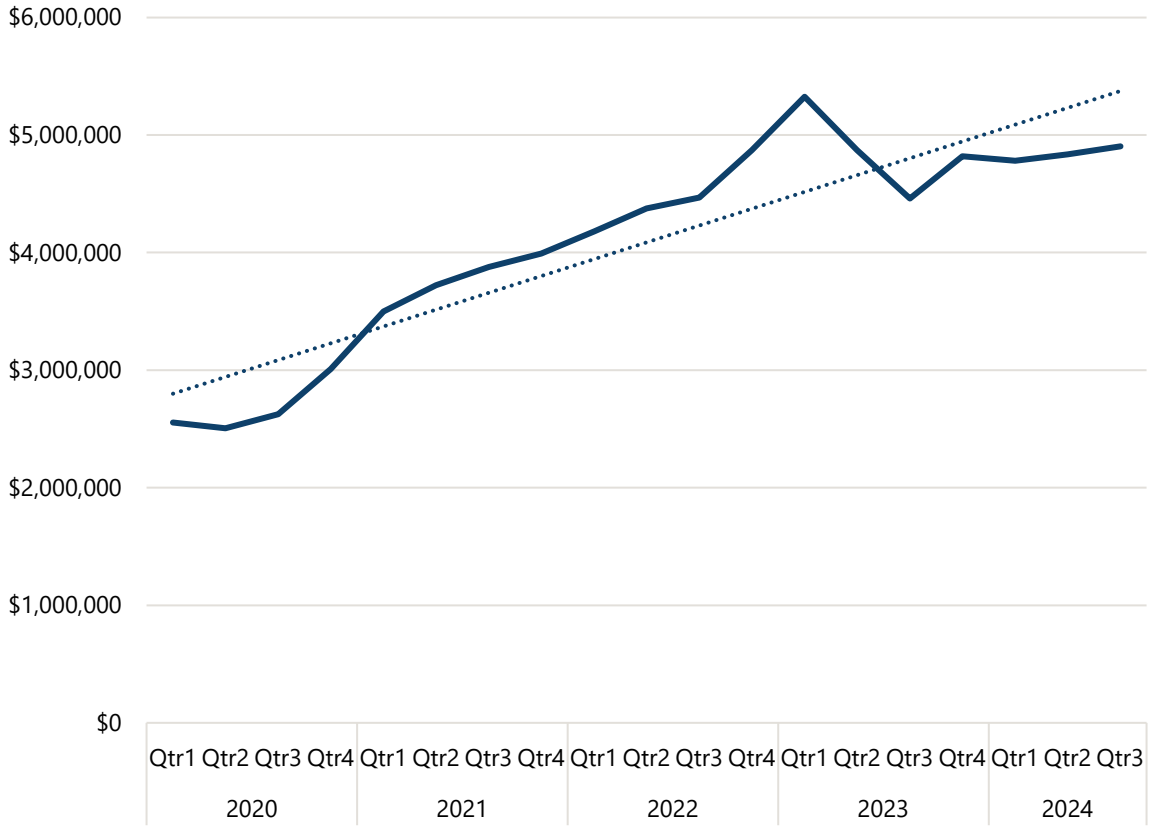
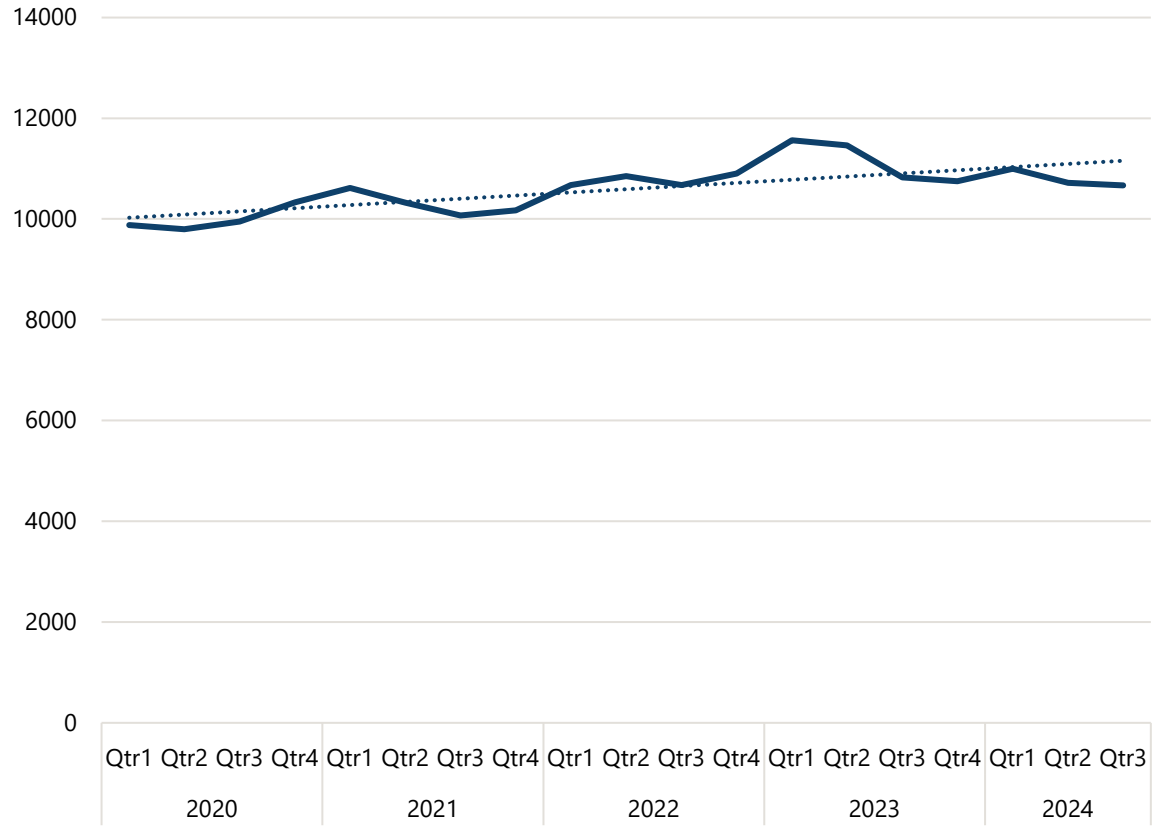
# Spend Increasing Faster Than Member Growth

- Antipsychotics, HIV, Oncology (Excluded Prior Authorization Classes)

Spend increased by 92% ($2.3 million per quarter)




Claims increased by 8%




**Related Bills:**
Senate Bill 2076 | Relating to Prior Authorization

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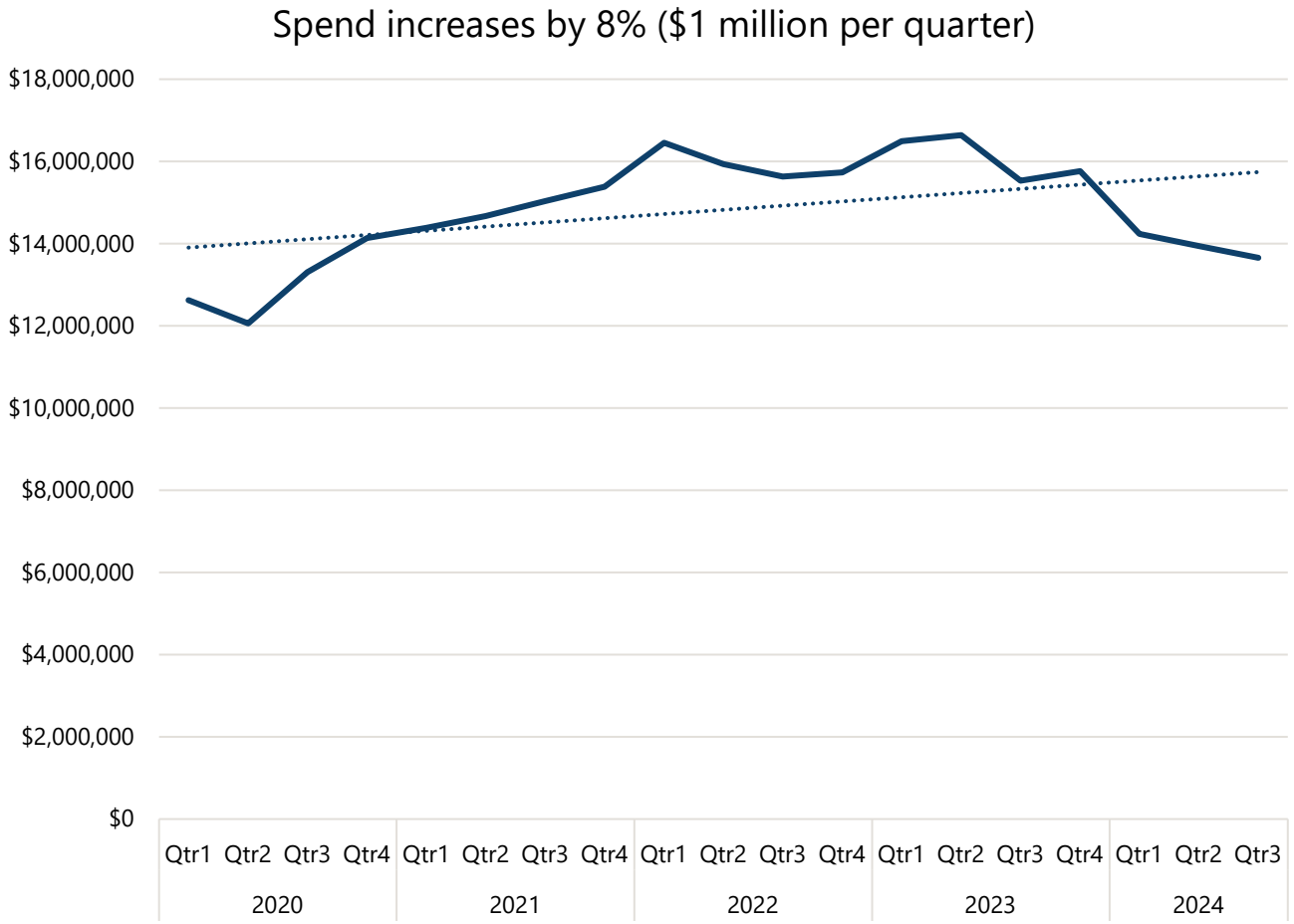
# Spend Increasing Faster than Member Growth

- All Other Classes




| Category | Increase in Spend |
|---|---|
| 3 Excluded Classes | 92% |
| 6 Cost Driver Classes | 138% |
| All Other Classes | 8% |

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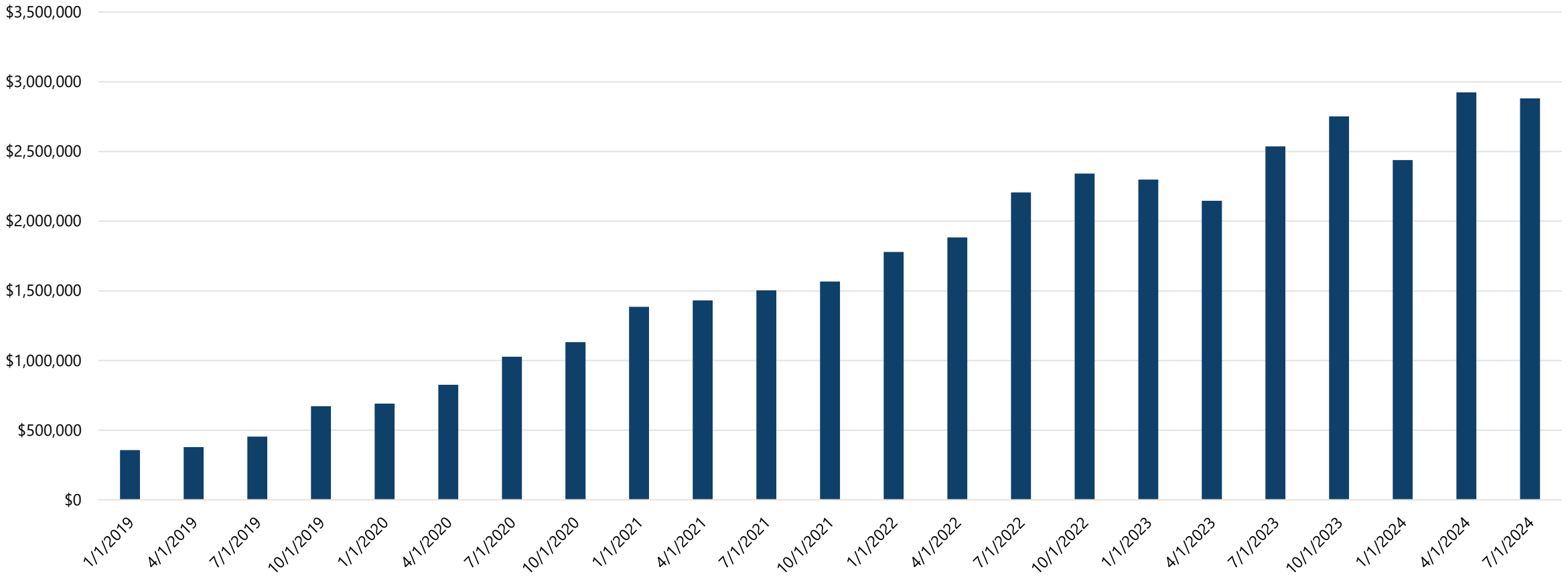
# Spend Increased in Cost Driver Classes

- Post-Rebate Spend increased over 800% in 5+ Cost Driver Classes

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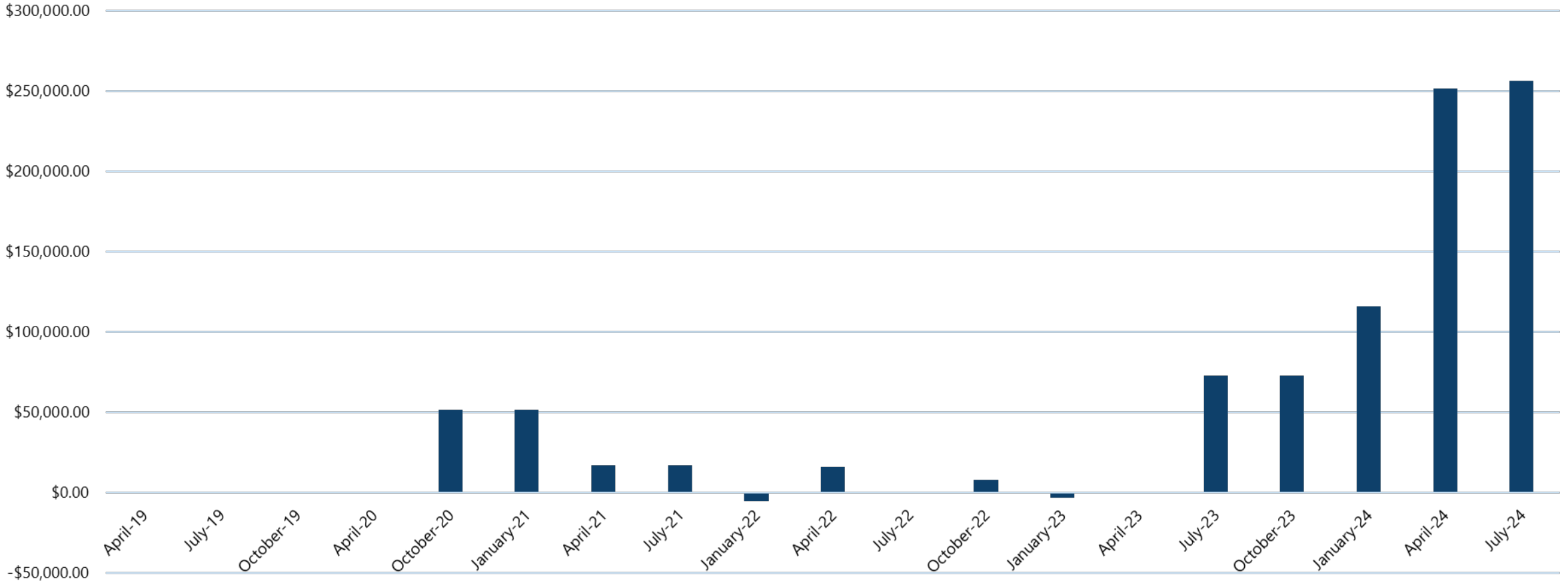
# Spend Increased for Rare Disease Classes

- Post-rebate spend for rare disease classes increased to $250,000 per quarter

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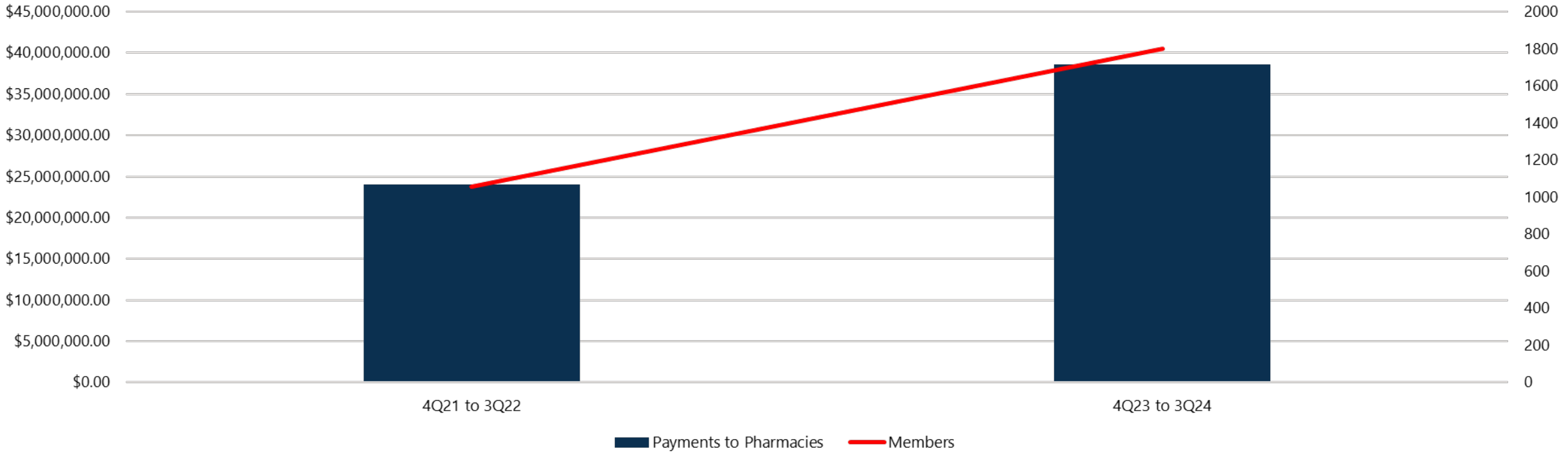
# TV ad spending in 2023

1. Skyrizi - $383.7 million (plaque psoriasis, psoriatic arthritis, Chron's disease, ulcerative colitis)
2. Rinvoq ER - $351.1 million (4 types of arthritis, Chron's and UC, others)
3. Dupixent - $307.2 million (COPD, asthma, atopic dermatitis, others)
4. Jardiance - $146.7 million (type 2 diabetes, heart failure and kidney disease protection)
5. Rexulti - $141.2 million (antipsychotic class, major depressive disorder, agitation with dementia assoc with Alzheimer's)
6. Sotyktu - $132.5 million (plaque psoriasis)
7. Ozempic - $130.3 million (type 2 diabetes)
8. Vraylar - $126.6 million (antipsychotic class, bipolar 1, major depressive disorder)
9. Mounjaro - $114.8 million (type 2 diabetes)
10. Trelegy – $114.4 million (COPD, asthma)

# Areas of Focus – Hyper Cost Drugs

For the same 50 hyper-cost drugs

- Over $24.0 million spend for 1058 members in 4Q21 to 3Q22
- Over $38.5 million spend for 1799 members in 4Q23 to 3Q24

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# Areas of Focus – Hyper Cost Drugs

- These 50 hyper-cost drugs make up 33.7% of the drug budget (4Q23 to 3Q24)
  - Antipsychotics (Caplyta, Long-acting injectable aripiprazole, paliperidone and risperidone, Lybalvi, Rexulti, Vraylar)
    - Over $9.5 million for 1116 members
  - Cystic Fibrosis (Kalydeco, Orkambi, Trikafta)
    - Over $3.3 million for 21 members
  - Hemophilia (Jivi)
    - Over $800,000 for 1 member
  - Hepatitis C (sofosbuvir-velpatasvir)
    - Over $3.2 million for 144 members

# Areas of Focus – Hyper Cost Drugs (cont.)

- HIV (Biktarvy, Dovato, Genvoya, Triumeq)
  - Over $2.6 million for 123 members
- Immunomodulators (Cosentyx, Dupixent, Rinvoq ER, Skyrizi, Stelara, Taltz, Tremfya)
  - Over $10.6 million for 247 members
- Multiple Sclerosis (Kesimpta)
  - Over $600,000 for 7 members
- Opioid Use Disorder (Brixadi, Sublocade)
  - Over $1.2 million for 171 members

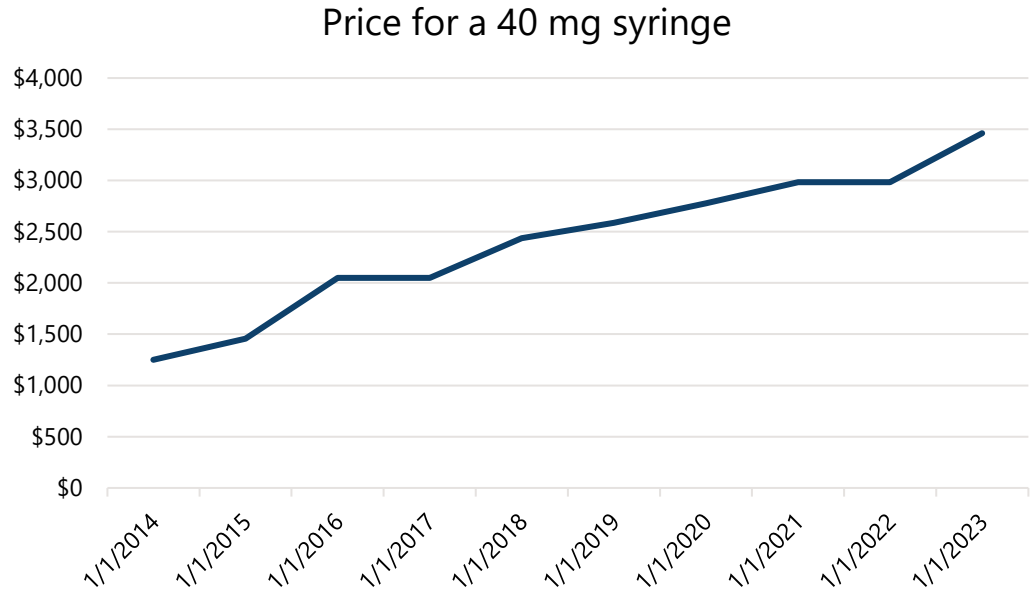
# Areas of Focus – Hyper Cost Drugs (cont.)

- Oncology (Imbruvica, Inlyta, Lonsurf, Lyparza, Revlimid, Tagrisso, Tibsovo, Xtandi, Xejula)
  - Over $1.9 million for 18 members
- Pulmonary Hypertension (Adempas, Remodulin, Tyvaso, Uptravi)
  - Over $800,000 for 8 members
- Tardive Dyskinesia (Austedo, Ingrezza)
  - Over $1.7 million for 32 members
- Others (Daybue, Epidiolex, Gattex, Hizentra, Koselugo, Ocaliva, Oxervate, Prevymis, Winrevair)
  - Over $2 million for 33 members

# Areas of Focus – Drug Price Increases

- Indication Expansion and Interval Creep

  Humira has increased its price by 177% since 2014 despite having 11 indication expansions and interval creep
  - 2009 FDA approved for 40 mg every 2 weeks
  - 2025 compendia supported for 80 mg every week
  - With interval creep – **potential spend has increased by over 1000%**




| Year | Dosing schedule | Annual Cost |
|---|---|---|
| 2014 | 40 mg every 2 weeks | $32,533.93 |
| 2025 | 80 mg every week | $359,977.02 |

# Areas of Focus – Drug Price Increases (cont.)

- Indication Expansion and Interval Creep

Stelara has increased its price by 130% since 2013 despite having 6 indication expansions and interval creep

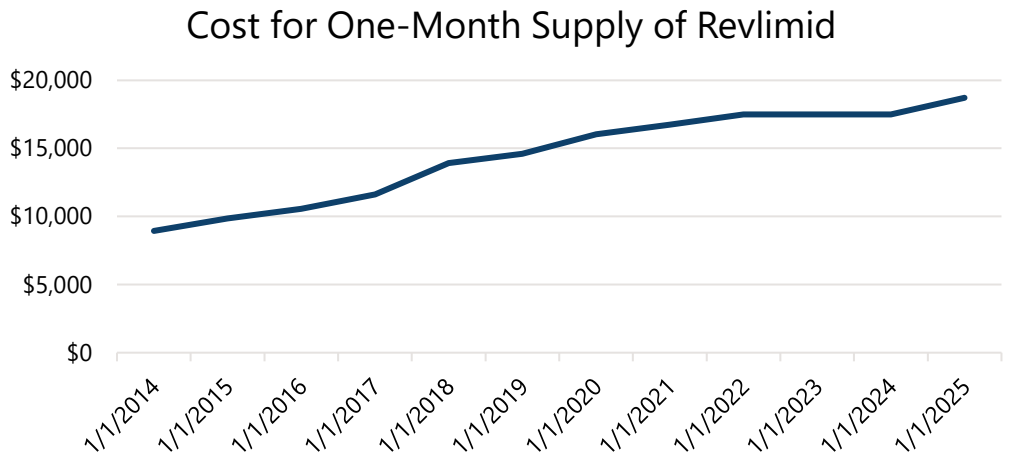
- 2009 FDA approved for every 12-weeks
- 2016 FDA approved for every 8-weeks
- 2024 compendia supported for every 4-weeks
- With interval creep – **potential spend has increased by almost 700%**

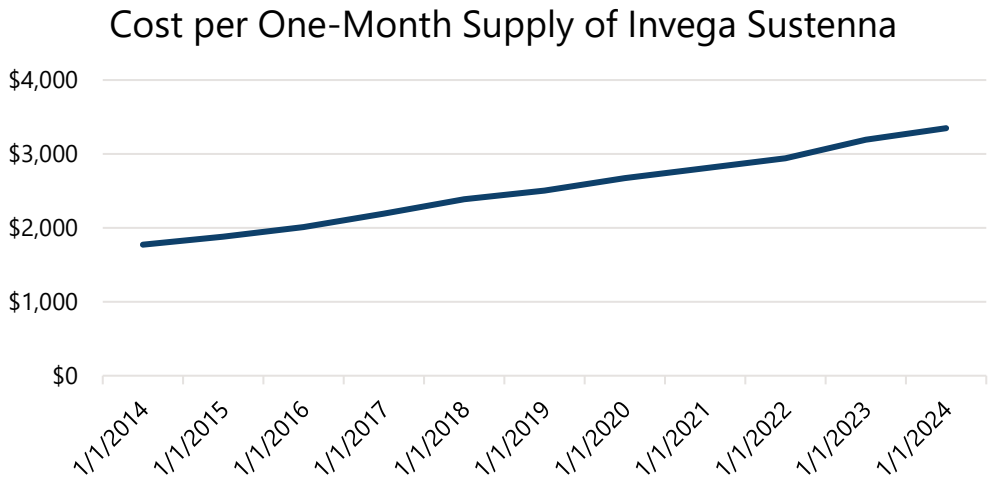
| Year | Dosing schedule | Annual Cost |
|---|---|---|
| 2013 | every 12-week dosing | $52,311.48 |
| 2025 | every 4-week dosing | $361,957.05 |

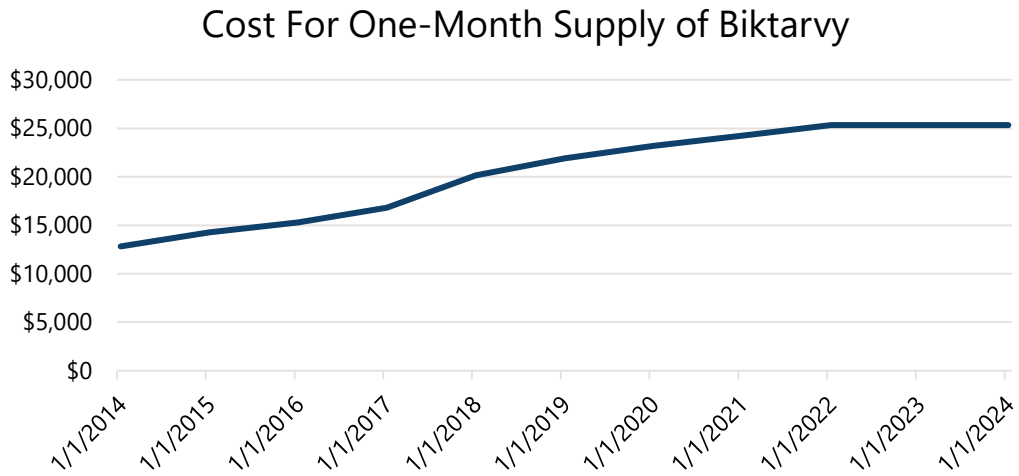
Cosentyx has received 6 indication expansions since 2015 and has increased its price by over 116%
Dupixent has received 13 indication expansions since 2017 and has increased its price by over 33%

# Areas of Focus – Drug Price Increases

- Drug price increases of drugs are also notable in prior authorization excluded classes – Antipsychotics, HIV and Oncology

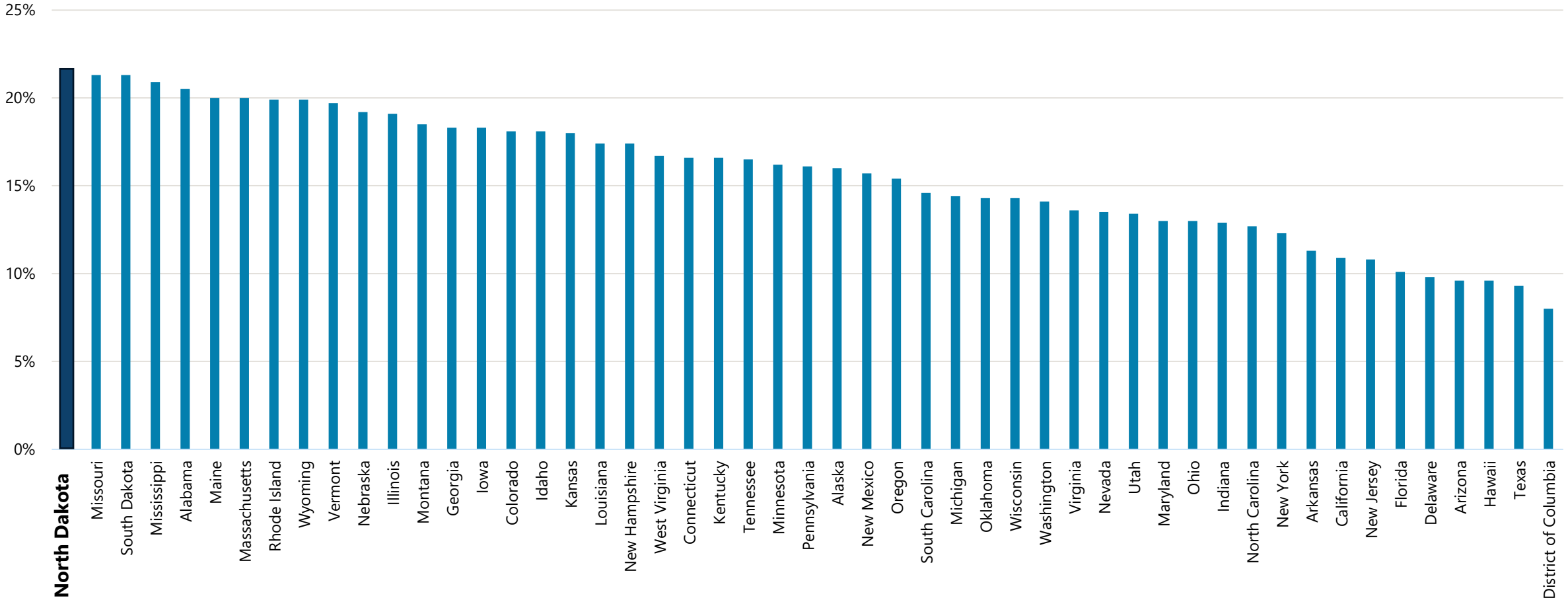


# Areas of Focus – Core Measures

Percentage of Long-Stay Nursing Home Residents Who Received an Antipsychotic Medication – FFY 2023




Note: Lower is better

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# Areas of Focus – Accelerated Approval

- Approved off surrogate endpoints rather than clinical outcomes, so confirmatory trials are necessary to establish efficacy and safety

- According to a 2022 Office of Inspector General Report:
  - 278 drugs have been granted accelerated approval as of 2021
    - 13% have been withdrawn
    - 34% of accelerated approval drugs have at least one confirmatory trial past its original planned complete date
    - $3.6 billion has been spent nationally from Medicaid from 2018 to 2021 on 18 of the drugs with delayed confirmatory trials

# Areas of Focus – Accelerated Approval (cont.)

- Exondys 51 –
  - Approved in 2016 for Duchenne Muscular Dystrophy based on trials involving a total of 12 patients on Exondys 51 with continued approval based on verification of confirmatory trials
  - Failed to show difference in clinical outcome from placebo and external control group, median increase in dystropin levels after 48 weeks was 0.1%
  - Confirmatory trial results expected end of 2026 (original deadline 2020)
  - Annual Cost: $1.2 million for a 50 kg (110 lb) child

- Oxbryta –
  - FDA approved in 2019 for Sickle Cell Disease for the surrogate endpoint of increased hemoglobin
  - Removed from market in 2024 after showing a higher number of deaths than placebo
  - Annual Cost: $125,000

# Summary

- Drugs continue to get more expensive due to many factors:
  - New drugs continue to list at higher and higher prices
  - The drugs being used are more expensive as newer more effective drugs are available
  - Many more cell and gene therapies are coming with limited opportunity for value-based agreements
  - More drugs are being approved for rare diseases and oncology at very expensive list prices, some without evidence of efficacy
  - Congressional changes (AMP cap removal and increased offset amounts)
  - Shortages

- Tools to minimize growth in spend:
  - Finding rebate opportunities
  - Utilization management
  - Eliminating fraud, waste, or abuse potential

**Related Bills:**
House Bill 1451 | Relating to medical assistance prescription drug benefits for antiobesity medication

# 2025 – 2027 Budget & Other Resource Requirements

Medical Services

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# Decision Package Detail

## By Ongoing, One-Time and Funding Source

| Decision Package | Decision Package Grouping | General | Federal | Total | |
|---|---|---|---|---|---|
| Private Duty Nursing & Home Health Targeted Rate Increase[1] | Services - DOJ | $1,235,768 | $1,235,768 | $2,471,536 | Ongoing |
| Cross Disability Waiver Implementation | Services – Home and Community Based Services (HCBS) | $2,474,226 | $2,474,226 | $4,948,452 | Ongoing |
| Targeted Medicaid Rate Increase for Ambulance Services | Healthcare Workforce | $2,189,770 | $2,189,770 | $4,379,540 | Ongoing |
| Provider Inflation | Additional Executive Decision Packages | $6,949,693 | $9,266,071 | $16,215,764 | Ongoing |
| | | | | | |
| Value Based Purchasing[2] | Compliance & Quality | $1,000,000 | $1,000,000 | $2,000,000 | Ongoing |

Note:
1. Private Duty Nursing & Home Health Targeted Rate Increase was discussed in Long Term Care Budget slides.
2. Value Based Purchasing is located in the Long Term Care Budget.

# Comparison of budgets and funding

## By Budget Account Code

| DESCRIPTION | 2023-2025 LEGISLATIVE BASE | 2025-27 EXECUTIVE BUDGET RECOMMENDATION | Increase/ (Decrease) |
|---|---|---|---|
| 511x Salaries - Regular | $ 13,729,287 | $ 16,077,000 | $ 2,347,713 |
| 513x Salaries Temp | 1,307,533 | 1,277,132 | (30,401) |
| 516x Salaries Benefits | 5,971,524 | 7,446,311 | 1,474,787 |
| **Total Salaries & Benefits** | **$ 21,008,344** | **$ 24,800,444** | **$ 3,792,100** |
| 52x Travel | 94,824 | 94,824 | - |
| 53x Supply | 20,628 | 24,166 | 3,538 |
| 54x Postage & Printing | 162,889 | 168,714 | 5,825 |
| 55x Equipment under $5,000 | 2,100 | 2,100 | - |
| 58x Rent/Leases - Bldg/Equip | 12,036 | 43,866 | 31,830 |
| 61x Professional Development | 77,192 | 94,489 | 17,297 |
| 62x Fees - Operating & Professional | 70,423,976 | 92,650,619 | 22,226,643 |
| 53x Supplies | 10,334 | 4,724 | (5,610) |
| 60x IT Expenses | 3,997 | 70,089,037 | 70,085,040 |
| 71x Grants, Benefits, & Claims | 1,722,386,862 | 1,615,753,456 | (106,633,406) |
| **Total Operating & Grants** | **$ 1,793,194,838** | **$ 1,778,925,995** | **$ (14,268,843)** |
| **Total** | **$ 1,814,203,182** | **$ 1,803,726,439** | **$ (10,476,743)** |
| | | | |
| **Total General** | **$ 471,540,015** | **$ 488,714,780** | **$ 17,174,765** |
| **Total Federal** | **$ 1,283,426,536** | **$ 1,254,437,540** | **$ (28,988,996)** |
| **Total Other** | **$ 59,236,632** | **$ 60,574,119** | **$ 1,337,487** |

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# Operating Schedule

| DESCRIPTION | 2023-25 BIENNIUM AMOUNT | INCREASE/ (DECREASE) | 2025-27 EXECUTIVE BUDGET RECOMMENDATION | | | |
|---|---|---|---|---|---|---|
| | | | TOTAL | GENERAL FUND | FEDERAL FUND | OTHER FUND |
| Customer Support Contracts | $ 3,432,000 | $ 810,810 | $ 4,242,810 | $ 4,242,810 | $ - | |
| Direct Service Support Contracts | 1,086,895 | $ 595,130 | 1,682,025 | 841,013 | 841,013 | - |
| Federally Required Activity Contracts | 13,456,994 | $ 8,865,307 | 22,322,301 | 10,418,289 | 11,904,012 | - |
| Professional Services Contracts | 6,202 | $ 1,798 | 8,000 | 4,000 | 4,000 | - |
| Quality Improvement Contracts | 945,108 | $ 162,407 | 1,107,515 | 643,453 | 464,063 | - |
| Quality Improvement (one-time) Contracts | 1,861,657 | $ - | 1,861,657 | 1,861,657 | - | - |
| Subject Matter Expert Contracts | 1,987,726 | $ 1,144,757 | 3,132,483 | 1,566,242 | 1,566,242 | - |
| Clawback | 49,291,723 | $ 9,002,105 | 58,293,828 | 58,293,828 | - | - |
| | - | $ - | - | - | - | - |
| **GENERAL FUND** | **$ -** | **$ -** | **$ 77,871,291** | **$ 77,871,291** | **$ -** | **$ -** |
| **FEDERAL FUND** | **-** | **14,779,329** | **14,779,329** | **-** | **14,779,329** | **-** |
| **OTHER FUND** | **-** | **-** | **-** | **-** | **-** | **-** |
| **GRAND TOTAL** | **$ 72,068,305** | **$ 20,582,314** | **$ 92,650,619** | **$ 77,871,291** | **$ 14,779,329** | **$ -** |

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# Grants Schedule

| DESCRIPTION | 2023-25 BIENNIUM AMOUNT | INCREASE/ (DECREASE) | 2025-27 EXECUTIVE BUDGET RECOMMENDATION TOTAL | GENERAL FUND | FEDERAL FUND | OTHER FUND |
|---|---|---|---|---|---|---|
| County Jail Claims | $ 1,000,000 | $ - | 1,000,000 | $ - | $ - | $ 1,000,000 |
| Health Tracks | 127,804 | - | 127,804 | 63,902 | 63,902 | - |
| **GENERAL FUND** | **$ 63,902** | **$ -** | **$ 63,902** | **$ 63,902** | **$ -** | **$ -** |
| **FEDERAL FUND** | **63,902** | **-** | **63,902** | **-** | **63,902** | **-** |
| **OTHER FUND** | **1,000,000** | **-** | **1,000,000** | **-** | **-** | **1,000,000** |
| **GRAND TOTAL** | **$ 1,127,804** | **$ -** | **$ 1,127,804** | **$ 63,902** | **$ 63,902** | **$ 1,000,000** |

# Grants on a Walkthrough

| DESCRIPTION | 2025-27 BASE BUDGET | COST TO CONTINUE | FMAP | SAVINGS PLAN | UNDERFUNDING | TOTAL CHANGES | TO GOVERNOR |
|---|---|---|---|---|---|---|---|
| TRADITIONAL MEDICAID | $ 918,642,286 | $ 45,160,756 | $ (3,913,031) | $ (8,709,580) | $ (28,930,539) | $ 3,607,606 | $ 922,249,892 |
| INPATIENT HOSPITAL | 227,650,273 | 3,082,453 | - | - | - | 3,082,453 | 230,732,726 |
| OUTPATIENT HOSPITAL | 125,343,902 | 131,436 | - | - | - | 131,436 | 125,475,338 |
| PROFESSIONAL SERVICES | 137,991,523 | 10,212,973 | - | - | - | 10,212,973 | 148,204,496 |
| DRUGS | 84,898,305 | 3,344,118 | - | (1,500,000) | - | 1,844,118 | 86,742,423 |
| INDIAN HEALTH SERVICES | 58,583,364 | 33,871,506 | - | - | - | 33,871,506 | 92,454,870 |
| PRTF SERVICES | 24,340,239 | (3,368,924) | - | - | - | (3,368,924) | 20,971,315 |
| DENTAL SERVICES | 36,094,013 | 81,672 | - | - | - | 81,672 | 36,175,685 |
| PREMIUMS | 54,734,853 | 1,960,057 | - | - | - | 1,960,057 | 56,694,910 |
| OTHER SERVICES | 169,005,814 | (4,154,535) | (3,913,031) | (7,209,580) | (28,930,539) | (44,207,685) | 124,798,129 |
| EXPANSION MEDICAID | 802,616,834 | (140,517,494) | - | - | - | (140,517,494) | 662,099,340 |
| **TOTAL FUNDS** | **$ 1,721,259,120** | **$ (95,356,738)** | **$ (3,913,031)** | **$ (8,709,580)** | **$ (28,930,539)** | **$ (136,909,888)** | **$ 1,584,349,232** |
| **GENERAL FUND** | **$ 408,309,812** | **$ (6,464,511)** | **$ 15,065,244** | **$ (450,000)** | **$ (28,930,539)** | **$ (20,779,806)** | **$ 387,530,006** |

| DESCRIPTION | TO GOVERNOR | INFLATION | SERVICES - COST TO CONTINUE | SERVICES- DOJ | HEALTHCARE WORKFORCE | TOTAL CHANGES | TO HOUSE |
|---|---|---|---|---|---|---|---|
| TRADITIONAL MEDICAID | $ 922,249,892 | $ 16,215,764 | $ 7,209,580 | $ 2,471,536 | $ 4,379,540 | $ 30,276,420 | $ 952,526,312 |
| INPATIENT HOSPITAL | 230,732,726 | 4,703,996 | - | - | - | 4,703,996 | 235,436,722 |
| OUTPATIENT HOSPITAL | 125,475,338 | 1,646,360 | - | - | - | 1,646,360 | 127,121,698 |
| PROFESSIONAL SERVICES | 148,204,496 | 3,349,422 | - | - | - | 3,349,422 | 151,553,918 |
| DRUGS | 86,742,423 | - | - | - | - | - | 86,742,423 |
| INDIAN HEALTH SERVICES | 92,454,870 | 2,099,873 | - | - | - | 2,099,873 | 94,554,743 |
| PRTF SERVICES | 20,971,315 | 473,952 | - | - | - | 473,952 | 21,445,267 |
| DENTAL SERVICES | 36,175,685 | 817,570 | - | - | - | 817,570 | 36,993,255 |
| PREMIUMS | 56,694,910 | - | - | - | - | - | 56,694,910 |
| OTHER SERVICES | 124,798,129 | 3,124,592 | 7,209,580 | 2,471,536 | 4,379,540 | 17,185,248 | 141,983,377 |
| EXPANSION MEDICAID | 662,099,340 | - | - | - | - | - | 662,099,340 |
| **TOTAL FUNDS** | **$ 1,584,349,232** | **$ 16,215,764** | **$ 7,209,580** | **$ 2,471,536** | **$ 4,379,540** | **$ 30,276,420** | **$ 1,614,625,652** |
| **GENERAL FUND** | **$ 387,530,006** | **$ 6,949,693** | **$ -** | **$ 1,235,768** | **$ 2,189,770** | **$ 10,375,231** | **$ 397,905,237** |

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# Comparison of budget expenditures and projections

## By Budget Account Code

| DESCRIPTION | 2023-25 LEGISLATIVE BASE | Expended as of 12/31/2024 | PROJECTION THROUGH 6/30/2025 | UNDER/(OVER) BUDGET |
|---|---|---|---|---|
| 511x Salaries - Regular | $ 13,729,287 | $ 10,037,320 | $ 13,702,435 | $ 26,852 |
| 513x Salaries Temp | 1,307,533 | 572,729 | 1,250,080 | 57,453 |
| 514x Salaries Overtime | - | 79,463 | 79,463 | (79,463) |
| 516x Salaries Benefits | 5,971,524 | 4,662,337 | 6,531,713 | (560,189) |
| **Total Salaries & Benefits** | **$ 21,008,344** | **$ 15,351,849** | **$ 21,563,691** | **$ (555,347)** |
| 52x Travel | 94,824 | 70,220 | 112,975 | (18,151) |
| 53x Supply | 20,628 | 5,530 | 11,866 | 8,762 |
| 54x Postage & Printing | 162,889 | 71,960 | 132,125 | 30,764 |
| 55x Equipment under $5,000 | 2,100 | 1,615 | 2,665 | (565) |
| 58x Rent/Leases - Bldg/Equip | 12,036 | 34,717 | 45,679 | (33,643) |
| 61x Professional Development | 77,192 | 69,830 | 88,513 | (11,321) |
| 62x Fees - Operating & Professional | 70,423,976 | 48,881,778 | 74,403,826 | (3,979,850) |
| 53x Supplies | 14,331 | 5,433 | 12,440 | 1,891 |
| 71x Grants, Benefits, & Claims | 1,722,386,862 | 1,113,295,489 | 1,559,610,024 | 162,776,838 |
| **Total Operating & Grants** | **$ 1,793,194,838** | **$ 1,162,436,570** | **$ 1,634,420,112** | **$ 158,774,726** |
| **Total** | **$ 1,814,203,182** | **1,177,788,419** | **$ 1,655,983,803** | **$ 158,219,380** |
| | | | | |
| **Total General** | **$ 471,540,015** | **$ 332,007,548** | **$ 435,257,475** | **$ 36,282,540** |
| **Total Federal** | **$ 1,283,426,536** | **$ 830,447,937** | **$ 1,158,157,412** | **$ 125,269,124** |
| **Total Other** | **$ 59,236,632** | **$ 15,332,933** | **$ 62,568,915** | **$ (3,332,283)** |

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# Legislative Bills with Potential Budget Impact

- HB 1067 – allows Medicaid coverage for otherwise eligible children lawfully present in the US and extends the Autism Spectrum Disorder waiver age to 21.
- HB 1451 – requires Medicaid coverage for antiobesity medication.
- HB 1454 – would prohibit step therapy for medications.
- HB 1464 – requires coverage of doula services in Medicaid & Medicaid Expansion.
- HB 1485 – increases personal needs allowance by $10.
- SB 2096 – creates regional acute psychiatric treatment and residential supportive housing services.
- SB 2190 – mandates coverage of ABA services for a variety of psychological and medical diagnoses.
- SB 2231 – adds select dental services for Medicaid Expansion members.
- SB 2271 – revises adults residential rate methodology.
- SB 2305 – requires Medicaid waivers to include paid family caregiving.
- SB 2316 – requires Medicaid to contract for regional providers for ventilator and psychiatric long term care.

# Summary

Key Budget Drivers & Take Aways

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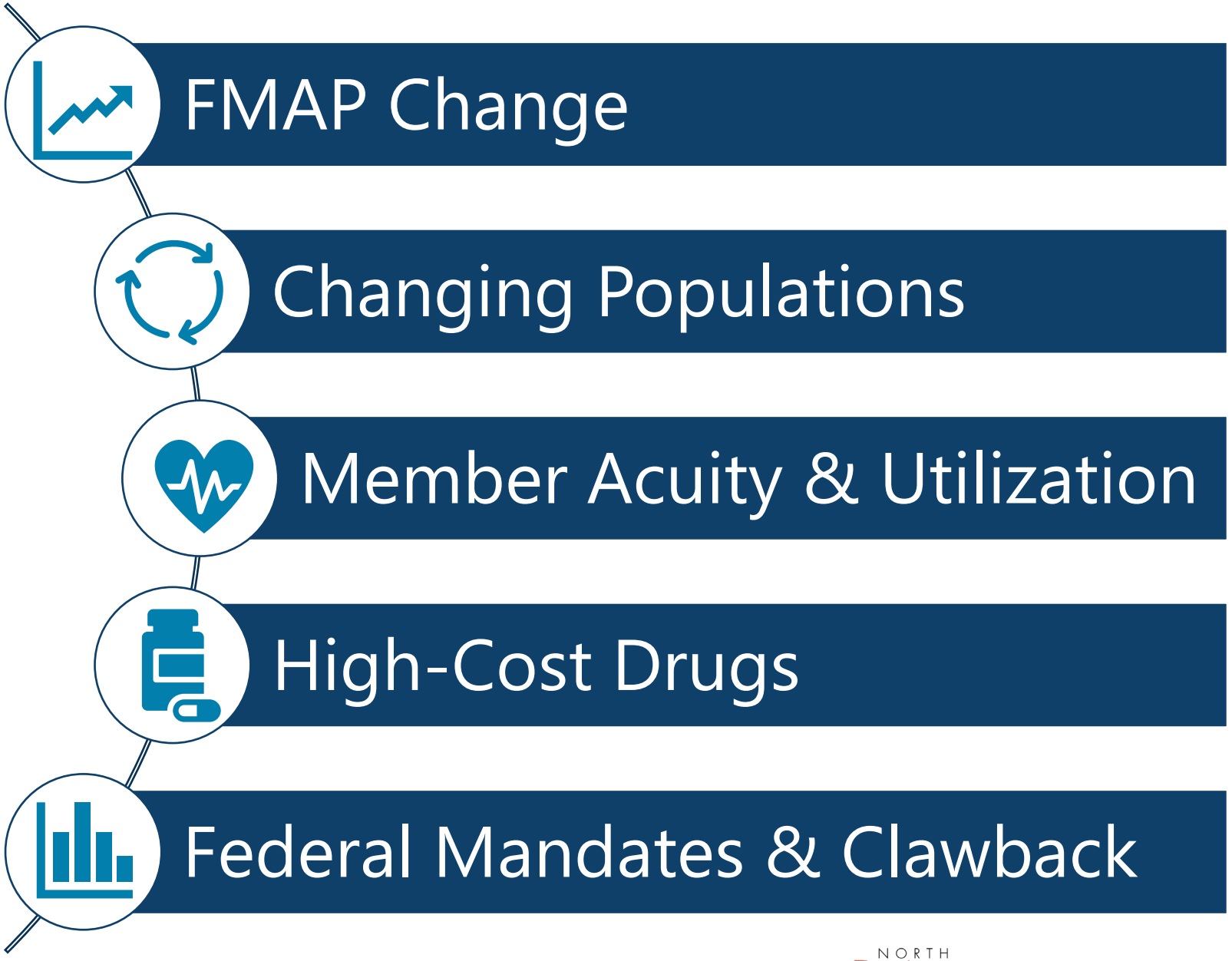
# Key Budget Drivers

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# Take-Aways

- Bending the Cost Curve
  - Value Based Care
- Delivering Whole Person Care
  - Cross Disability Waiver
- Promoting Sustainability & Value
  - Targeted Provider Rate Increases: Home Health and Private Duty Nursing, Qualified Service Providers, Ambulance
- Improving the Member & Provider Experience

# Contact information


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