

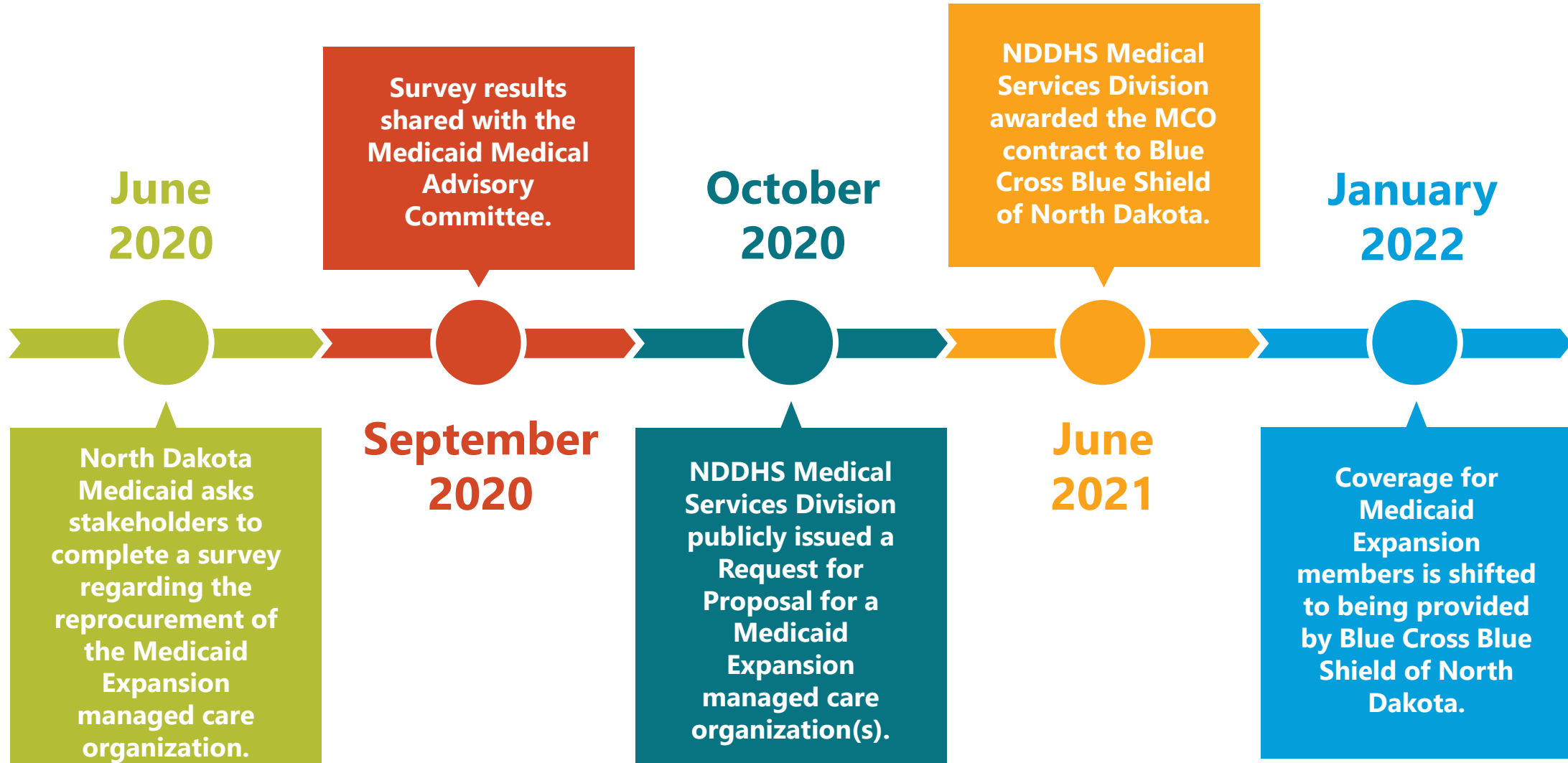


Update on North Dakota Medicaid Expansion Contract

Summary of Legislative Action

- The 2013 Legislative Assembly authorized implementation of Medicaid Expansion (HB 1362) and was signed into law by Governor Dalrymple in April 2013 with coverage effective January 1, 2014.
- In the 2019 legislative session, the Uniform Payment structure was added. This required consistent payment to defined “provider types” and allowed for different payment based on performance as defined by quality of care received. *“The managed care organization under contract with the department to manage the medical assistance expansion program shall reimburse providers within the same provider type and specialty at consistent levels and with consistent methodology and may not provide incentive, quality, or supplemental payments to providers, unless part of a value-based program approved by the department.”*
- In the 2021 session the legislature highlighted quality and value again
 - SB 2135 instructed DHS to start reporting on quality to the legislature
 - HB 1012 included a value based purchasing program for hospitals and reduced the base budget by ~4% (for the traditional fee-for-service program)

Medicaid Expansion Timeline

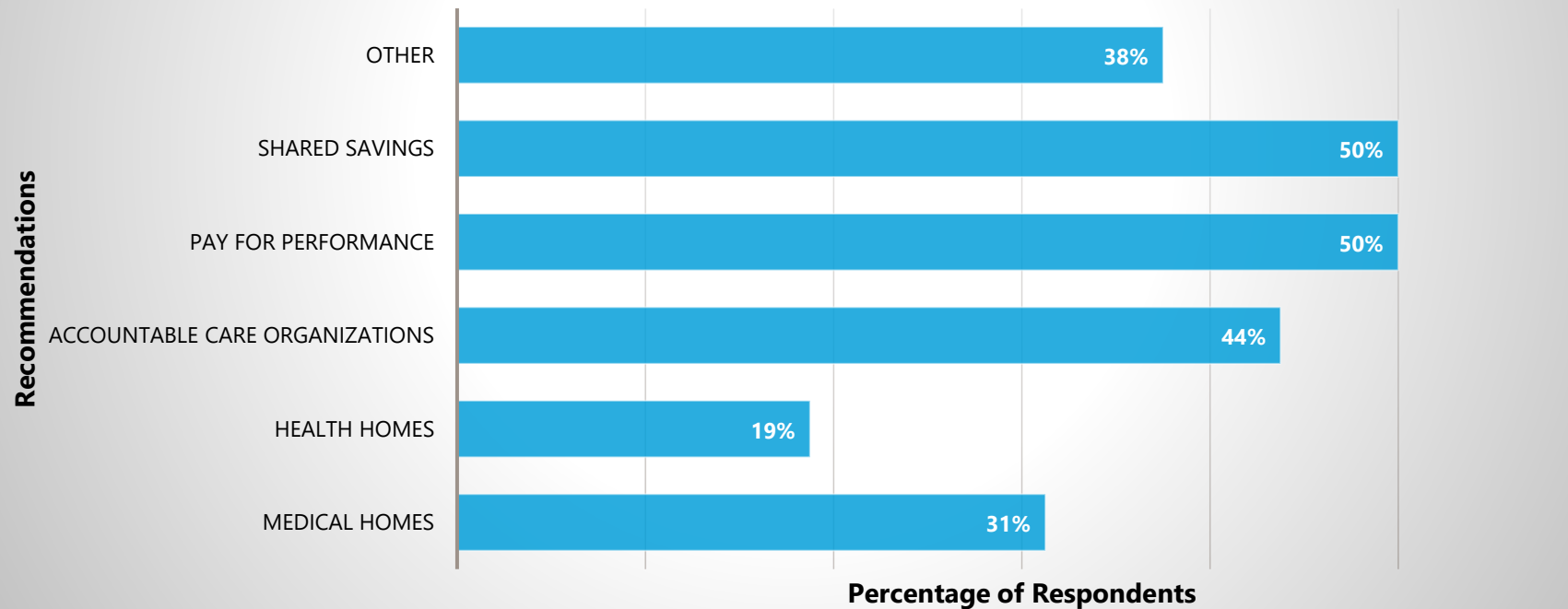


North Dakota Medicaid Expansion Update

Preparing for the Requests for Proposals

- The renewal and extension options of the original contract had all been exhausted as of 31 December 2021. DHS was required therefore to reprocure the contract.
- In preparation for this reprocurement, DHS administered a Managed Care survey to all stakeholders. The survey asked about what they wanted in a new managed care contract and what their capacity was to implement alternative payment models
 - 28 respondents answered and the survey results were presented publicly at the September 2020 MMAC meeting

Many MCOs use value-based purchasing to drive better outcomes in health care. What types of value-based purchasing arrangements has your organization participated in for commercial payers or Medicare? Check all that apply.



*16 out of 28 provided a response

North Dakota Medicaid Expansion Update

Requests for Proposals & Award

- DHS published the Request For Proposals (RFP) and the Model Contract online on October 20, 2020. Anyone, not just bidders, could review these documents at any time.
- The evaluation process specifically awarded points for bidders who had experience in developing and implementing a value-based purchasing program.
- BCBS was awarded the contract on June 7, 2021.
- Between the contract award and January 1, 2022, the following types of activities occurred by DHS:
 - DHS and BCBS finalized the capitation rate
 - Rates were sent to CMS for approval as well as the contract
 - Letters were sent to members about the transition, 19 and 20 year old members were transitioned back to fee-for-service.

North Dakota Medicaid Expansion Update

DHS received many questions on how the Medicaid Expansion program is funded

- DHS proposes an estimated amount to the legislature for the expansion program in the appropriation process.
- DHS' estimation takes the current blended capitation payment, multiplies by the current caseload, and then multipliers are used to forecast the caseload and capitation payment.
- Legally, DHS can exceed the appropriation for increases in expansion program caseload numbers and new services (such as 1915i).
- There is no legal requirement to spend the entire appropriation. DHS can, and has in the past, not spent the total appropriation. When that occurs, all general funds dollars are returned to the general fund.

North Dakota Medicaid Expansion Update

DHS received many questions on how the Medicaid Expansion program is funded

- The State's actuarial firm is not involved in setting the appropriation. The actuarial firm also is not given the appropriation to work from when they enter into rate setting on an annual basis. Therefore, the appropriation (proposed by DHS and approved the by legislature) and the capitation rate (proposed by the actuary and negotiated with the vendor) are not one in the same.
- The blended capitation rate is required to be actuarially sound and based on past experience of our members. It also accounts for any program changes and several trend factors, such as patterns in utilization and cost. Exogenous circumstances are also accounted for, such as paying for the COVID vaccine and the 1915i services.
- The State's actuary and the managed care organization negotiate and agree upon final capitation rates for the effective rating period. Once the managed care organization knows that rate, they use that to negotiate contracts with providers. These negotiations and discussions are proprietary and confidential and are only between the provider and the plan. Anti-trust laws do not allow for collaboration among providers.

NDDHS RFP Vision for Managed Care

- Effectively and efficiently provide health care coverage to Medicaid Expansion (ME) members in a manner that **exceeds** State and federal requirements and standards;
- Improve health outcomes for the enrolled ME population, including through **high-touch care management**;
- Deliver high-quality, evidence-based care that is **cost-effective**;
- Utilize a **whole-person approach** to care that addresses physical, behavioral, and social risk factors to positively affect individuals' health; and,
- Employ innovative approaches to delivering and paying for services, including **value-added services**.

Definition of Managed Care

- Managed Care is a health care delivery system organized **to manage cost, utilization, and improve quality.**
- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a **negotiated per member per month** (capitation) payment for these services.
- By contracting with MCOs to deliver Medicaid health care services to their members, states can better manage utilization of health services and take advantage of MCO's experience in payment and care innovations.

How Medicaid Managed Care Works



JENNIFER

AGE: 38

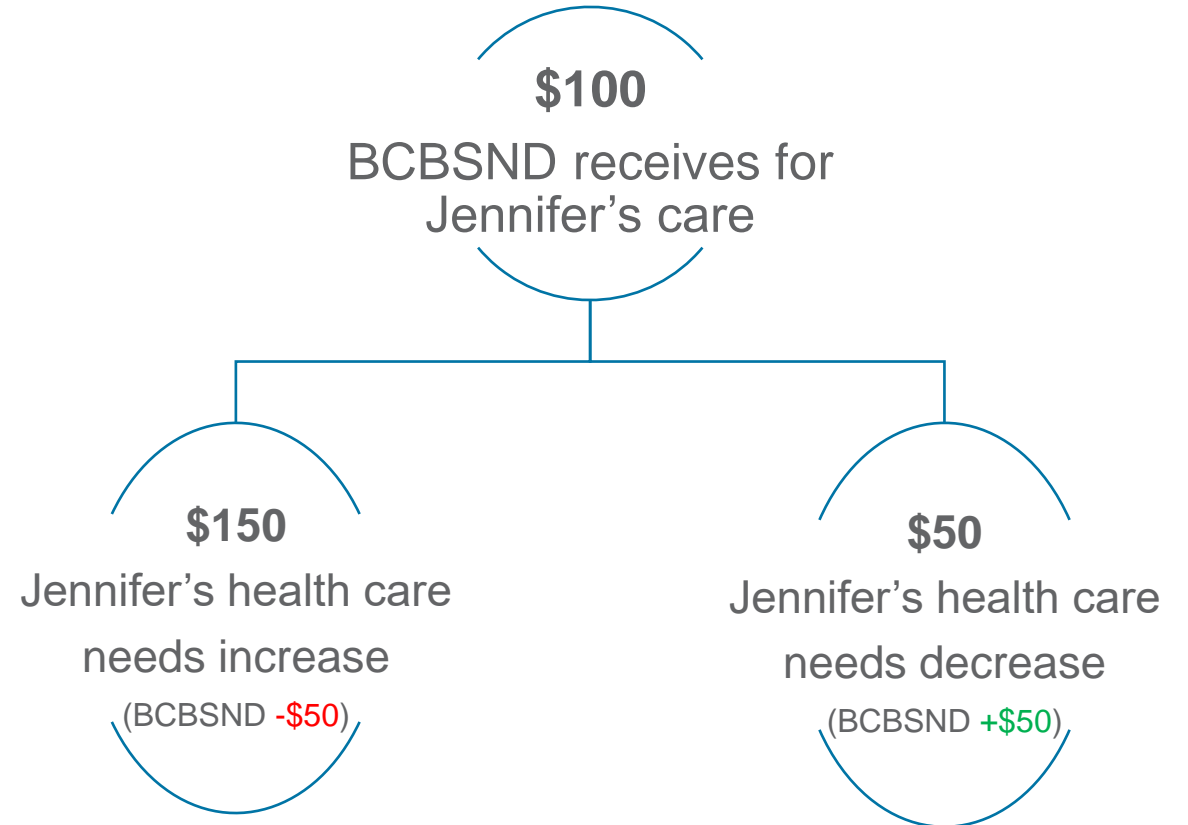
RESIDENCE: Streeter, ND

MEET JENNIFER

- Residing in Streeter, North Dakota, Jennifer has multiple health issues, including Hepatitis C, diabetes, hypertension, depression, multiple ER visits for pain, and back problems.
- She had two pregnancies complicated by hypertensive disease of pregnancy.
- There are no physical therapy services available in the member's immediate area.
- Complicated home life with no access to quality childcare.
- Jennifer has been receiving pain management through her primary care physician for several years and her PCP is recommending surgery.

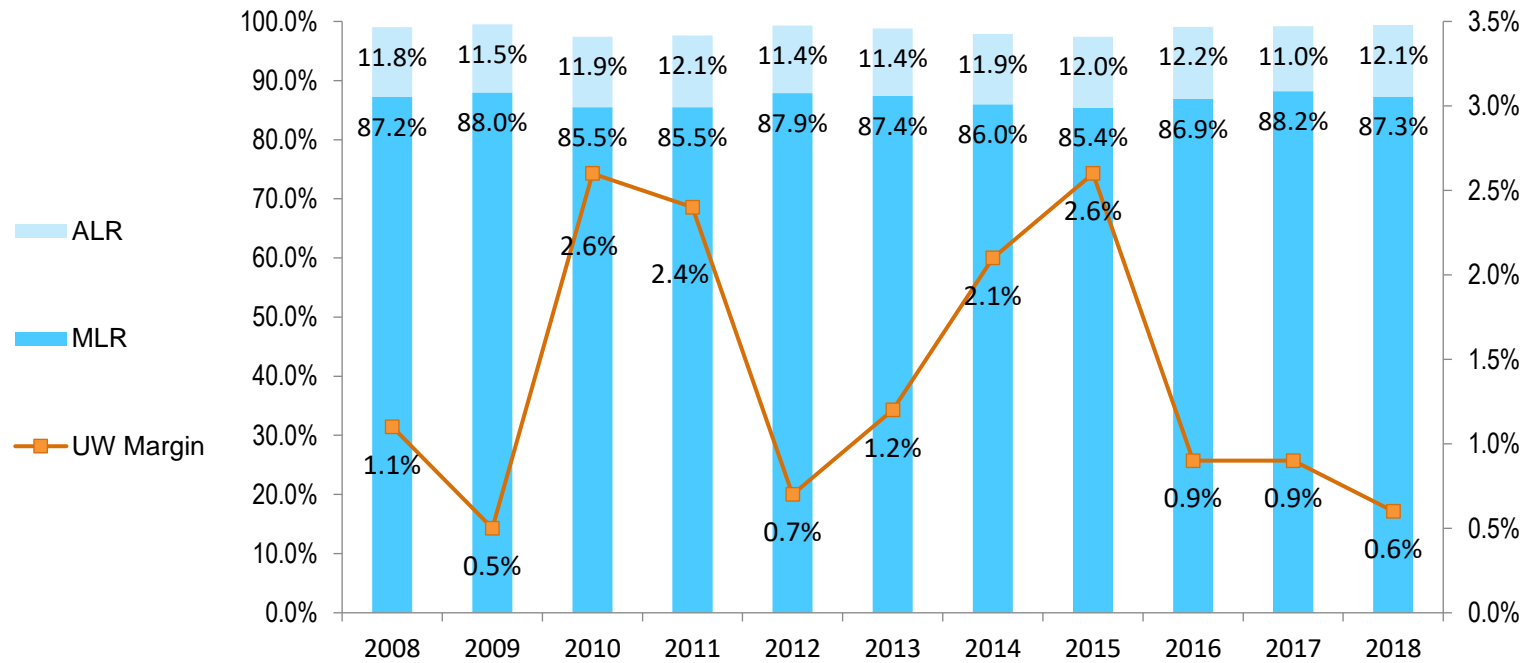
Example of How Medicaid Managed Care is Funded

- For example, State's contracted actuaries review claims history and set per member, per month capitation rate *annually* (\$100)
- State monitors BCBSND's performance against set standards



Medicaid MCO Financial Performance

Financial Results for Medicaid MCOs Across the Country¹



MLR = Medical Loss Ratio | ALR = Administrative Loss Ratio | UW = Underwriting

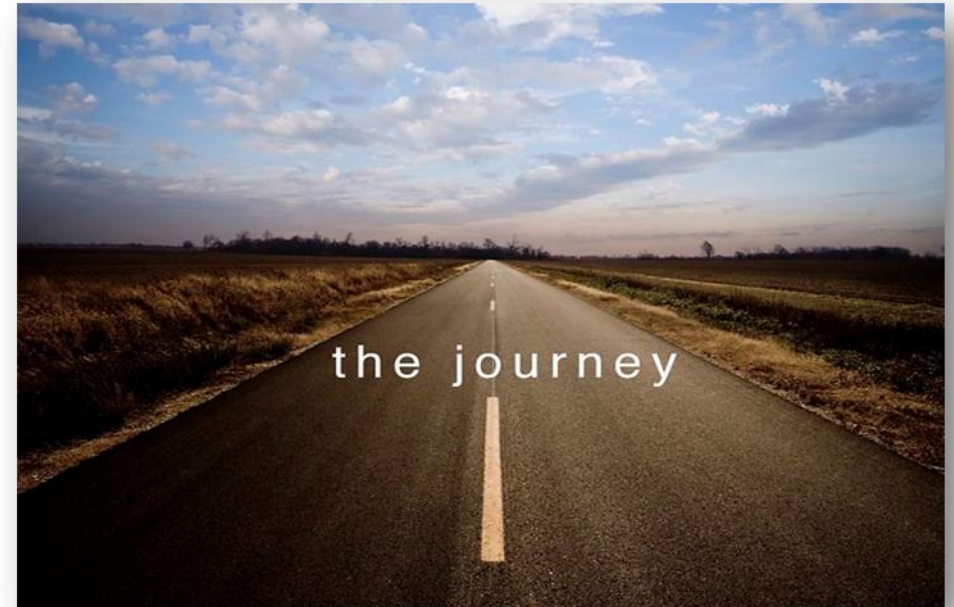
Source: 1) Milliman Report, "Medicaid Risk-based Managed Care: Analysis of Financial Results," 2008 – 2018

BCBSND Implementation Efforts

- January 1, 2022 go-live
- 28,000+ members enrolled and received:
 - Welcome packets
 - Identification cards
- Alignment with BCBSND commercial business
- We are pleased all health systems joined and will participate in our value-based payment model

Roadmap to Adopt Value-Based Payment (VBP)

- Centers for Medicare and Medicaid Services (CMS) believes there is opportunity in Medicaid
- Medicare reports 90% of payments were part of VBP arrangements vs. 32% in Medicaid
- CMS advises states can facilitate shifts to value by:
 - Participating in multi-payer efforts (alignment)
 - Seeking extensive stakeholder engagement
 - Focusing on sustainability and continued aligned incentives



Source: HMA Weekly Roundup, September 23, 2020



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BCBSND's Value-Based Payment Journey

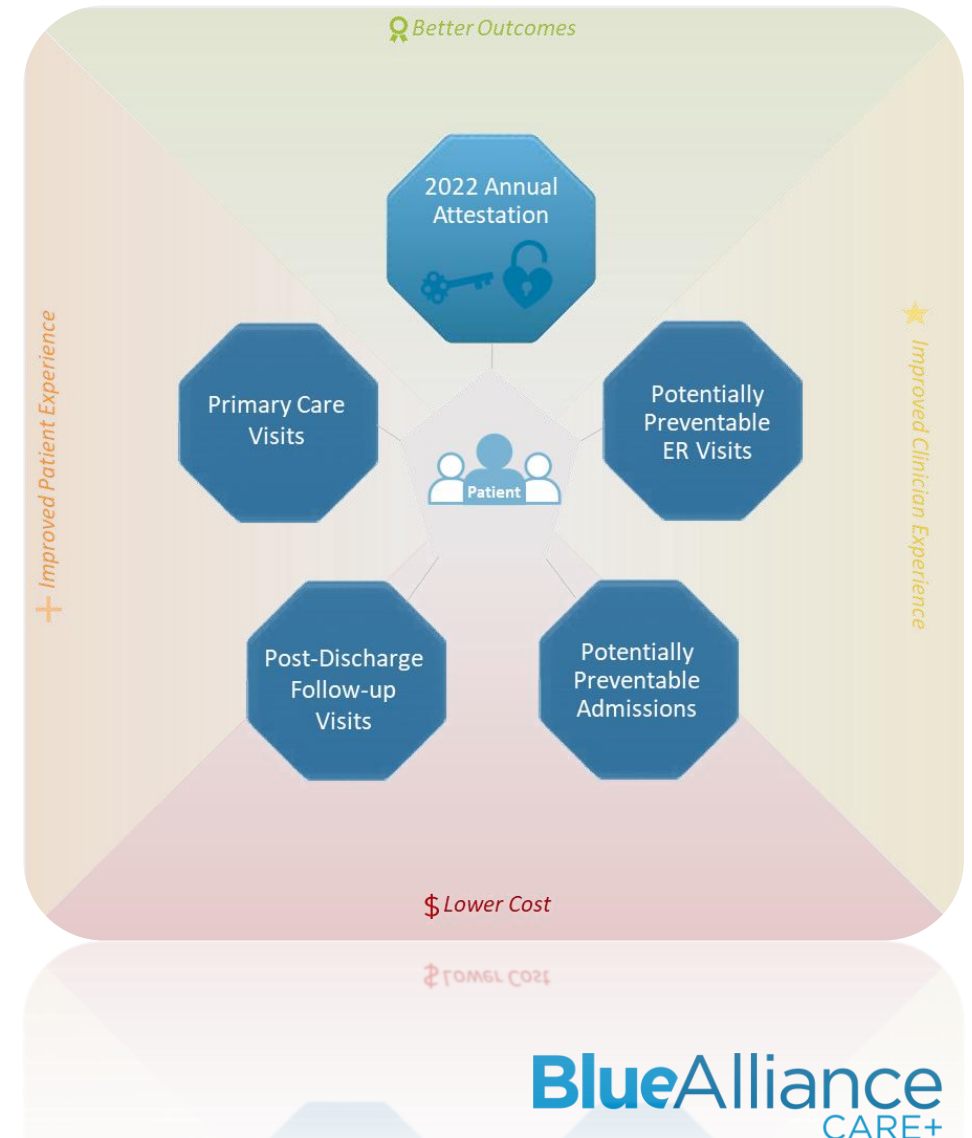
- 2009 – MediQHome
- 2011 – Total Cost of Care
- 2016 – BlueAlliance
- 2018 – Comprehensive Primary Care Plus

Over **90%** of primary care providers participate



Quality Alignment

- Clinical Quality Committee
 - Clinical leadership representation from all areas of North Dakota
 - Provide feedback on quality measurement options
 - Current requirements on facilities for quality reporting
- Collaborative for Clinical Quality
- Simplified the process over time
- Provided dedicated support team to practices seeking further help

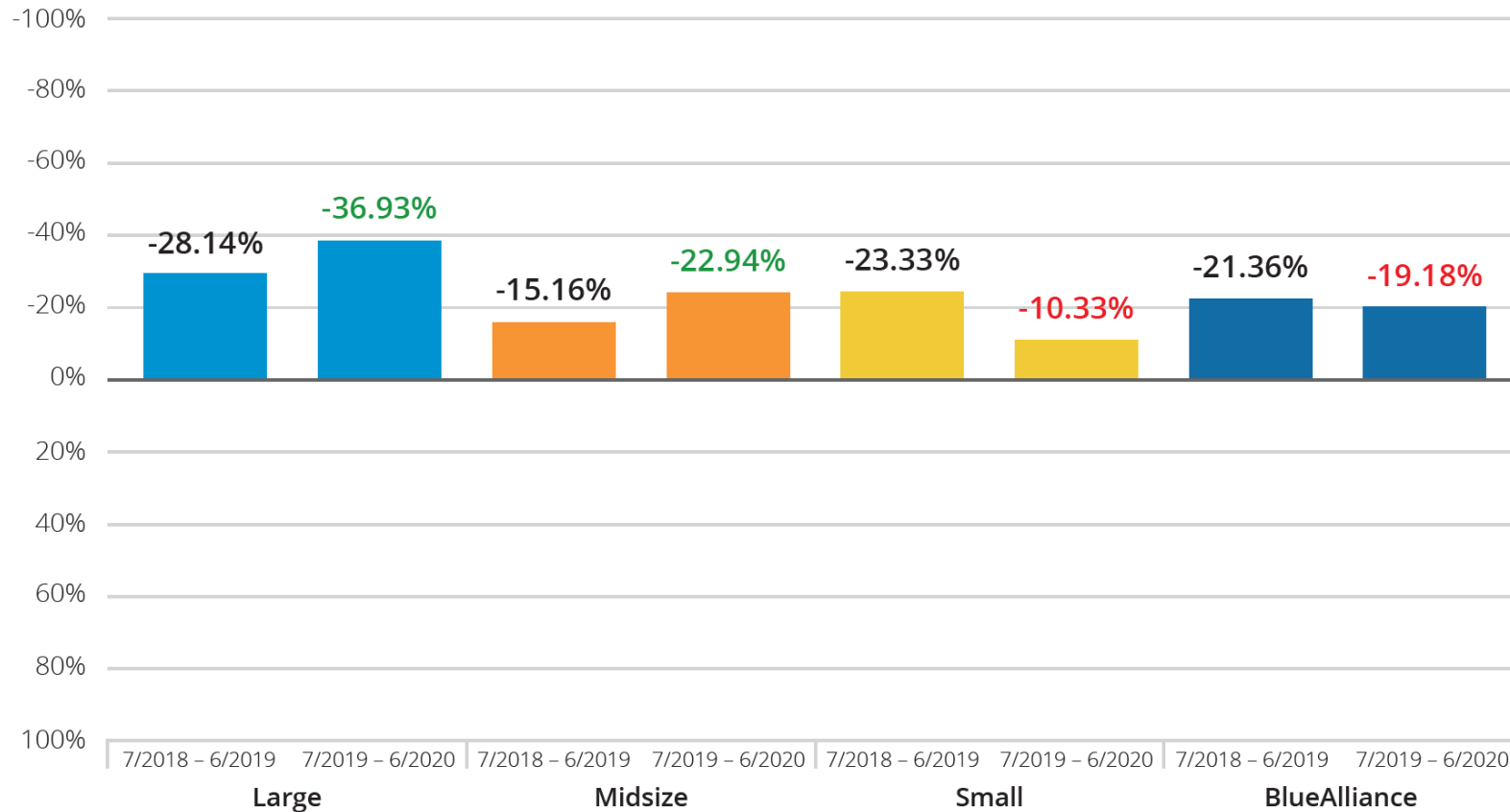


Quality Improvement Success

- Lower trend in avoidable hospitalizations
 - Also known as potentially preventable hospital admissions (PPA)
- Decreases in potentially preventable emergency room visits
- Increases in well child visits in infants and young kids
- Lower overall total cost of care trends

Potentially Preventable Hospital Admissions (PPA)

Potentially Preventable Admission (PPA) Rate
BlueAlliance Program & Peer Group Trending



Value-Based Payment in Medicaid Expansion

- No value-based payment program previously
- Leveraging existing and familiar BlueAlliance framework in the market for six years
- Alignment with existing measures and dashboards for monitoring performance
- One year agreement in an effort to create alignment with DHS' work on traditional Medicaid value-based payment model

Key Terms and Definitions

- Alternative Payment Model (APM): A different way to pay for health care, aligning better outcomes with payment versus volume. Other common terms used: Accountable Care Organizations, Value-Based Care, Value-Based Payment
- Attribution: How a member is assigned to a primary care provider or group of providers.
- Capitation: Negotiated per member, per month amount for management of a population.
- Commercial insurance: Employer-sponsored coverage or Marketplace individual plans.
- Fee-for-Service (FFS): Traditional payment that involves payment for each service, regardless of outcome. More tests = more money.
- Medical Loss Ratio (MLR): Refers to the percentage of the premium dollars (or capitated amount in this case) that an insurance company spends to provide health care and improve the quality of care, versus how much the company spends on administrative and overhead costs.
- Network Adequacy: Ensuring members have access to health care services within a federally-defined distance and time.
- Profit Margin: Profit generated to the managed care organization after paying for medical expenses and accounting for administrative costs.