Medical Services Budget- House Bill 1012 Expansion

House Appropriations Human Resources Division, Chairman Nelson

Caprice Knapp, PhD Medical Services Director

NORTH Dakota | Human Services

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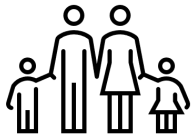
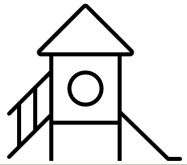
DHS 2021-2025 KEY PRIORITIES



Strong Stable Families

- Maintain family connections
- Improve stability and prevent crises
- Promote and support recovery and well-being



Early Childhood Experiences

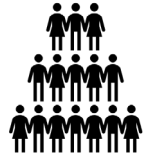
- Support workforce needs with improved access to childcare
- Help kids realize their potential with top quality early experiences
- Align programs for maximum return on investment

Services Closer to Home

- Create pathways that help people access the right service at the right time
- Engage proactively with providers to expand access to services

Efficiency Through Redesign

- Embrace process redesign to find efficiencies in our work
- Leverage technology to support greater efficiency, quality and customer service



High-Performing Team

- Develop a One DHS Team culture
- Engage team with opportunities for learning and development
- Implement fiscal scorecard to drive efficiency and effectiveness

Reinforce the Foundations of Well-being

Economic Health | Behavioral Health | Physical Health

MEDICAL SERVICES DIVISION

Our Values

We help...

our members receive safe, appropriate, quality care in a timely manner.

We communicate...

by listening, sharing information, and seeking feedback.

We partner...

with stakeholders, other state agencies, and tribes to achieve shared goals.

We oversee...

Medicaid to ensure integrity, efficiency, and stewardship of public resources.

Medicaid Expansion Eligibility for Adults

Family Size	Medicaid Expansion 138% of PL
	Monthly
1	$ 1,468
2	$ 1,983
3	$ 2,498
4	$ 3,013
5	$ 3,529
6	$ 4,044
7	$ 4,559
8	$ 5,074
9	$ 5,589
10	$ 6,105
+1	$ 516

$17,609 per year

$36,156 per year

$14,000 per capita in health care benefits

MEDICAL SERVICES DIVISION

How We Pay

Contracted Services 1915(b) Waiver

- States design an Alternative Benefit Plan that describes the services and must include Essential Health Benefits

- Medicaid Expansion **does not** cover:
  - Skilled Nursing Facility Services*
  - Dental Care Office Visits**
  - Routine Eye Care**
  - Any waivered services
  - Long Term Care services
  - Room and board for Residential Treatment services**

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

Medicaid Expansion

Managed Care Organization:

- Risk Based Capitation paid on a per member, per month basis
- Current Vendor: Sanford Health Plan (SHP)
- Contract is currently being re-bid
  - Notice of Intent to Award will be issued approximately 5/21/2021
  - Contract Start will be approximately 1/1/2022

Medicaid Expansion:

http://www.nd.gov/dhs/medicaidexpansion/

EXECUTIVE REQUEST 2021-2023

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NORTH DAKOTA LEGISLATION TO DATE

Since the initial implementation, each subsequent session of the ND Legislative Assembly has reauthorized ND Medicaid Expansion as administered and managed through a **Private Carrier**.

The 2019 ND Legislative Assembly (SB 2012) did make the following updates to the ND Medicaid Expansion Program:

- Directed the Department to continue the utilization of a private carrier for the administration and management **except for pharmacy services**, effective January 1, 2020.
- Directed the Managed Care Organization (MCO), while under contract with the Department, to
  - **Develop and implement a uniform provider reimbursement methodology**
  - **Added 1915(i) Behavioral Health Services through the MCO**

ND Medicaid Expansion Transition Principles

All North Dakota Medicaid **members** should be valued the same, **regardless of Category of Eligibility**, and should have **access to the same core services.**

All North Dakota Medicaid **providers** should be valued the same, **regardless of traditional or expansion**, and should have **equity in reimbursement.**

Taxpayers should be assured that their state and federal taxpayer dollars are not being used to disproportionately support **able bodied adults**, who can work and **transition off government assistance** unlike most traditional Medicaid clients.

Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Rates

Medicaid Expansion Comparison: under 100K People Delivery of Care Model

Medicaid Expansion Population

No MCOs

- Maine 19,812
- Alaska 51,144
- Vermont 55,431
- Montana 98,741

1 MCO

- North Dakota 20,369

Only State with 1 MCO

2 MCOs

- New Hampshire 70,000 **3 MCOs serve ~213K*
- Delaware 62,534 **2 MCOs serve traditional and expansion ~199K*
- Rhode Island 66,641 **2 MCOs serve traditional and expansion ~250K*

Source: Medicaid Enrollment Report Updated 2/2020
https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html
https://www.kff.org/medicaid/stateindicator/totalmedicaidmcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Comparison Medicaid Expansion 2019 Churn Numbers

Medicaid Expansion 2019 Churn

Month	Expansion SHP Members	Expansion SHP Members Non-Expansion Eligibility	Expansion SHP Members Any Medicaid Eligibility	Percent Remaining in Expansion SHP	Percent Remaining with Any Medicaid Eligibility
Jan 2019	20,719		20,719	100.0%	100.0%
Feb 2019	19,441	270	19,711	93.8%	95.1%
Mar 2019	18,399	436	18,835	88.8%	90.9%
Apr 2019	17,515	624	18,139	84.5%	87.5%
May 2019	16,594	812	17,406	80.1%	84.0%
Jun 2019	15,551	1,002	16,553	75.1%	79.9%
Jul 2019	14,672	1,155	15,827	70.8%	76.4%
Aug 2019	13,873	1,295	15,168	67.0%	73.2%
Sep 2019	13,117	1,372	14,489	63.3%	69.9%
Oct 2019	12,523	1,463	13,986	60.4%	67.5%
Nov 2019	11,937	1,532	13,469	57.6%	65.0%
Dec 2019	11,491	1,579	13,070	55.5%	63.1%

Medicaid Expansion Reimbursement Comparison

Per Capita Costs Per State

	Expansion Group - TOTAL Spending	Expansion TOTAL Group Enrollment	Expansion TOTAL Per Capita Amount	Rank
North Dakota	$297,650,200	21,100	$14,107	1
Alaska	$412,994,600	45,300	$9,117	2
Delaware	$569,892,300	63,100	$9,032	3
New Hampshire	$510,384,900	57,400	$8,892	4
Maryland	$2,699,785,000	313,600	$8,609	5
Minnesota	$1,808,509,000	210,300	$8,600	6
Connecticut	$2,051,390,800	256,200	$8,007	7
Indiana	$3,492,894,100	449,500	$7,771	8
Illinois	$5,434,013,700	752,000	$7,226	9
Montana	$690,420,200	98,600	$7,002	10

North Dakota is **54% higher** than **Alaska**

Medicaid Expansion Reimbursement Comparison MCO Capitation Rates

Monthly capitation (premium) amounts paid for each individual enrolled with the MCO for ND Medicaid Expansion

RURAL Cohort

ND Medicaid Expansion recipients residing within ND except for the counties of Burleigh, Cass, & Grand Forks

CATEGORY	AGE	GENDER	Capitation Rate 1/1/2015	Capitation Rate 1/1/2021
Childless Adults	19-44	M	$844.00	$945.26
Childless Adults	19-44	F	$1,078.69	$846.48
Childless Adults	45-64	M	$1,804.04	$1,829.36
Childless Adults	45-64	F	$1,598.75	$1,474.70
Adults with Children	19-44	M	$293.78	$945.26
Adults with Children	19-44	F	$559.06	$846.48
Adults with Children	45-64	M	$1,024.31	$1,829.36
Adults with Children	45-64	F	$1,385.59	$1,474.70
Retroactive Month(s) ONLY			$1,252.92	$1,581.90

The chart below shows only the yearly changes since the January 1, 2014 implementation of ND Medicaid Expansion (prior to 2019 MCO Rates were reviewed and adjusted every 6 months).

Medicaid Expansion Reimbursement Comparison

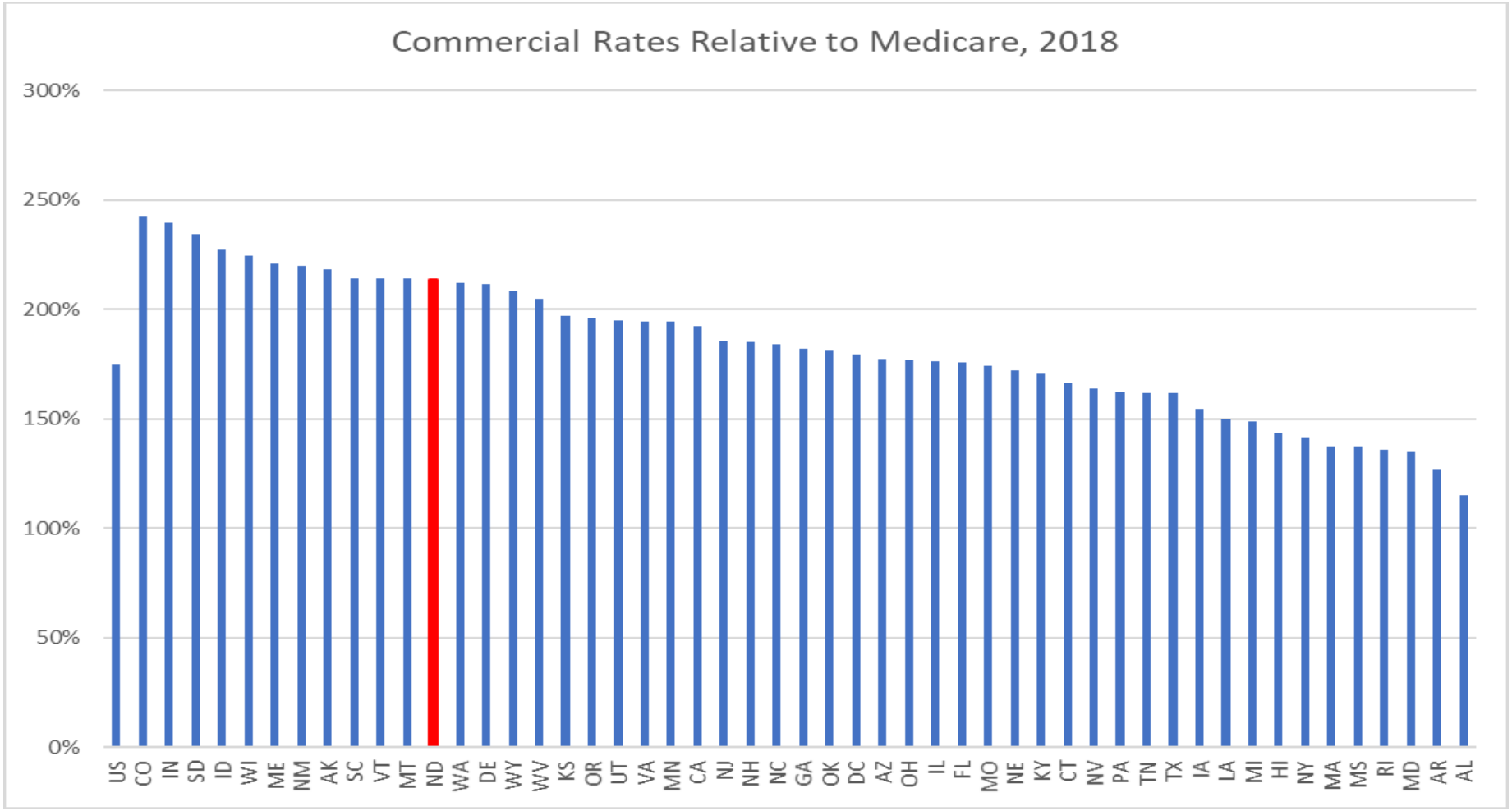
Provider Reimbursement % of Medicaid

Actual % of Medicaid*

Type of Service	CY17	CY18	CY19
Inpatient	158.7%	165.8%	151.7%
Outpatient	209.8%	208.0%	204.2%
Professional	168.2%	168.2%	165.4%
Total	**175.0%**	**177.8%**	**170.3%**

***Excludes pharmacy expenditures and FQHC/RHC/IHS expenditures**

Medicaid Expansion Reimbursement Comparison Commercial Insurance Payment Rates



- **Commercial payments** for hospital services in ND are **214%** of the Medicare rate.
- **ND's commercial-to-Medicare** rate ratio for hospital payments is the **12th highest** in the U.S.

Source: North Dakota Insurance Department, "North Dakota 66th Legislative Assembly Interim Health Care Study," August 12, 2020

Medicaid Expansion Reimbursement Comparison

Medicaid FFS Physician Index

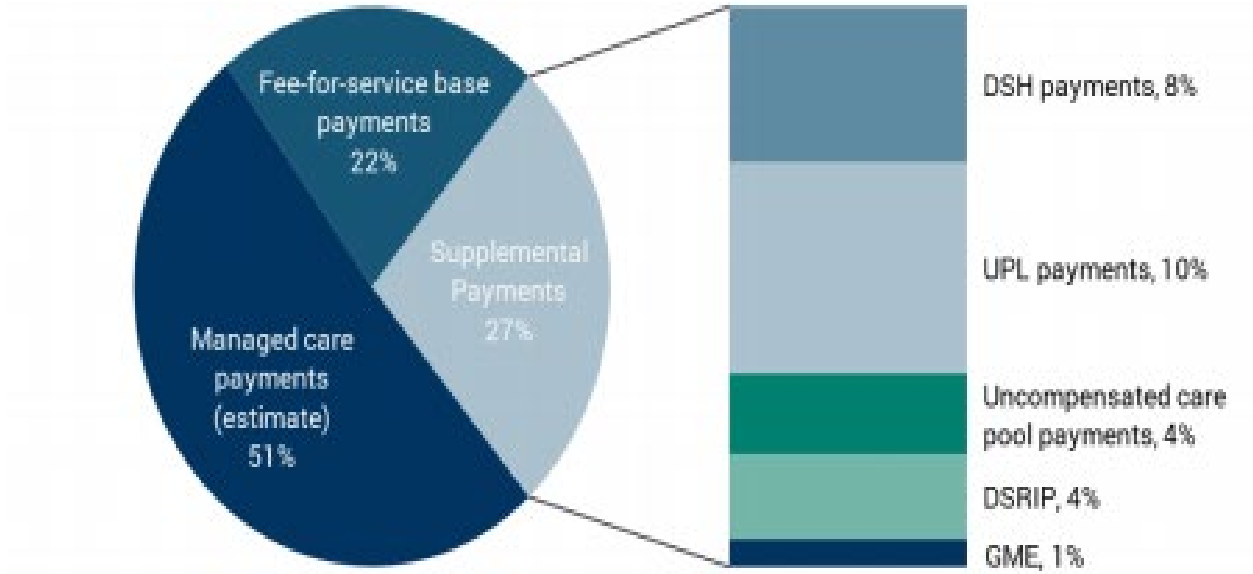
FFS MEDICAID PHYSICIAN INDEX		
ALL MD SERVICES	PRIMARY CARE	OTHER SERVICES
1. Alaska (2.28)	1. Alaska (2.55)	1. Alaska (1.94)
2. Montana (1.56)	2. Montana (1.65)	2. Nebraska (1.45)
3. Delaware (1.40)	3. Delaware (1.55)	3. Arkansas (1.44)
4. Wyoming (1.38)	***4. North Dakota (1.52)***	4. Montana (1.36)
5. Nevada (1.37)	5. Maryland (1.51)	5. South Dakota (1.34)
6. Maryland (1.35)	6. Nevada (1.50)	6. Delaware (1.28)
6. North Dakota (1.35)	7. Idaho (1.45)	7. Wyoming (1.27)
8. Washington, DC (1.27)	8. Wyoming (1.44)	8. New Mexico (1.25)
9. Idaho (1.25)	9. Washington, DC (1.39)	9. Iowa (1.22)
10. New Mexico (1.19)	10. Colorado (1.31)	10. Nevada (1.21)
10. Utah (1.19)	11. Utah (1.30)	11. Wisconsin (1.17)
12. Mississippi (1.17)	12. Mississippi (1.29)	***12. North Dakota (1.15)***

Source: Kaiser Family Foundation State Health Facts, based on Stephen Zuckerman, Laura Skopec, and Marni Epstein, "Medicaid Physician Fees After the ACA Primary Care Fee Bump," Urban Institute, March 2017.
Note: Other services excludes ob/gyn.

Medicaid Expansion Reimbursement Comparison

DHS Payments to Hospitals

FIGURE 1. Base and Supplemental Payments as a Share of Total Medicaid Payments to Hospitals, FY 2018



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "Medicaid Base and Supplemental Payments to Hospitals, March 2020 Issue Brief.

Medicaid Expansion Reimbursement Comparison

DHS Payments to Hospitals

Medicaid DSH Payments to Hospitals

- Medicaid disproportionate share hospital (DSH) payments offset hospitals' uncompensated care costs

- Federal rules provide Medicaid matching funds up to a maximum level of DSH payments. Federal limits apply at the individual hospital level and statewide. State DSH allotments are largely based on historical DSH payments.

- The DSH limit is the maximum amount of uncompensated care costs that a State can reimburse a hospital under Medicaid. It is based on **"cost"** of inpatient and outpatient services provided by each hospital and defined as sum of:
  1. **Medicaid shortfall:** the difference between a hospital's Medicaid payments and its cost to provide services to Medicaid-enrolled patients, and
  2. **Uninsured losses:** the cost of providing care to those without insurance for services received, less payments from uninsured.

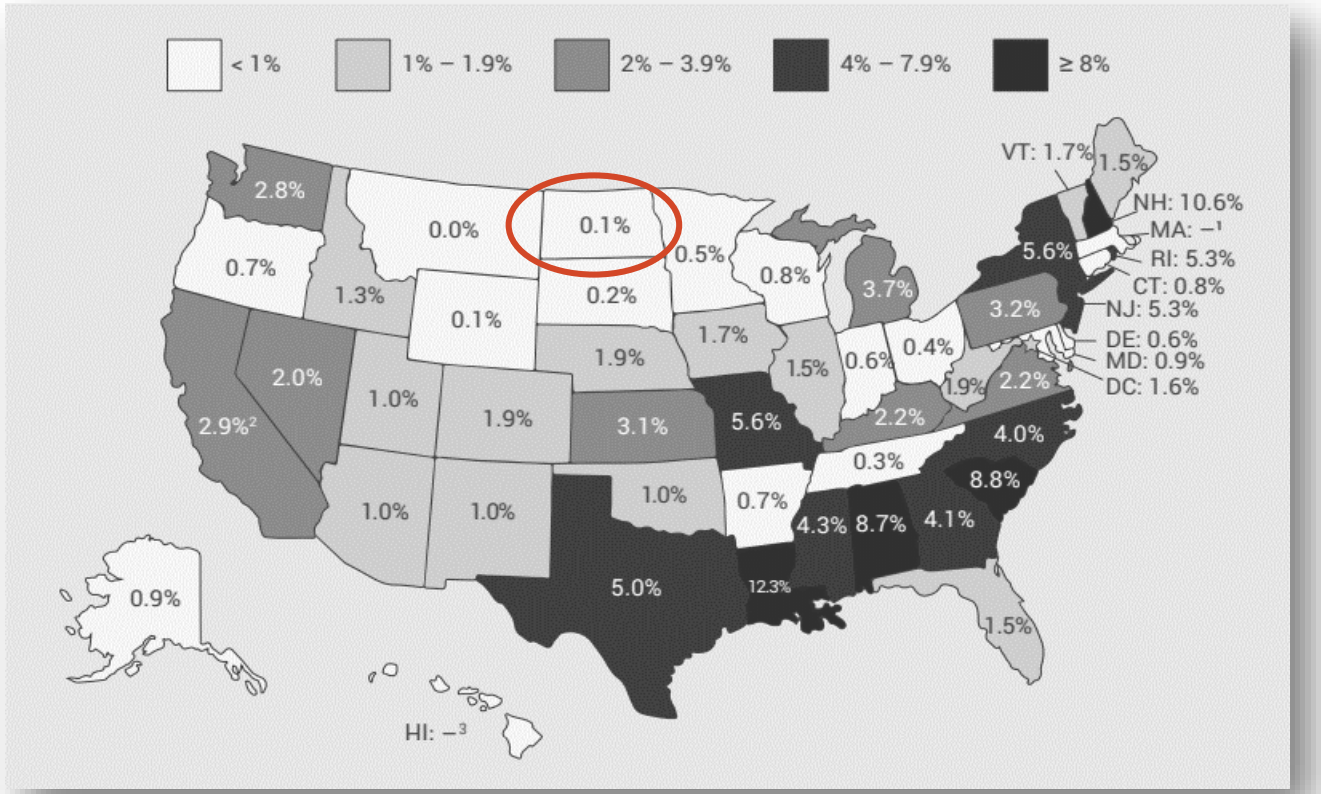
Medicaid Expansion Reimbursement Comparison

DHS Payments to Hospitals

Medicaid DSH Payments to Hospitals

- **North Dakota Medicaid DSH spending is among the lowest in the nation** – both in terms of share of Medicaid spending (0.1%) and absolute dollars ($22.3 million federal and state)
- **North Dakota's Medicaid DSH allotment is about the same as South Dakota** ($22.4 million) and smaller than all other states except for Hawaii, Montana and Wyoming.

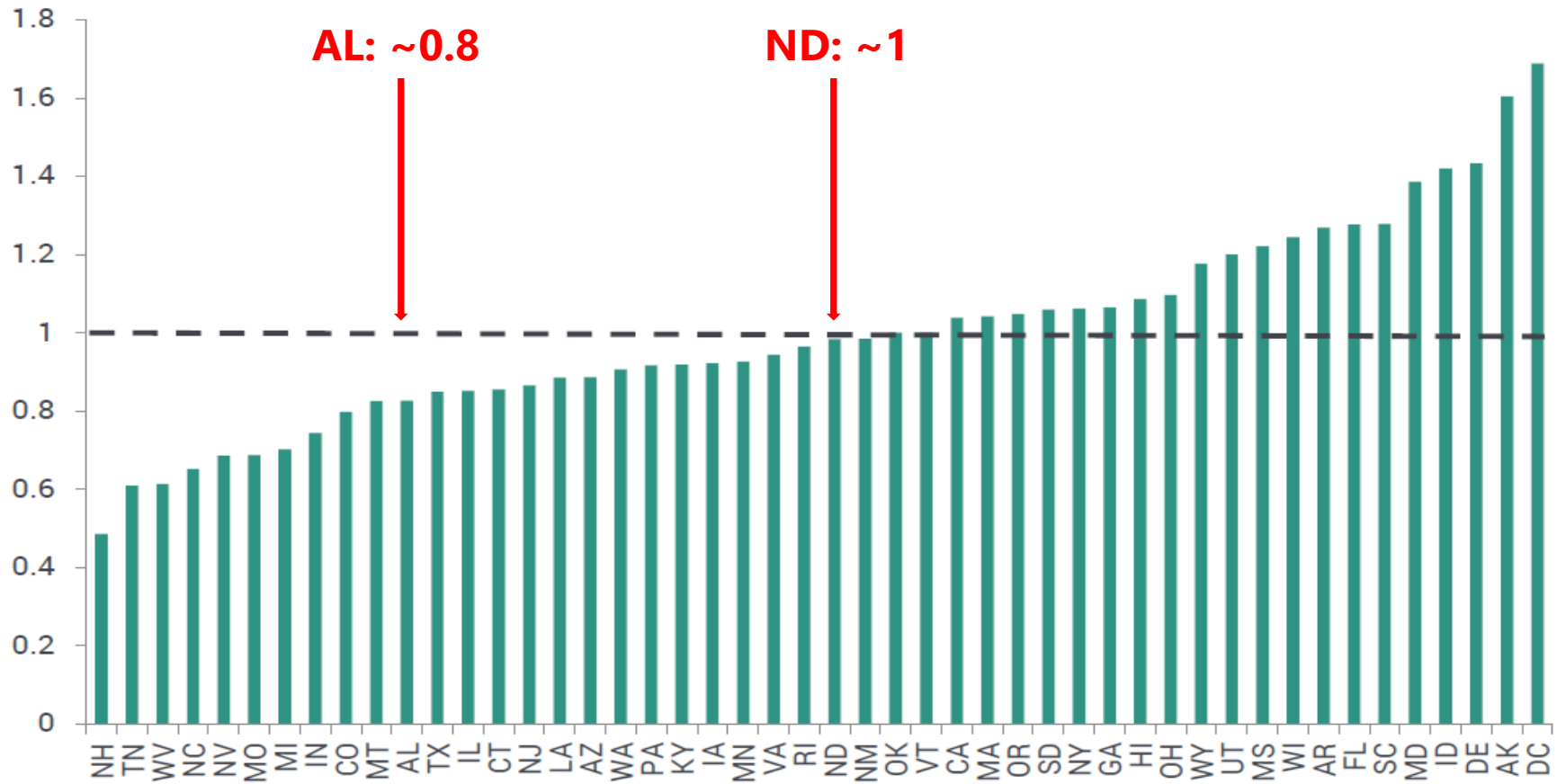
DSH Spending as % of Total Medicaid Benefit Spending by State, FY 2018



Source: Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," Washington, DC, March 2020.

Medicaid Expansion Reimbursement Comparisons Inpatient FFS Payment Index

EXAMPLE: MEDICAID-TO-MEDICARE INPATIENT FEE-FOR-SERVICE PAYMENT INDEX, CY 2010

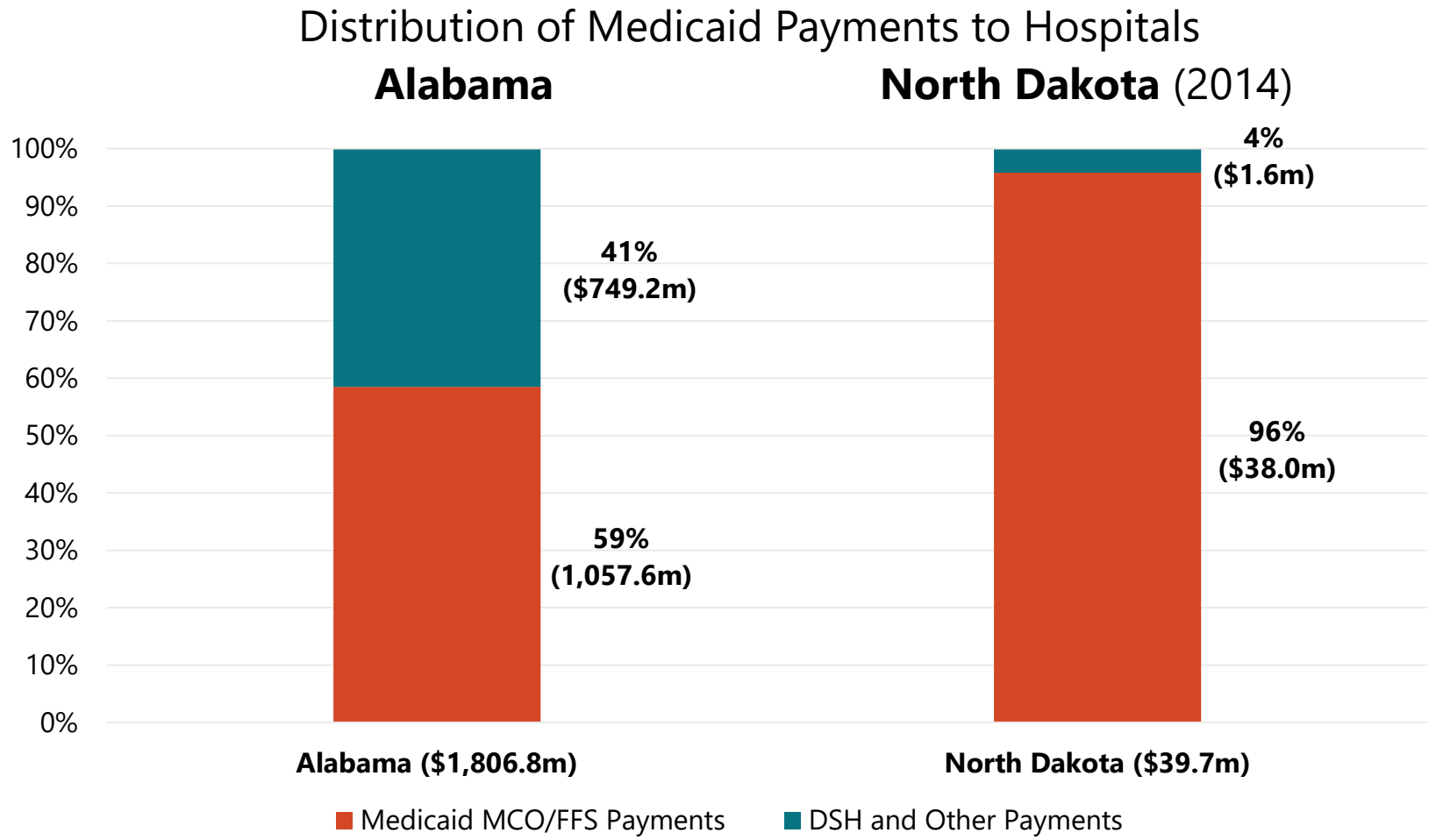


SOURCE: MACPAC. "Medicaid Hospital Payment: A Comparison Across States and to Medicare," Issue Brief, April 2017.
NOTE: The payment index values are normalized around the national average, which has a value of 1.0. For example, a state with an index value of 1.10 would have payments that were 10 percent higher than the national average. Kansas, Maine and Nebraska were excluded due to missing data.

Medicaid Expansion Reimbursement Comparisons

ND's Medicaid Payments

EXAMPLE: NORTH DAKOTA'S MEDICAID PAYMENTS ARE LARGELY IN BASE PAYMENTS



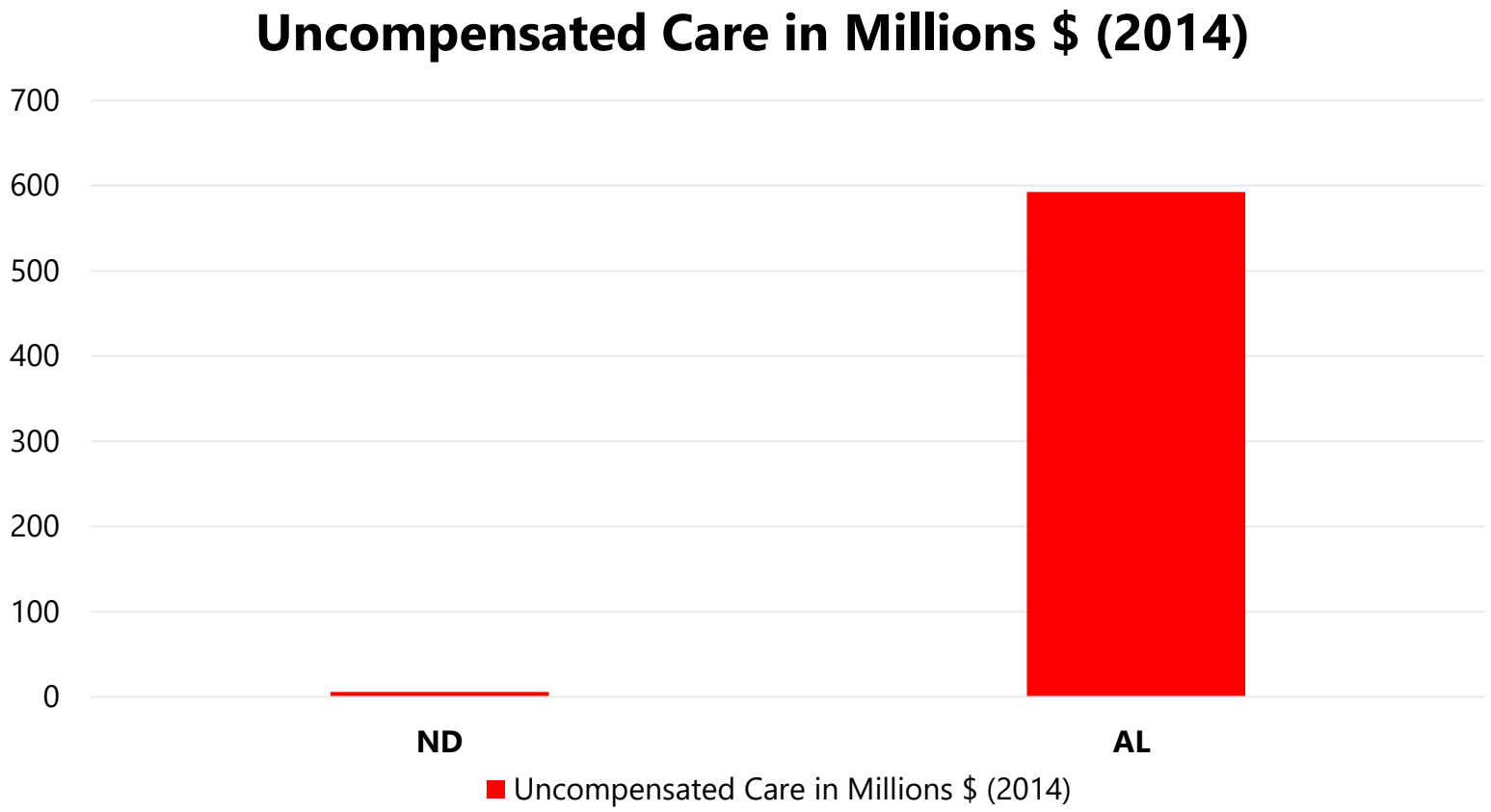
SOURCE: U.S. Government Accountability Office, "States' Use and Distribution of Supplemental Payments to Hospitals," July 2019

Medicaid Expansion Reimbursement Comparison

Hospital Uninsured & Uncompensated Care Comparison

ND hospitals uncompensated care is a fraction of AL uncompensated care

North Dakota	ALABAMA
7.9% uninsured	12.1% uninsured
$5.9 million total uncompensated care	$592.4 million total uncompensated care



SOURCE: U.S. Government Accountability Office, "States' Use and Distribution of Supplemental Payments to Hospitals," July 2019

Summary of Medicaid Expansion Reimbursement Comparisons

North Dakota Medicaid expansion costs per capita are the highest in the country. 54% higher than the second highest state of Alaska.

North Dakota Medicaid FFS rates for physicians are:

- higher than average and comparable to neighboring states

North Dakota hospital expenses are highest per capita and in growth in the U.S.

DSH payments in North Dakota are among the lowest in the United States

Summary of Medicaid Expansion Reimbursement Comparisons

North Dakota Medicaid rates are not equitable

Payment to providers for the care of non-institutional, able-bodied adults, who can work and transition off Medicaid, are 75% to 100% higher than payments to providers for the care of other Medicaid populations like children, elderly, pregnant women, non-institutionalized adults.

Across all other state non-institutionalized programs, none incur per capita expenses as high as $14,107 for Medicaid expansion.

- Per pupil education $12,453
  - Per pupil Kindergartener $10,373
- Per pupil higher education $7,780
- Unemployment insurance $5,379 (average payment pf $448.26 times 12)

Summary of Medicaid Expansion Reimbursement Comparisons

- Transition from managed care to DHS administration will occur July 1, 2022 giving providers time to adjust, plan, and account for COVID impacts.
- As of 12/18/2020 North Dakota Medicaid providers received $326 million in provider relief funds from the federal government.
- HHS expected to **release $24.5 billion more** in provider relief funds so that providers can make up nearly 90% of lost revenues and net change in expenses. Payments will be made from 12/16/2020-1/31/2021.
  - **The department noted that more than 35,000 applicants won't receive an additional payment because the total relief they've received so far is 88% of their losses or they had no change in revenues or net expenses due to COVID-19.**

Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Administration

Comparison Medicaid Expansion Financial Arrangement

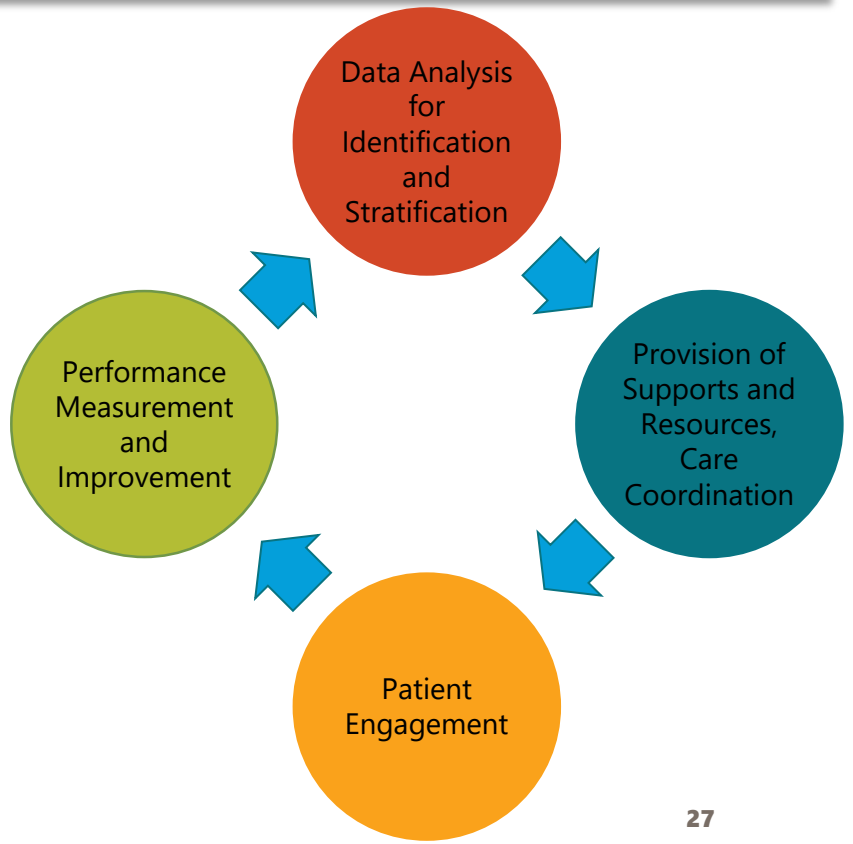
What is Managed Care?

Goal: to **control costs** while simultaneously **improving health care quality and outcomes**

Requires more than just care coordination, it involves a set of activities intended to **identify populations** to prioritize for extra support care planning and coordination, patient engagement, and analysis of data to evaluate outcomes and improve processes.

Activities to Improve Health Care Quality & Outcomes

- Intensive management of high-cost individuals.
- Selective contracting with providers willing to offer services at discounted rates.
- Initiatives to steer consumers away from high cost, low value services towards low cost, high value services.
- Requiring enrollees to obtain prior authorization from their primary care physician to gain access to specialty services.
- Focusing on preventive services.
- Monitoring the use of basic and ancillary services and using incentives to reward below-average use and disincentives to discourage excess use.
- Requiring providers to assume part of the financial risk or cost overruns for services they control, directly or indirectly.



Comparison Medicaid Expansion Financial Arrangement

Why do State Medicaid Programs use MCOs?

1. Managed Care Organization Takes on the Risk versus the State
2. Budget Predictability
3. Budget Savings
4. Improved Outcomes

Risk & Predictability

- As in any risk-based model the more people in the risk pool the more likely the managed care organization can spread the risk across health and less health individuals
- The larger the risk pool, the more predictable and stable premiums will be.
- Premiums also rely on the average health care costs of the enrollees
- Adverse selection occurs when the insurer attracts individuals when they have greater health care needs
- In **North Dakota**, the
  - **risk pool** is the **smallest** in the **entire country** using managed care
  - **premiums** have **not** been **predictable** or **stable**
  - **churn rate** indicates that **adverse selection** is probably occurring

Comparison Does Managed Care Save Money?

Inconclusive Evidence

Lewin Group Analysis

- AHIP funded
- Meta-analysis, a review of 24 studies
  - none were peer reviewed
  - proposes that cost savings range from 0.5% to 20%
  - Point to decreases in inpatient utilization but at that time inpatient was going down throughout the U.S. health system

Mathematica 5-State Analysis

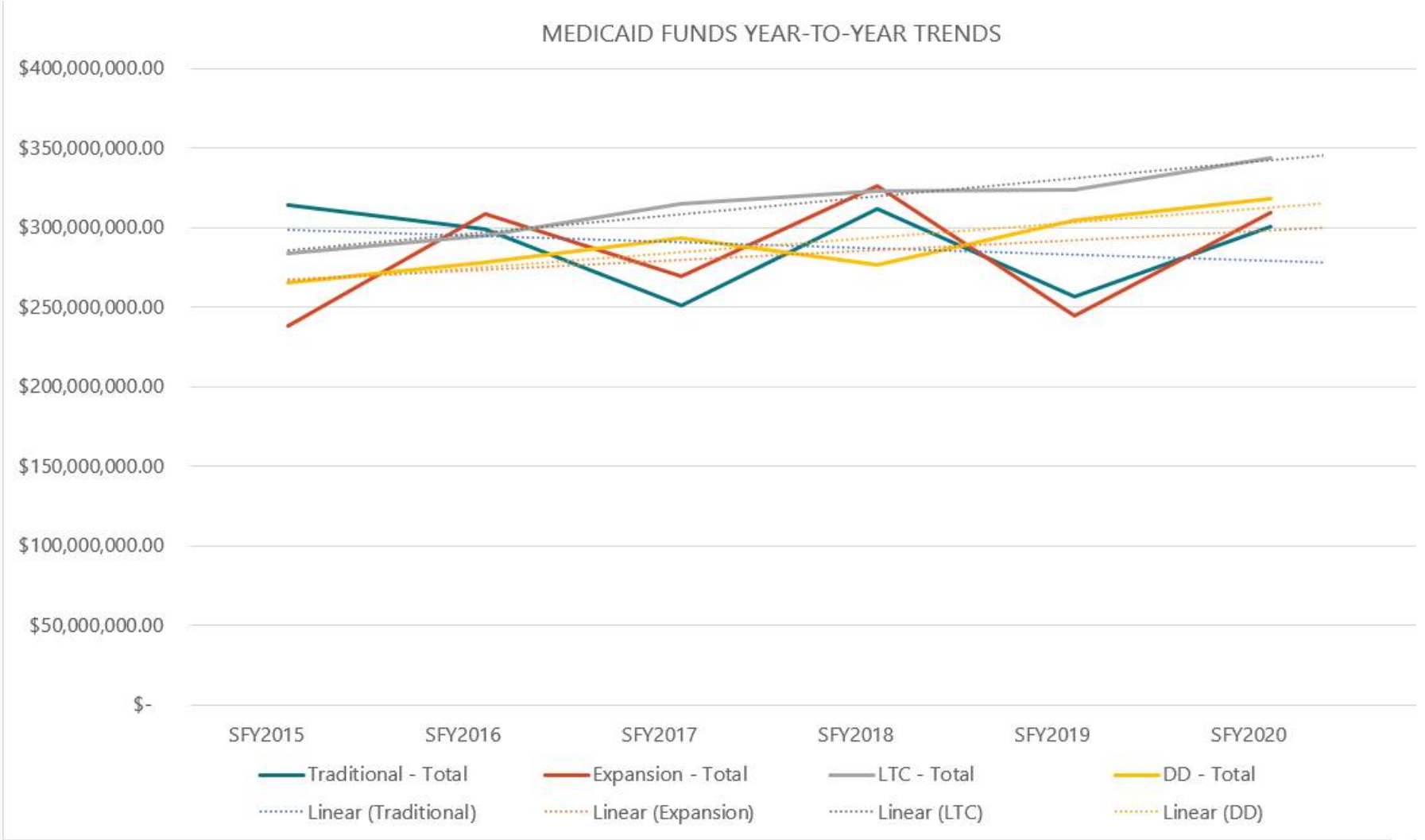
- Found no savings

Duggan Study from NBER Analysis

- Showed moving to managed care resulted in no improvement in health care and substantial increases in government spending.
- MCO did little to nothing to reduce spending.

Source:https://www.healthaffairs.org/do/10.1377/hblog20180430.510086/full/

Comparing Has Medicaid Expansion Saved Money in North Dakota?



Comparing Has Medicaid Expansion Improved Health?

HEDIS and CAHPS measures are skewed toward members with **continuous enrollment**. In expansion we know the churn rate is high (~11,000 members) and we know that expenditures keep going up and not down.

The State's contracted actuary uses a different analytical tool to get a better idea of the **effectiveness of the managed care** organization called Prometheus.

- 43 episodes are built such as diabetes and knee surgery
- Compares the utilization and cost based on clinical standards
- Sorts potential waste and identifies care that should have been potentially avoided using the right interventions and clinical management

What is Care Coordination in an MCO?

Prior testimony in 2019 session on the number of care coordinators in managed care organization

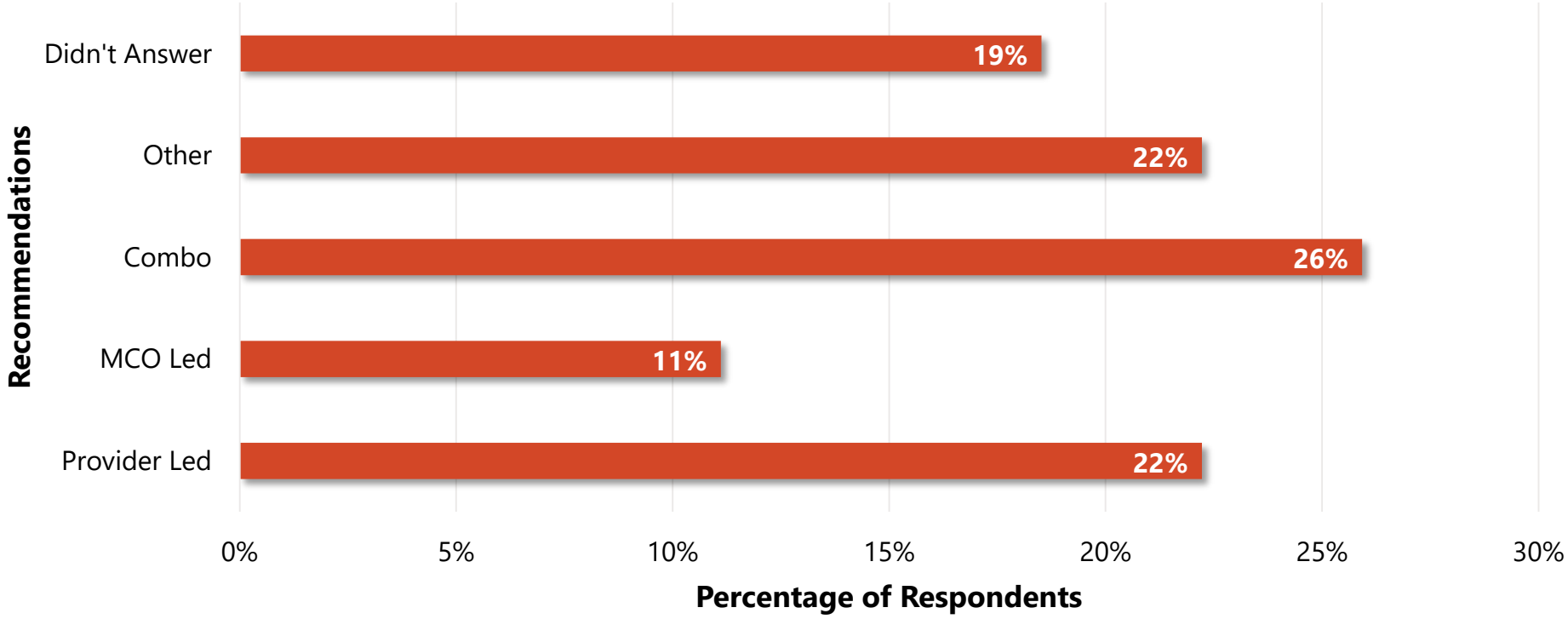
- Difference between care coordination, case management, and population health in managed care:
  - Care Coordination: contracted to primary care providers
  - Case Management: typically done by the MCO typically and targets high risk members, high touch and costly
  - Population Health: typically done by MCO and relies on data analytics to target sub-groups.

ND Medicaid Expansion MCO Survey

There are different approaches to care management by a MCO:

1. **Provider-led** (with an enhanced payment to providers for outcomes)
2. **MCO-led** (MCO has its own care managers)

What do you think is the ideal care management approach, why?



ND Medicaid Expansion MCO Survey

"Provider led care management because the care managers are direct member of the patients care team coordinating care and service for the patient. Hybrid models work will where MCO's support provider led programs with expertise in certain programs such as behavioral health."

"I believe the best method should be a combination of provider-led, when possible, and MCO-led, when necessary. Not all providers will be able to perform necessary care management, but that doesn't mean the MCO should simply take on all care management when there are providers who can and do perform important care management to the benefit of their patients. As such, those high performers should be eligible for enhanced reimbursement. Different strengths and areas of expertise to the table that complement each other.

"Ideally, we feel the care management should be owned by the primary care providers who work closest with the patient. With the enhanced primary care models, we are able to fill in the gaps more easily by being closely connected to the patients and providing ongoing care management to the patients through calls, virtual care, patient portals, goal setting and management, mental health counseling, and medication management."

"The ideal approach is a hybrid of the two. Both the MCO carrier and the provider."

"I feel that provider lead would be more beneficial as they understand the needs of their patients and understand barriers to service delivery unlike MCO. I have learned that direct contact with individuals allows for feedback and ability to understand how policies affect direct practice."

What did providers comment in the MCO Survey?

Proposed Solution
Health Homes

Transition from managed care to managed fee-for-service

- requires a more robust management program than current PCCM program

DHS brought in presenters from

- Alabama (Medical Homes to ACO)
- South Dakota (Health Homes Model)
- Connecticut (ASO model) in early 2020

South Dakota avoided $7.3 million in costs using Health Homes in 5 years

Feedback from North Dakota Medicaid Stakeholders

- Noted that **Health Homes** was the preferred model
- Subsequent meeting with outpatient stakeholders

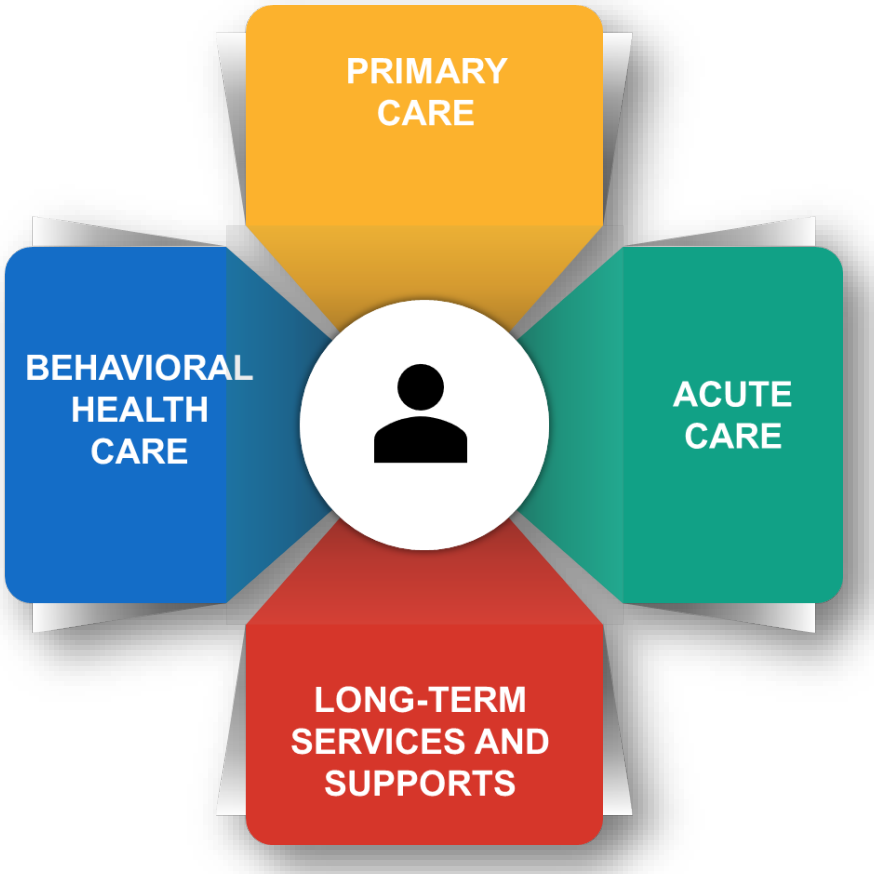
2021-2023 Executive Request

- Authorizes DHS to plan for **Health Homes** and seek CMS approval
- Enhanced payment will offset some of the reduction in rates.

Proposed Solution
Health Homes

Medicaid Health Homes

- Builds on the PCMH model
- Fosters a **"whole-person"** orientation to care for individuals with **chronic conditions** through the integration and coordination of:
  - Primary Care
  - Acute Care
  - Behavioral Health Care
  - Long-Term Services & Support



Proposed Solution
MCO → DHS Administration

Parity to Medicaid members

- Adults in **household** will have **same benefit package**
- Adult **dental** and **vision** will be **part of benefit package**

Significant administrative simplification

- Staff time available to develop an overall care coordination for Traditional and Expanded Medicaid, including review of Targeted Case Management, Primary Care Case Management, and Coordinated Services Program
- Client repayment for eligibility overpayments will be limited to actual claims paid vs. the cost of the monthly premium
- Administrative rules and procedures are the same for providers across the entire Medicaid program
- Only one program to manage, evaluate, and report on

Legislature has more control as compared to privately contracted services

Proposed Solution MCO → DHS Administration

Streamlined movement between traditional and expansion

- One ID card, one provider network, one set of letters and notifications, zones have one set of policies.
- Current situation:
  - Creates **confusion** as to which coverage option is applicable for date(s) of service
  - **Interrupts continuity** which can lead to fragmented care due to differences between the model processes such as the following:
    - Available Benefits
    - Utilization Management or Case Management
    - Service Authorization requirements and requests
    - Appeals for Adverse Benefit Determinations
    - Claims Submission
    - Provider Enrollment – Credentialing
    - Quality or Value Based Purchasing requirements
    - Oversight Requirements

MEDICAL SERVICES
Medicaid Expansion Transition

NORTH Dakota | Human Services
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From MCO Administration to DHS In-House Administration

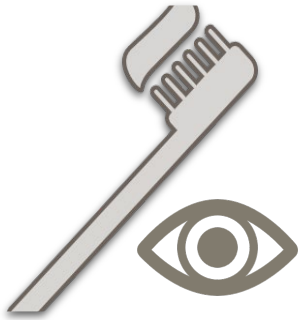
SAVINGS

Transition from MCO to In-House Traditional (Grants)

$(11,017,190.00)

MCO Administrative PMPM Savings

$(1,573,182.00)



Addition of Dental and Vision Coverage

$1,169,714.00

DHS Administrative Expenses

Staff Costs	$568,234.00
Contracts	$ 79,520.00
Other (Notices)	$ 23,332.00

$(10,749,572.00)

Medicaid Expansion: Transition from Managed Care to DHS Administration

Other Issues from Public Testimony

Prior Testimony
Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals.
Handout shows the Medicaid percentage of payer mix for all hospitals. Average Medicaid is 8% of payer mix across all hospitals. According to enrollment data, about 20% of that is expansion enrollees.

Average estimated expansion payer mix for CAHs is 1.58% and 1.3% for PPS

HOSPITAL NAME	TOWN	HOSPITAL TYPE	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
ST ALEXIUS MEDICAL CENTER	BISMARCK	SHORT TERM		4%	4%	5%	4%	3%	1%	7%	7%	6%
TRINITY HOSPITALS/ST JOES	MINOT	SHORT TERM		0%	0%	0%	3%	4%	11%	11%	13%	13%
SANFORD MEDICAL CENTER - FARGO	FARGO	SHORT TERM		6%	4%	3%	4%	7%	9%	8%	8%	8%
SANFORD BISMARCK	BISMARCK	SHORT TERM		7%	7%	7%	5%	8%	7%	7%	8%	6%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	GRAND FORKS	SHORT TERM		10%	10%	10%	12%	8%	9%	9%	8%	
INNOVIS HEALTH	FARGO	SHORT TERM		5%	5%	5%	6%	7%	7%	8%	6%	6%
TIOGA MEDICAL CENTER	TIOGA	CRITICAL ACCESS HOSPITALS		0%	0%	0%	1%	1%	1%	1%	1%	1%
MOUNTRAIL COUNTY MEDICAL CENTER	STANLEY	CRITICAL ACCESS HOSPITALS		0%	0%	1%	2%	2%	2%	3%	3%	2%
MCKENZIE COUNTY HEALTHCARE SYSTEM	WATFORD CITY	CRITICAL ACCESS HOSPITALS		1%	1%	1%	3%	4%	6%	5%	4%	4%
GARRISON MEMORIAL HOSPITAL	GARRISON	CRITICAL ACCESS HOSPITALS		19%	20%	17%	26%	25%	25%	23%	22%	24%
TURTLE LAKE COMMUNITY HOSPITAL	TURTLE LAKE	CRITICAL ACCESS HOSPITALS		9%	23%	25%	28%	30%	34%	30%	11%	26%
KENMARE COMMUNITY HOSPITAL	KENMARE	CRITICAL ACCESS HOSPITALS		0%	0%	0%	25%	33%	26%	25%	19%	17%
COOPERSTOWN MEDICAL CENTER	COOPERSTOWN	CRITICAL ACCESS HOSPITALS		1%	1%	3%	9%	0%	4%	3%	6%	6%
ST ANDREWS HEALTH CENTER	BOTTINEAU	CRITICAL ACCESS HOSPITALS		12%	13%	14%	18%	16%	14%	14%	17%	13%
NELSON COUNTY HEALTH SYSTEMS-HO	MCVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	1%	0%	1%	1%	3%
SANFORD MAYVILLE	MAYVILLE	CRITICAL ACCESS HOSPITALS		1%	1%	3%	1%	2%	3%	3%	3%	3%
DAKAKAWEA MEDICAL CENTER	HAZEN	CRITICAL ACCESS HOSPITALS		5%	2%	2%	4%	3%	1%	5%	6%	5%
LISBON AREA HEALTH SERVICES	LISBON	CRITICAL ACCESS HOSPITALS		6%	8%	11%	9%	11%	10%	4%	7%	8%
NORTHWOOD DEACONESS HEALTH CENTER	NOTHWOOD	CRITICAL ACCESS HOSPITALS		1%	1%	1%	2%	4%	3%	4%	5%	5%
SOUTHWEST HEALTHCARE SERVICES	BOWMAN	CRITICAL ACCESS HOSPITALS		1%	1%	2%	2%	3%	2%	2%	1%	1%
JACOBSON MEMORIAL HOSPTAL	ELGIN	CRITICAL ACCESS HOSPITALS		1%	2%	23%	20%	19%	21%	20%	19%	19%
OAKES COMMUNITY HOSPITAL	OAKES	CRITICAL ACCESS HOSPITALS		4%	2%	2%	3%	7%	6%	2%	8%	9%
PRESENTATION MEDICAL CENTER	ROLLA	CRITICAL ACCESS HOSPITALS		0%	13%	12%	19%	24%	21%	28%	17%	20%
CARRINTON HEALTH CENTER	CARRINGTON	CRITICAL ACCESS HOSPITALS		1%	4%	4%	3%	5%	5%	2%	2%	6%
PEMBINA COUNTY MEMORIAL HOSPITAL	CAVALIER	CRITICAL ACCESS HOSPITALS		2%	1%	1%	4%	4%	2%	14%	2%	1%
UNITY MEDICAL CENTER	GRAFTON	CRITICAL ACCESS HOSPITALS		4%	4%	3%	3%	3%	6%	5%	4%	5%
WISHEK COMMUNITY HOSPITAL	WISHEK	CRITICAL ACCESS HOSPITALS		3%	3%	2%	1%	1%	2%	2%	2%	2%
ASHLEY MEDICAL CENTER	ASHLEY	CRITICAL ACCESS HOSPITALS		33%	11%	11%	1%	1%	1%	2%	2%	2%
CAVALIER COUNTY MEMORIAL HOSPITAL	LANGDON	CRITICAL ACCESS HOSPITALS		1%	8%	2%	3%	3%	1%	8%	1%	4%
MERCY HOSPITAL OF VALLEY CITY	VALLEY CITY	CRITICAL ACCESS HOSPITALS		2%	4%	3%	4%	6%	7%	4%	1%	9%
ST LUKES HOSPITAL	CROSBY	CRITICAL ACCESS HOSPITALS		5%	1%	1%	1%	0%	2%	1%	4%	3%
FIRST CARE HEALTH CENTER	PARK RIVER	CRITICAL ACCESS HOSPITALS		3%	3%	2%	2%	4%	3%	3%	3%	3%
ST ALOISIUS MEDICAL CENTER	PARVEY	CRITICAL ACCESS HOSPITALS		0%	0%	0%	4%	3%	5%	5%	4%	4%
LINTON HOSPITAL	LINTON	CRITICAL ACCESS HOSPITALS		0%	2%	1%	1%	3%	2%	3%	4%	2%
SANFORD HILLSBORO	HILLBORO	CRITICAL ACCESS HOSPITALS		28%	27%	31%	43%	3%	2%	2%	3%	4%
WEST RIVER REGIONAL MEDICAL CENTER	HETTINGER	CRITICAL ACCESS HOSPITALS		28%	1%	2%	1%	3%	1%	3%	3%	
TOWNER COUNTY MEDICAL CENTER	CANDO	CRITICAL ACCESS HOSPITALS		1%	1%	1%	1%	2%	3%	3%	3%	2%
HEART OF AMERICA MEDICAL CENTER	RUGBY	CRITICAL ACCESS HOSPITALS		1%	21%	26%	21%	2%	25%	30%	3%	14%
MERCY HOSPITAL OF VALLEY CITY	DEVILS LAKE	CRITICAL ACCESS HOSPITALS		12%	16%	15%	20%	23%	26%	10%	14%	34%
MERCY MEDICAL CENTER	WILLISTON	CRITICAL ACCESS HOSPITALS		4%	3%	4%	5%	4%	6%	6%	41	6%
JAMESTOWN REGIONAL MEDICAL CENTER	JAMESTOWN	CRITICAL ACCESS HOSPITALS		9%	9%	8%	9%	10%	13%	13%	7%	10%
ST JOSEPHS HOSPITAL AND HEATLH CENTER	DICKINSON	CRITICAL ACCESS HOSPITALS		5%	6%	5%	5%	8%	8%	7%	2%	8%

Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals

- DHS collected and extracted information from PPS and CAH cost reports for 2019
  - Medicare is the **primary payer source** for the CAHs
  - Net operating margins were on average -**1.8%** *(Larger CAHs have better net operating margins)*
  - Historically, CAH **net operating margins are negative** and Medicare **sequestration** have **exacerbated** this issue.
- In 2019, estimated **total Medicaid revenues** were **9.9%** of total revenues
  - If 20% of the expenditures are for expansion, DHS estimates that CAHs will have reduced revenues of **approximately $4.7 million to $12.8 million** (75% of inpatient and 100% of outpatient)

Prior Testimony Critical Access Hospital Impact

Prior testimony implied that DHS has not considered the impact on critical access hospitals

Actuary studied CAH revenue structure for expansion at traditional and expansion rates. Would remove about **$7 to $7.5 million** from the CAH payment system.

	CY17 Number of CAHs	CY18 Number of CAHs	CY17 Percent of CAHs	CY18 Percent of CAHs
Repriced > Incurred Dollars	16	14	44.4%	38.9%
Incurred > Repriced Dollars	20	22	55.6%	61.1%

Prior Testimony Critical Access Hospital Impact

Another Source of Funding:

- CAHs can participate in Health Homes if they have a Rural Health Clinic or FQHC *(Large CAHs were included in value-based purchasing discussion as well)*

Possible solutions:

- Increase supplemental payment by **$7.5 million up to $12.8 million**, there is room in the Upper Payment Limit for Outpatient Hospital Expenditures of about $50 million of which about $15 million can be used for expansion. This would mean rebasing CAHs for inpatient and outpatient care.
- Could consider providing **$7.5 million** more in revenue to CAHs which is about **7% rate increase** on traditional spending for CAH acute and outpatient care.

Prior Testimony Critical Access Hospital Impact

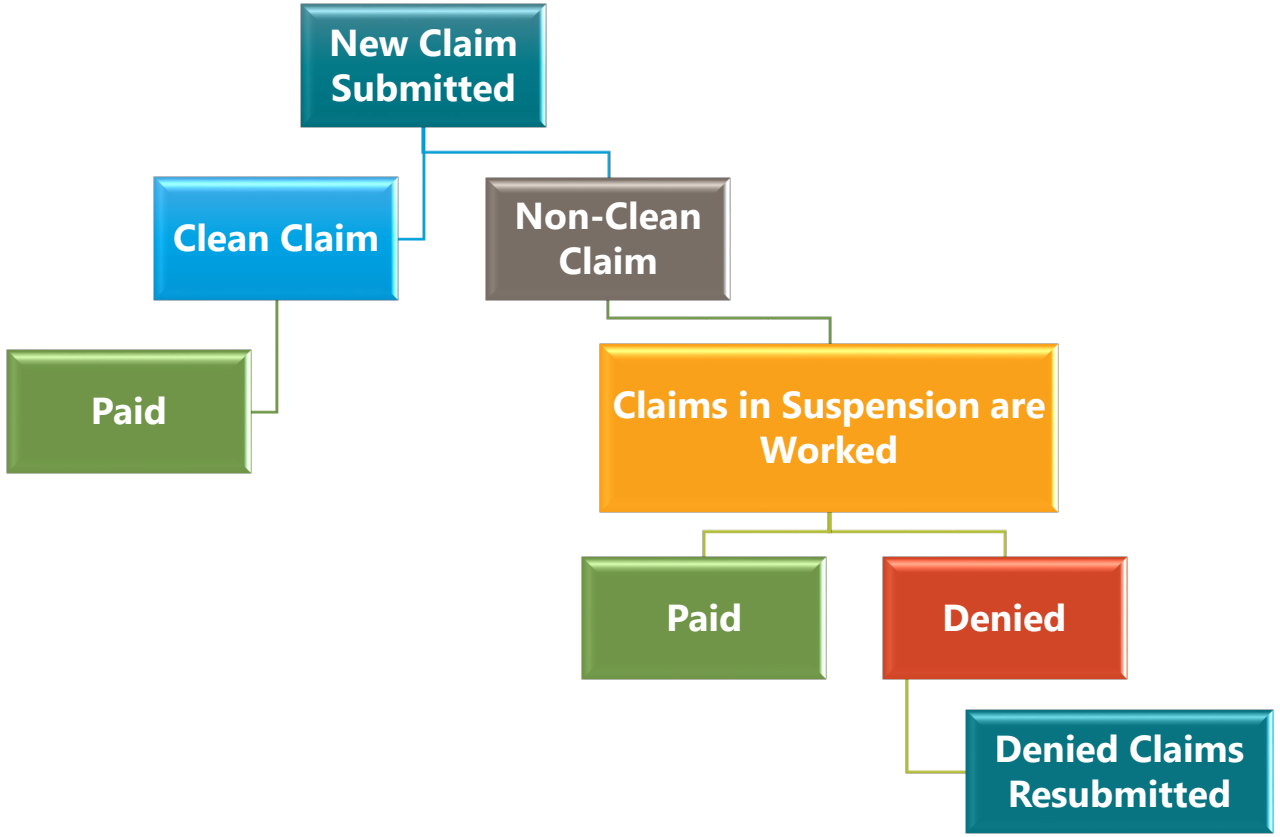
Prior testimony implied that critical access hospitals would close

- **DOH record on hospital closures-**
  - **Dakota Heartland Health System**, Fargo closed in 2002 (PPS)
  - **Richardton Memorial Hospital and Health Center**, Richardton closed in 2009 (CAH)
  - **Red River Behavior Health Systems**, Grand Forks closed in Sept 2020 (Psych)
  - **Altru Rehabilitation Center**, Grand Forks terminated their state hospital license in 2019 (Rehab) *(Altru still remains certified as a hospital and has 2 licensed locations)*

2 Hospital Closed Before Expansion &
2 Closed Since Expansion was Implemented

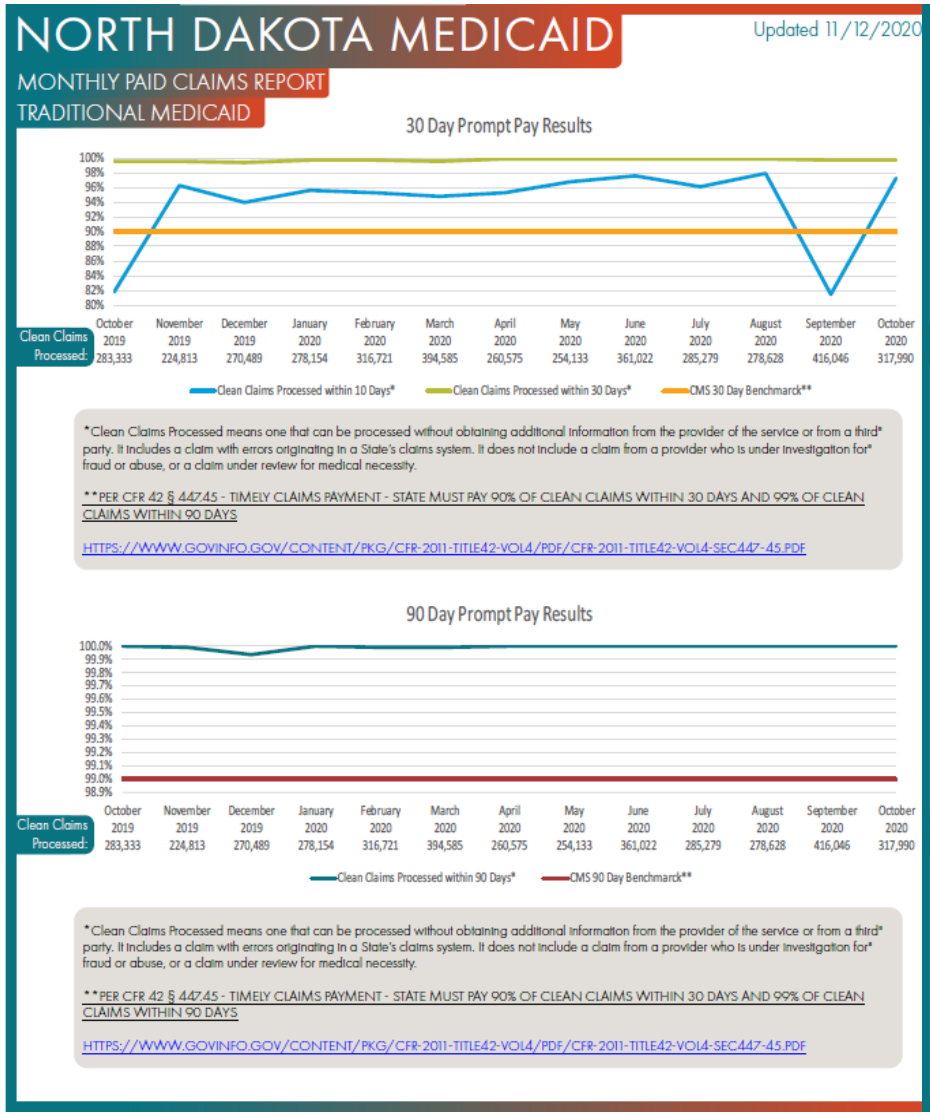
Prior Testimony Claims Payment Turn Around

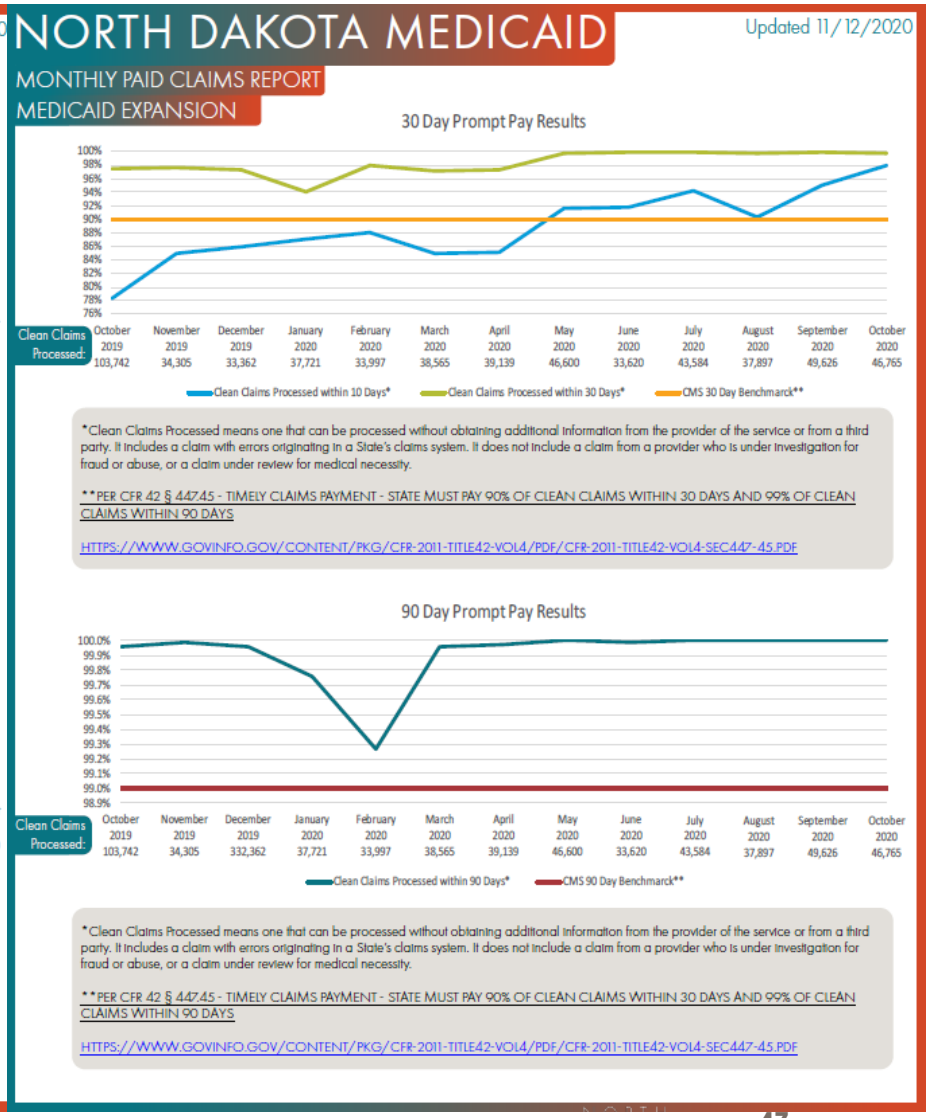
Lifecycle of a Claim



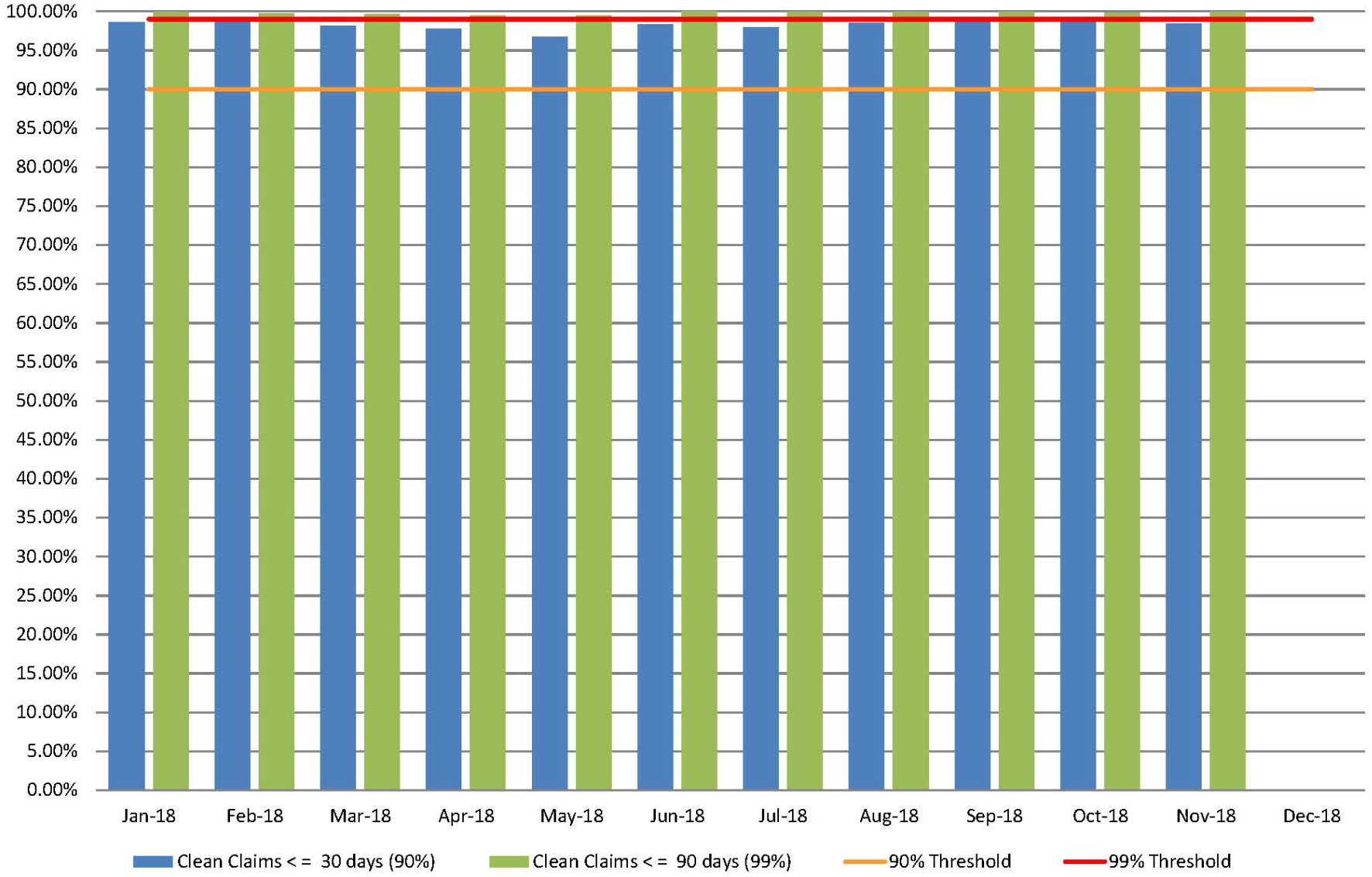
Prior Testimony
Claims Payment Turn Around

Clean Claim payment turnaround times between ND Traditional FFS Medicaid and MCO Medicaid Expansion



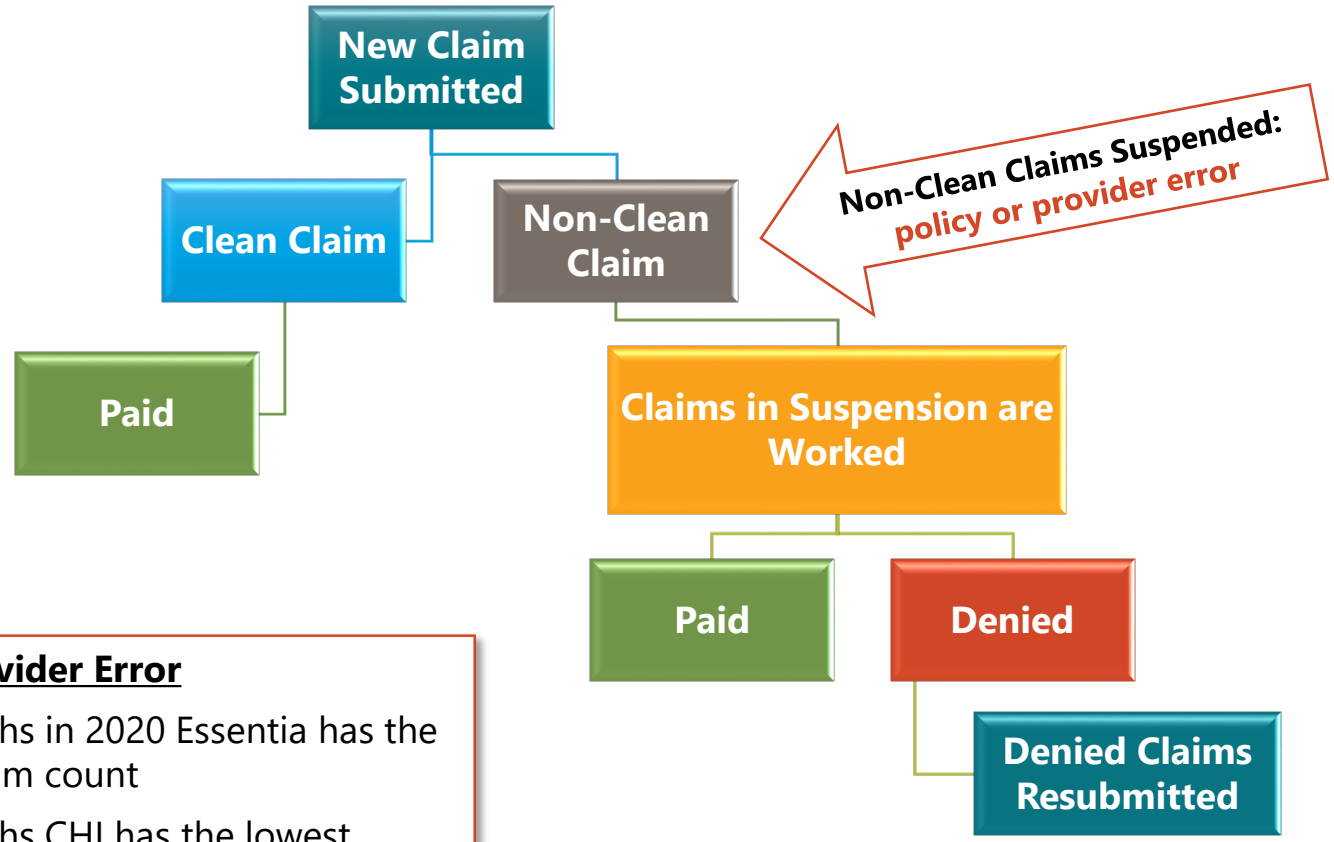


Prior Testimony
Claims Payment Turn Around



Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim

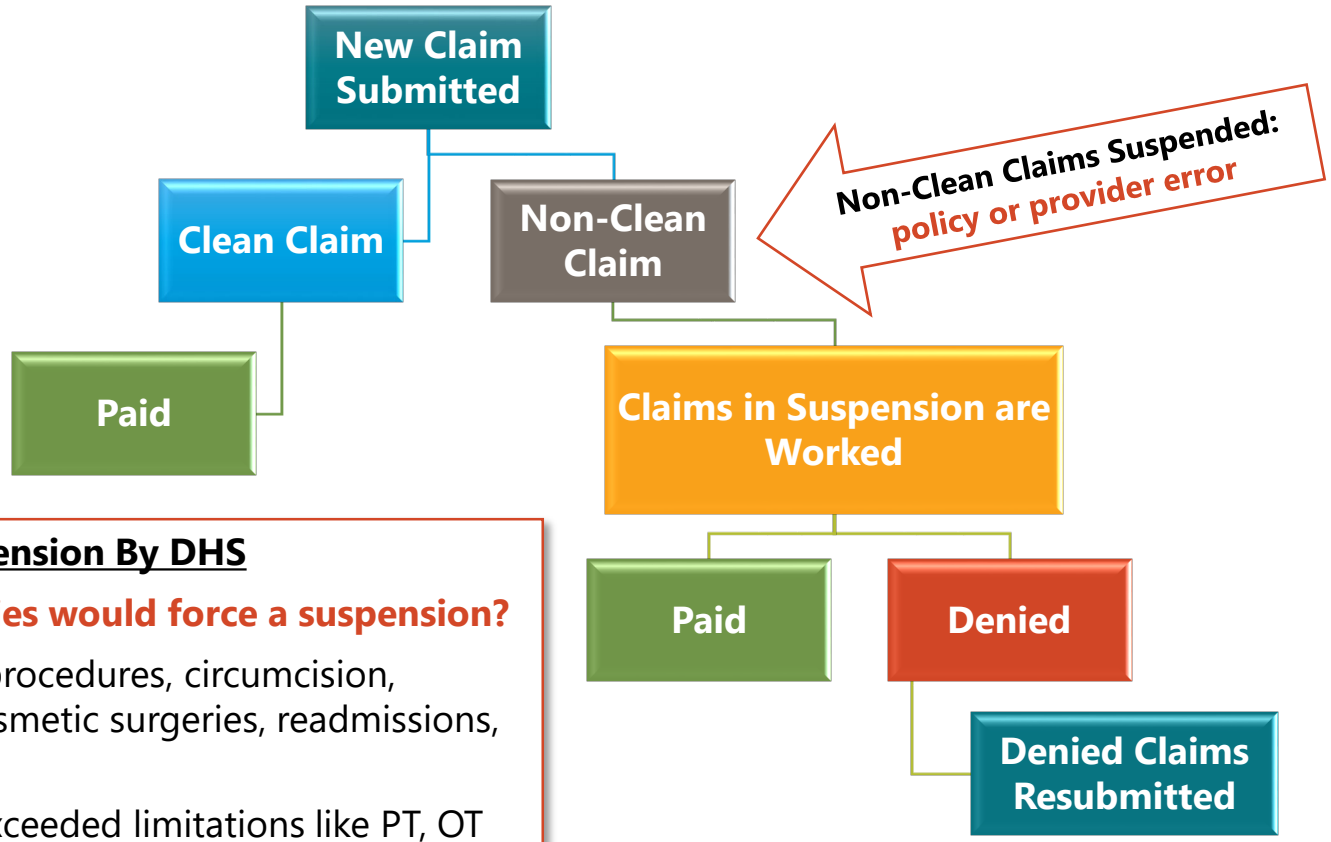


Provider Error

- 7 out of 12 months in 2020 Essentia has the highest clean claim count
- 6 out of 12 months CHI has the lowest
- 4 out of 12 months Altru has the lowest

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

What Medicaid policies would force a suspension?

- Review of certain procedures, circumcision, appendectomy, cosmetic surgeries, readmissions, etc.
- If a member has exceeded limitations like PT, OT
- Third party liability (TPL) as Medicaid is the payer of last resort
- DRGs not appropriate

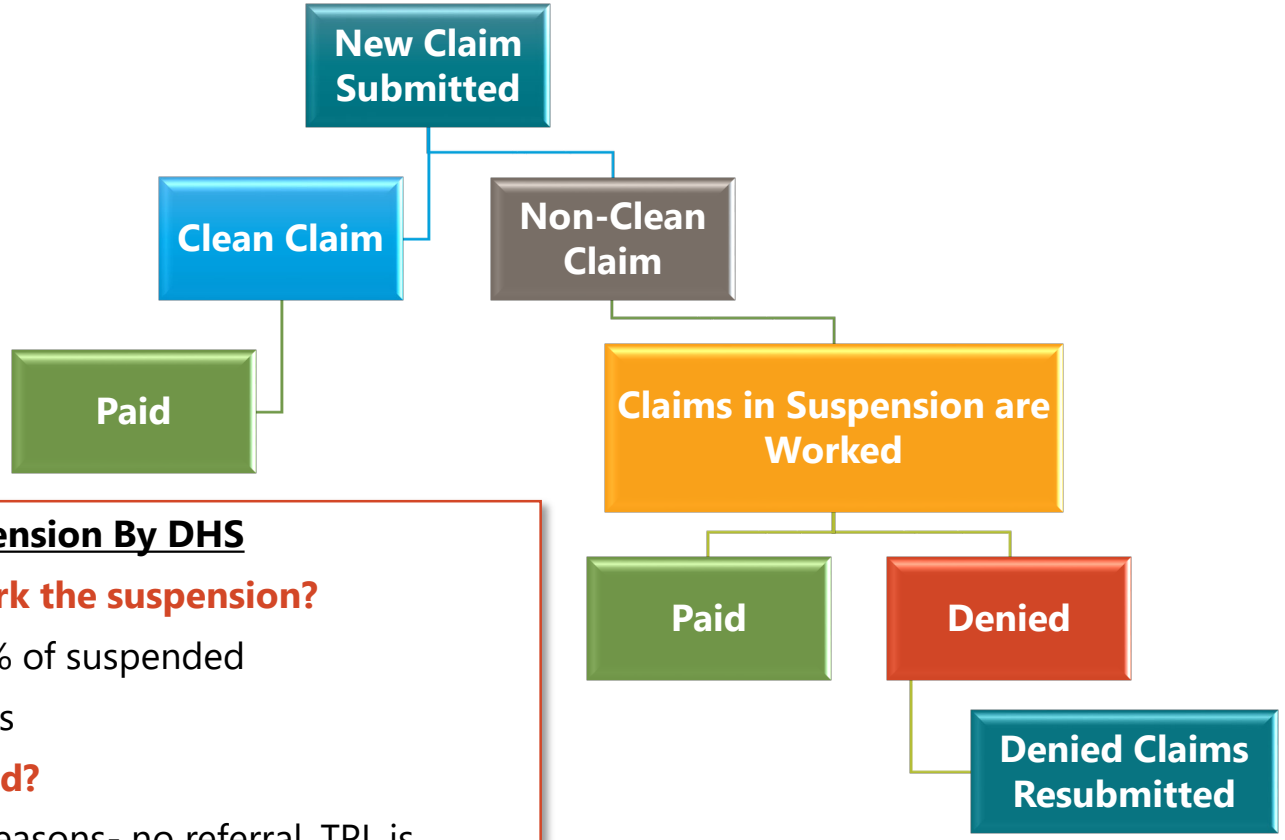
Prior Testimony Claims Payment Turn Around

MEDICAID ANNUAL PROFILE REPORT
Provider Review Results
Peer Group 1
Reviews: 7/1/2017 - 6/30/2018

Provider	# of Cases	# Cases Denied	Billing Denial	Technical Denial	Medical Necessity Denial	Denied %	Billing Denial %	Technical Denial %	Medical Necessity %	# DRGs Changed	% of Cases with DRG Changes
Sanford Medica Fargo	608	2	0	1	1	0.3%	0.0%	0.2%	0.2%	7	1.2%
Sanford Medica Bismarck	582	3	0	2	1	0.5%	0.0%	0.3%	0.2%	4	0.7%
Altru Hospital Grand Forks	437	10	0	0	10	2.3%	0.0%	0.0%	2.3%	21	4.8%
Trinity Hospital Minot	374	2	0	0	2	0.5%	0.0%	0.0%	0.5%	5	1.3%
St. Alexius Med Bismarck	275	9	1	0	8	3.3%	0.4%	0.0%	2.9%	9	3.3%
Essentia Health Fargo	187	4	0	2	2	2.1%	0.0%	1.1%	1.1%	6	3.2%
Peer 1	**2463**	**30**	**1**	**5**	**24**	**1.2%**	**0.0%**	**0.2%**	**1.0%**	**52**	**2.1%**

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

How long to take work the suspension?

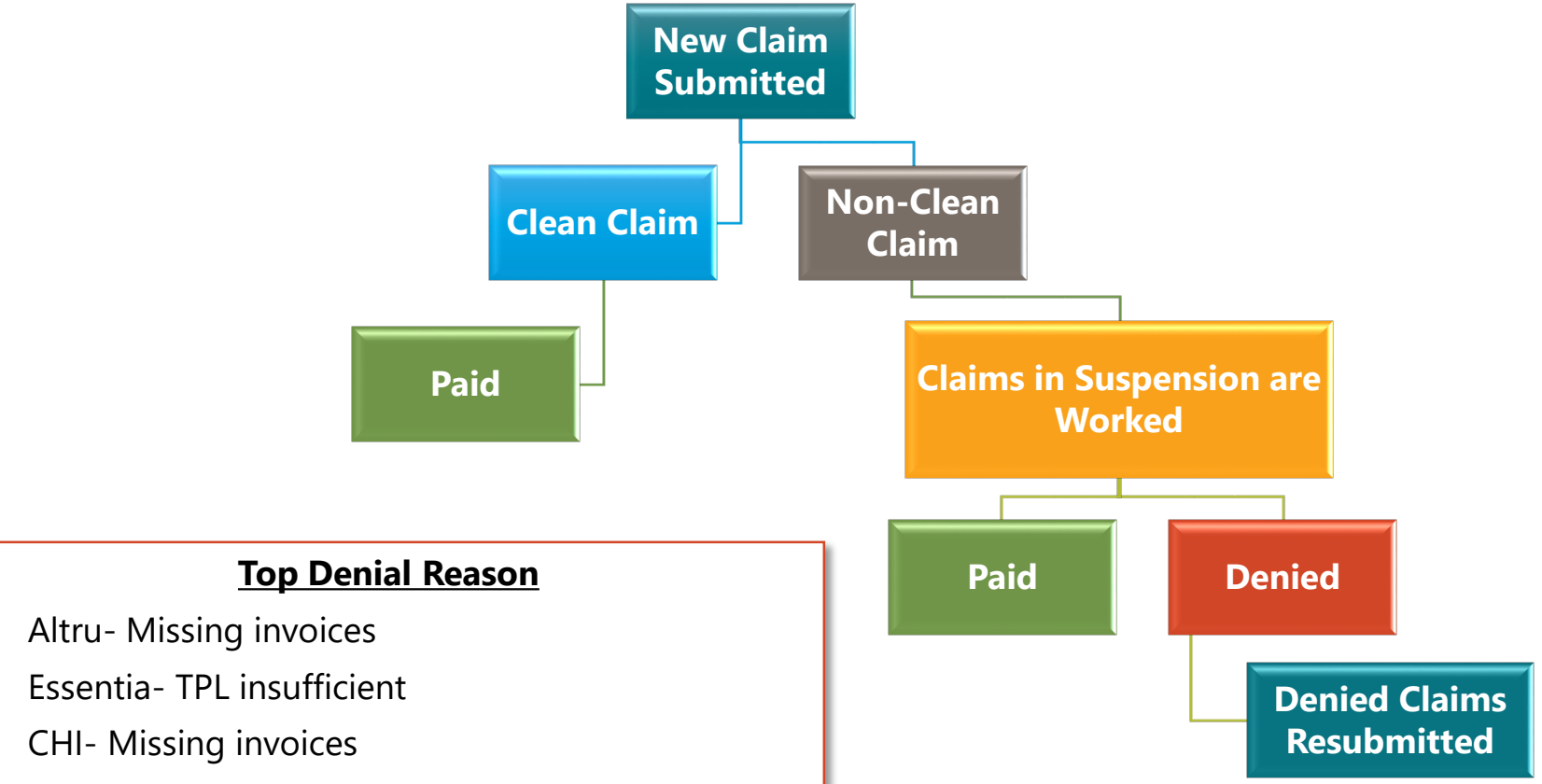
- Within 10 days 54% of suspended
- 84% within 30 days

Why are claims denied?

- These are provider reasons- no referral, TPL is insufficient, attending provider license expired, billing provider license expired, missing invoice
- These are state reasons to deny- diagnosis requires review, TPL issues, claim type on review, trauma/accident (looking for accident file like State Farm invoice)

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Top Denial Reason

- Altru- Missing invoices
- Essentia- TPL insufficient
- CHI- Missing invoices
- Trinity- Billing provider license expired
- Sanford Fargo- Billing provider license expired
- Sanford Bismarck- Billing provider license expired

Prior Testimony
ND Medicaid Savings

RX Claims- Net Costs By Quarter

Quarter	Spend	Per Member Per Month
3Q 2019	$3,030,829.88	$51.26
4Q 2019	$2,934,056.57	$49.27
1Q 2020	$2,419,967.44	$39.70
2Q 2020	$2,591,717.60	$40.15
3Q 2020	$2,794,276.77	$41.23

RX Claims Savings

- Rx Average PMPM 4Q17 – 4Q19
  - $48.16
- Rx average quarterly spend 4Q17 – 4Q19
  - $2.91 million
- Rx Average PMPM 1Q20 – 3Q20
  - $40.36
- Rx average quarterly spend 1Q20 – 3Q20
  - $2.6 million

Prior Testimony
ND Medicaid Savings

Savings From RX Carve Out- IHS

- **IHS claims are now 100% FMAP**
  - Prior to carve out, claims simply part of the rate
- **$3.6 million saved (1Q20 – 3Q20)**
  - Currently trending at $1.2 million per quarter
  - $3.6 million projected for next three quarters for total of $7.2 million in savings
- **Expansion contract included contractor being responsible for ensuring Medicaid Expansion was the payer of last resort**
- With DHS paying Rx claims, we have now included Expansion population in our processes for finding other coverage
- **A minimum of 190 recipients have been found to have Medicare coverage**
  - Premium ranges from roughly $900 to $1400 per month for different expansion recipients
  - 190 recipients X $1052 per month = $200,000 per month
- **$2.2 million in premium savings (Feb 2020 through Dec 2020)**
  - $1.2 million expected for next six months to total $3.4 million

Prior Testimony
ND Medicaid Savings

RX Carve Out Savings

	Realized Savings	Expected Total Savings
Claims	$ 1,509,000	$ 3,018,000
IHS	$ 3,600,000	$ 7,200,000
Premiums	$ 2,200,000	$ 3,400,000
Administration	$ 2, 641,000	$ 3,441,000
Total	**$ 9,950,000**	**$ 17,059,000**

Expected Total Savings

- Claims = $3.018 million (> $2.1 million projected in 2019 session)
- 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 HIPF going away in 2021)

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

Prior Testimony
ND Medicaid Savings

CHIP Savings (1Q20-3Q20)

Expected CHIP cost	**$6,706,332**
▪ *Average 2,378 kids per month x Average $313.38 premium per month*	
Actual CHIP cost	**$1,932,582**
Actual Provider Payments	**$2,872,734**
Drug rebates	**$940,152**
Savings	**$4,773,750**
% reduction	**71.18%**

Prior Testimony Commercial Premiums

Prior testimony implied that there would be an increase to commercial premiums if Medicaid expansion rates are set at traditional fee schedule.

Manatt Health Strategies consulted to see if there was any evidence of cost shifting due to decrease in government health payments for health care.

The answer was NO

Literature cited:

- Colorado Department of Health Care Policy and Financing, Colorado Hospital Cost Shift Analysis, January 2020
  - *"Despite significant reductions in uncompensated care and significant increases in Medicaid and Medicare rates, hospitals are persistently increasing the price of care."*
  - *"Cost shifts are driven by strategic hospital decisions, not by shortfalls from public insurance. The increased funding generated by public, taxpayer funded programs— which are intended to reduce private insurance premiums and out-of-pocket costs — are not being passed along to health care consumers and employers."*
- Kaiser Health News, Medicaid Expansion Boosts Hospital Bottom Lines — And Prices, March 2019
- Colorado Health Institute: The Cost Shift Myth

Historical studies and articles:

- JAMA Forum, Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers, January 2017
- Journal of Health Economics, Shock, But No Shift: Hospitals' Responses to Changes in Patient Insurance Mix, September 2016 (full article)
- New York Times, Hospitals Are Wrong About Shifting Costs to Private Insurers, March 2016
- Milbank Quarterly, How Much Do Hospitals Cost Shift? A Review of the Evidence, March 2011 (Pre-ACA)

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

Medicaid expansion is still 90%/10% match regardless of if it is under a managed care company or DHS.

Even though the State match is only 10%, it is more difficult to find that State match each session. 10% of **a larger number** is harder to find than 10% of a smaller number. Suppose the Legislature does not support this policy proposal the total appropriation (at current rates**) $708 million of which $80 million is General Fund. This is an increase of $73 million from 19-21 ($14 million in General Fund)**

This point implies that taxpayers only are concerned with the 10% State match. American taxpayers are responsible for the **entire amount** as it comes from federal taxes and some from State taxes.

The federal government continues to investigate Medicaid expansion spending. GAO reports typically are the first steps before legislative action, and several have already been commissioned:

- from 2017 https://www.gao.gov/products/GAO-17-145 and
- from 2020 https://www.gao.gov/products/GAO-20-260
- from 2020 https://www.gao.gov/products/GAO-20-157
- from 2020 https://www.gao.gov/assets/720/710680.pdf.

Prior Testimony Not Taking Advantage of Federal Funds

Prior testimony implied that transitioning Medicaid expansion from managed care to DHS administration would *"leave federal dollars on the table".*

During revenue downturns, 100% state-funded programs and **traditional Medicaid providers are disproportionately targeted for savings** versus expansion providers due to the funding split. Again, this creates a **non-equitable** Medicaid system.

100% General Fund or 50%/50%	**90%/10%**
Autism Voucher, Basic Care, AARP, Valley Senior Services, Alzheimer's Association, Independence Inc., Poppy's Promise, Red River Human Services Foundation, Enable Inc., Family Voices of ND, Mental Health America ND, Dacotah Foundation, Beyond Shelter, Cooper House, Edwin House, LaGrave on First, ShareHouse, Prairie St. John's, Northland PACE, ND Brain Injury Network, ND Brain Injury Advisory Council, ARC of ND, Nexus-PATH, Prairie Harvest Mental Health, Developmental Disabilities, HCBS, Nursing Homes, Dental, Vision, Pediatrics	**Expansion**

Developmental Disability providers and **Nursing Homes** have put in the hard work to have **more equitable reimbursement**, reducing the financial burden on the State

Other Solutions? 2019 NDHA Study

DHS is committed to considering all possible solutions brought forward by stakeholders.

In 2019 NDHA brought forth a study by Levitt that indicated Accountable Care Organizations (ACOs) would be a viable solution.

After careful review and study DHS has the following observations:

- ACOs, like managed care in general, requires a large enough risk pool to spread the risk. By continuing to separate traditional and expansion, there would not be a critical mass of members to make this a viable solution. NDHA members expressed this concern during recent value-based purchasing meetings.
- ACOs might be possible if hospitals would work together in a regional or statewide approach. NDHA members expressed concern about working in a regional approach at recent value-based purchasing meetings.
- ACOs do not bring down commercial rates.
- ACOs can only reduce costs if providers accept upside and downside risk. DHS could not identify any providers in the state that have accepted downside risk. Therefore, the state would only be sharing the savings when providers manage below the total cost of care. The State would realize no savings if providers were unable to manage under the total cost of care unless 2-sided risk was mandatory.

Possible Outcome of Solution:
Reduced Rates **NO**; Better Management **???**

Other Solutions? Use of Tribal Care Coordination Dollars

DHS is committed to considering all possible solutions brought forward by stakeholders

Tribal care coordination savings were mentioned as a way to save general fund dollars instead of transitioning Medicaid expansion

Below is an update on tribal care coordination savings:

- To date, IHS and 2 providers (Sanford and CHI) have entered into an agreement to coordinate care
- However, 100% FMAP cannot be claimed until tribes agree as well ***(Thus far, no tribe has agreed)***
- Legislation from 2109 set the savings split from the 100% FMAP at 60% State: 40% Tribes ***(No tribe has agreed to this split)***
- DHS did not include savings last biennium or this biennium on tribal care coordination as the decision to participate is solely left to the tribes
- DHS has been working with Sanford and CHI to ensure that when, and if, the agreements are signed the correct FMAP can be applied to the claims
- Note that this solution is independent of the managed care organization

Possible Outcome of Solution:
Reduced Rates **NO**; Better Management **Yes**,
for tribal members only

ND Medicaid
The Future

- Medical Services Division's aim is to restructure its Medicaid programs to promote better care and **quality** for members, **reduced burden** on providers, and be **trusted stewards** of taxpayer dollars.
- Medical Services aims to have **equity for all ND Medicaid members**, regardless of one's category of eligibility, allowing for continuity of care across the continuum to ensure high quality care and outcomes.
- Medical Services aims to **align benefits** across the entire Medicaid program. Legislators have inquired previously about providing dental benefits, vision benefits and long-term care and support services for expansion members.
- Medical Services strives for a comprehensive utilization management approach through **health homes** to ensure patient centered care across the continuum.
- Medical Services seeks to create a **realistic risk pool** that can ultimately be used to spread risk, lower cost, and drive value through the entire program.
- Medical Services aims to give providers **consistent processes** in relation to service authorization, appeals, claims submission, and provider enrollment.

Thank you!

North Dakota Medicaid

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NORTH Dakota | Human Services
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