House Bill 1012

House Appropriations | Human Resources Division
Representative Nelson, Chairman

Medical Services Overview | Sarah Aker | Executive Director

January 14, 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

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

- Who We Serve
- Who We Are
- Improving the Lives of North Dakotans
- 2025 – 2027 Budget & Other Resource Requirements
- Summary

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Who We Serve

North Dakota Medicaid

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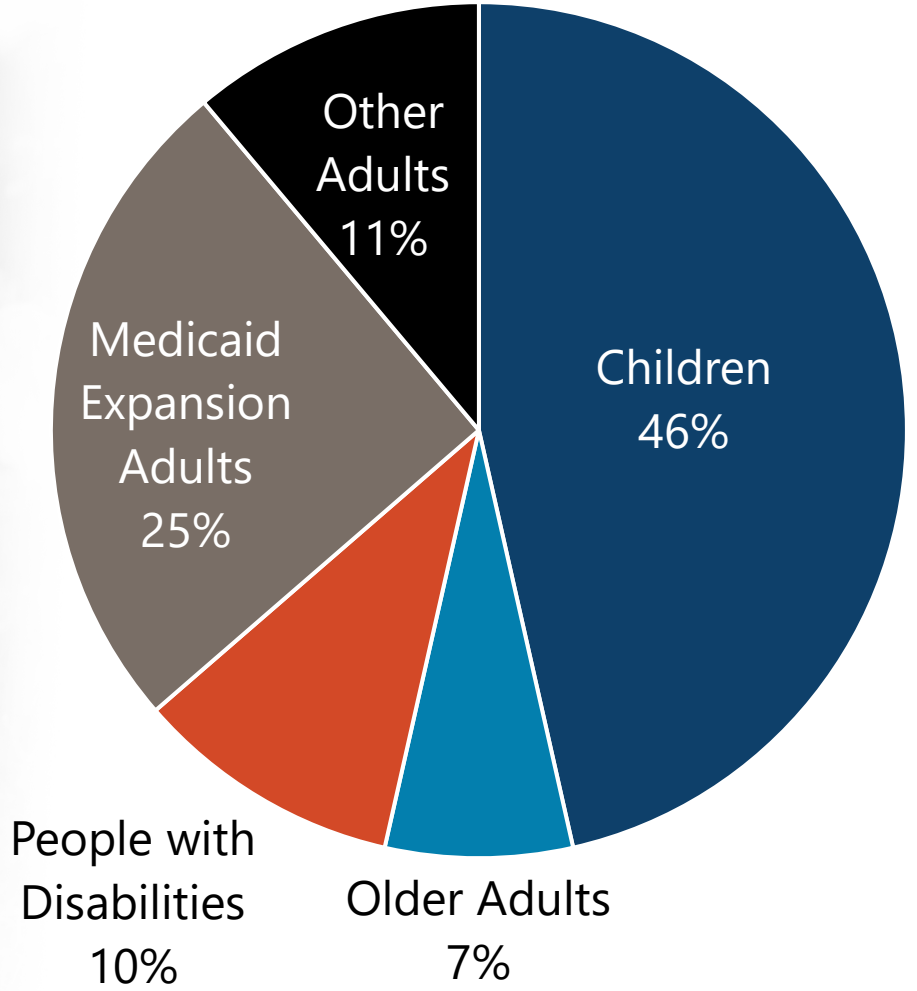
Who is covered by North Dakota Medicaid?



State Fiscal Year 2024

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

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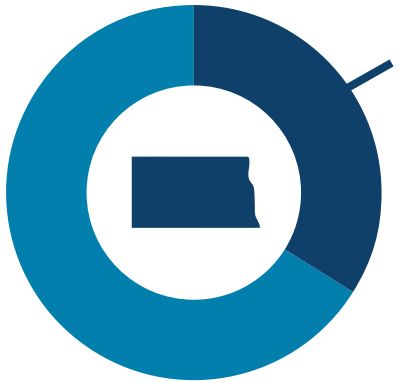
Who We Serve

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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Who We Are

Medical Services Division

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What is Medicaid?

- Medicaid is the nation's publicly financed health care coverage program for low-income people enacted in 1965 under Title XIX of the Social Security Act and Title XXI of the Children's Health Insurance Program (CHIP) enacted in 1997
  - An entitlement program that requires all eligibles to receive services and is funded through federal and state dollars
  - Provides health coverage for eligible individuals
  - It is a Federal – State partnership
- States administer the Medicaid program
  - Each state plan is different due to optional services provided making it difficult to compare states side-by-side
- Medicaid is separate from Medicare
  - Medicare is for individuals 65 years and older for all incomes, and for people with disabilities
  - Medicare is a federally administered and funded program
  - Individuals can be eligible for both Medicare and Medicaid.

Medicaid Regulations

Federal Government

Social Security Act (SSA)	Title XIX - Medicaid Title XXI - CHIP
Code of Federal Regulations (CFR)	42 CFR Part IV
State Medicaid Director Letters (SMDLs) and State Health Official (SHO) Letters	Supplemental guidance issued by the Center for Medicare and Medicaid Services (CMS) containing CMS policy interpretations of the SSA or CFR.
Medicaid State Plan & Medicaid Waivers	Acts as a contract between the state and the federal government describing how North Dakota administers the state's Medicaid program and waivers of the Medicaid program.

State Government

Century Code	50-24.1 – Medical Assistance for Needy Persons 50-24.6 – Medical Assistance Drug Use Review and Authorization 50-29 – Children's Health Insurance Program
Administrative Code	75-02-02 – Medical Services 75-02-02.1 – Eligibility for Medicaid 75-02-05 – Provider Integrity 75-02 – Economic Assistance 75-03 – Community Services 75-04 – Developmental Disabilities
State Billing and Policy Manuals	ND Medicaid guidance for providers regarding covered services and billing requirements.

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Mandatory and Optional Covered Services

Mandatory Services

- Inpatient hospital
- Outpatient hospital
- EPSDT: Early and Periodic Screening, Diagnostic and Treatment Services
- Nursing facility
- Home health
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Family planning services
- Nurse midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

North Dakota Optional Services

- Prescription Drugs
- Clinic services
- Physical therapy, occupational therapy and speech, hearing and language disorder services
- Respiratory care services
- Podiatry services
- Optometry services and eyeglasses
- Dental services and dentures
- Prosthetics
- Chiropractic services
- Personal Care and Private Duty Nursing services
- Hospice
- Case Management
- Services for Individuals Age 65 or Older in an IMD
- Services in an ICF for individuals with an intellectual disability
- 1915(i) and 1915(c) Home and Community Based Services
- Inpatient psychiatric services for individuals under age 21
- Basic Care

Medicaid Waivers

- Waivers are a method for a state to test new or different ways to deliver and pay for health care services
  - Cannot waive the basic tenants of Medicaid
  - Cannot cap overall Medicaid enrollment
  - Must be cost/budget neutral
- Can vary from existing federal Medicaid requirements in certain areas
  - Access to services
  - Level of care requirements
  - Services Provided
  - Population Served
- Specific process to obtain Waivers
  - Requires a series of detailed steps, including an application and public notice
  - Requires a series of negotiations between the state and the federal government
- Common waivers include 1915(c) and 1115 waivers.

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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 Programs for All Inclusive Care for the Elderly (PACE)	1915(i)
	Medicaid State Plan		
Children	Traditional Intellectual Disabilities and Developmental Disabilities HCBS Waiver Autism Spectrum Disorder Waiver	Waiver for Medically Fragile Children	1915(i)

Children's Hospice Waiver

Money Follows the Person

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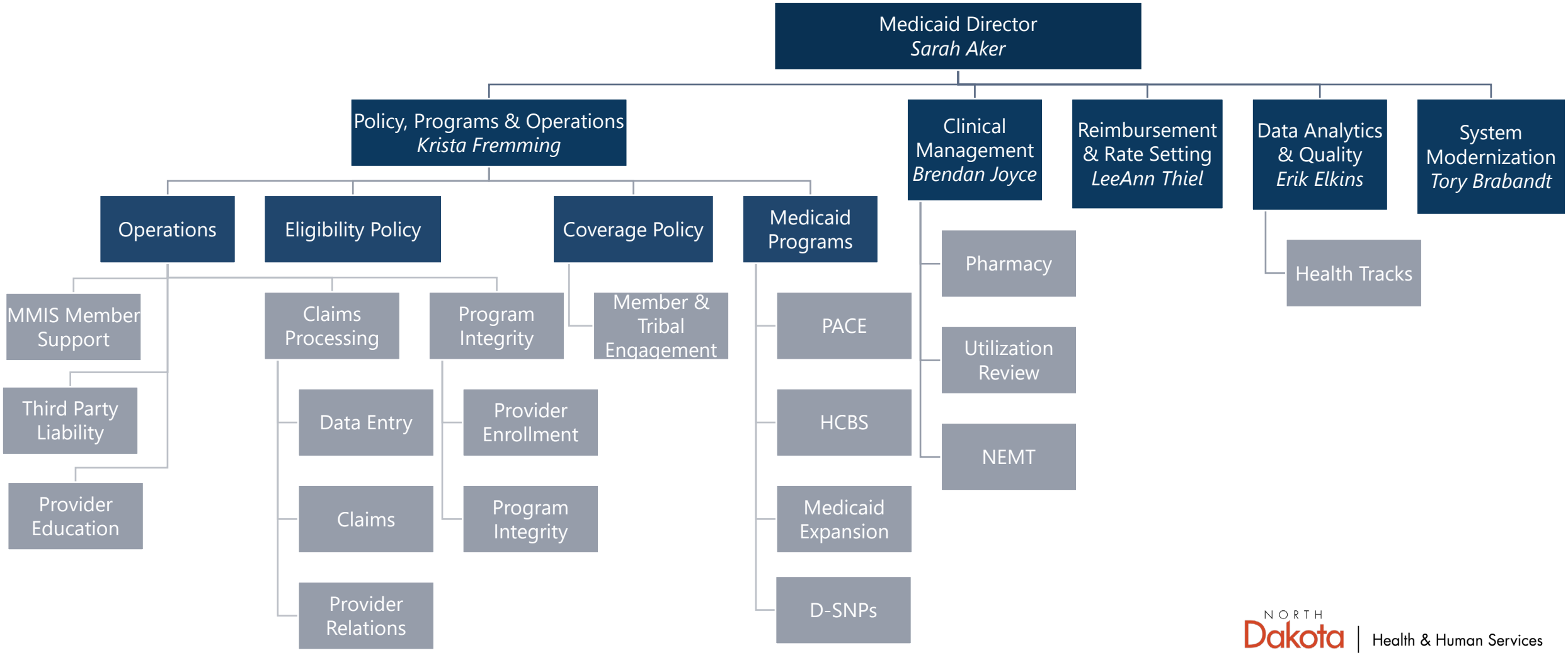
Federal Regulation Changes Issued in 2024

- Interoperability Final Rule
- Eligibility Final Rule
- Access to Care Final Rule
- Managed Care Final Rule
- Minimum Staffing Requirements Final Rule

Medical Services Division



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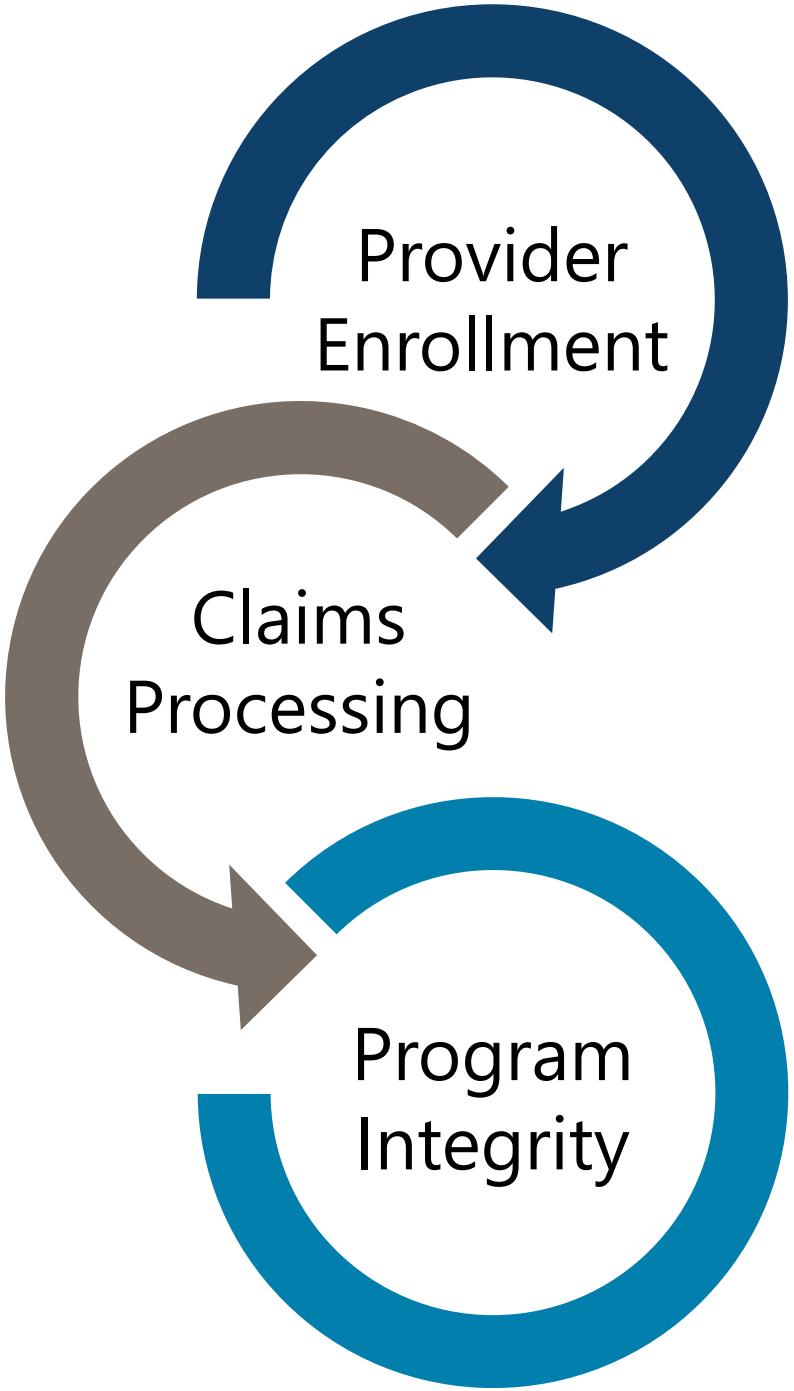

PROVIDER ENROLLMENT

- Ensures providers meet all federal and state standards to enroll as a Medicaid provider and remain an eligible provider.
- ND Medicaid has over 24,000 enrolled providers.
- On average, new enrollments were processed within 11 days.

CLAIMS PROCESSING

- Processes claims for services from Medicaid providers.
  - Includes claim functions for other state entities (ex. DOCR).
- Over 7 million claims processed annually. Claims were processed within 7 days of receipt during SFY24.
  - Data entered 44,115 paper claims in SFY24.
  - Manually processed 634,972 claims in SFY24.
- Answered over 52,000 annual calls from providers & members.

PROGRAM INTEGRITY

- Conducts federally mandated review process through post-payment provider reviews and investigates reports of fraud, waste and abuse.
- Medical Services staff works alongside the Medicaid Fraud Control Unit (MFCU) & CMS Program Integrity Contractors.

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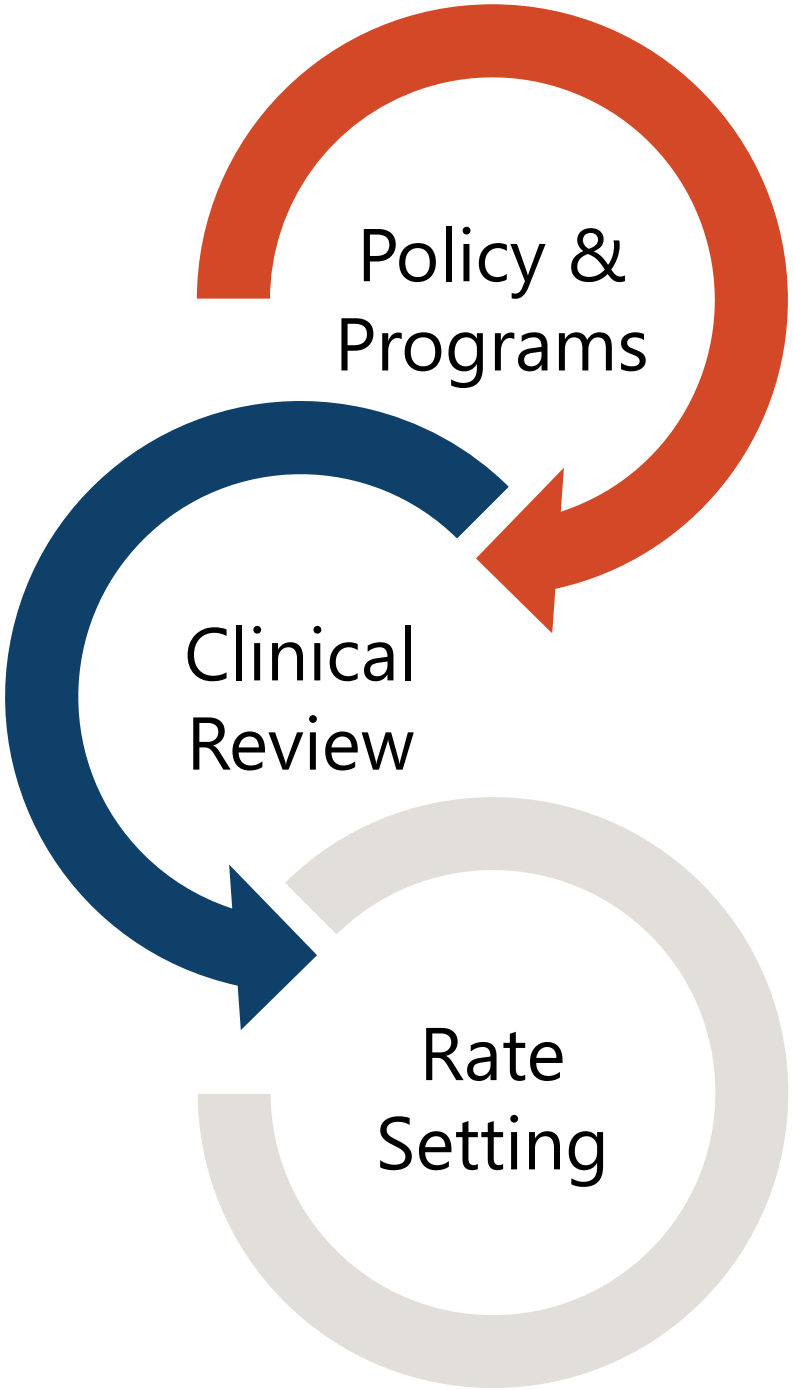
Program Integrity

- Post-Payment Reviews
- Ad Hoc Audits
- Recurring Audits
- Fraud, Waste, Abuse Investigations
- Payment Error Rate Measurement (PERM)
- Unified Program Integrity Contractor Coordination
- Medicaid Fraud Control Unit Coordination

- **2024 Provider Fraud, Waste, Abuse:**
  - Total Opened Cases: 49
  - MFCU Referrals: 4
  - Provider Terminations: 4
- PERM
  - ND last completed PERM in 2022. Current PERM audit in process.

	North Dakota 2022	National 2022	National 2023	National 2024
Fee-for-Service	3.0%	10.42%	6.90%	4.83%
Eligibility	5.0%	11.89%	5.95%	3.31%
Overall	6.9%	15.62%	8.58%	5.09%



POLICY & PROGRAM ADMINISTRATION

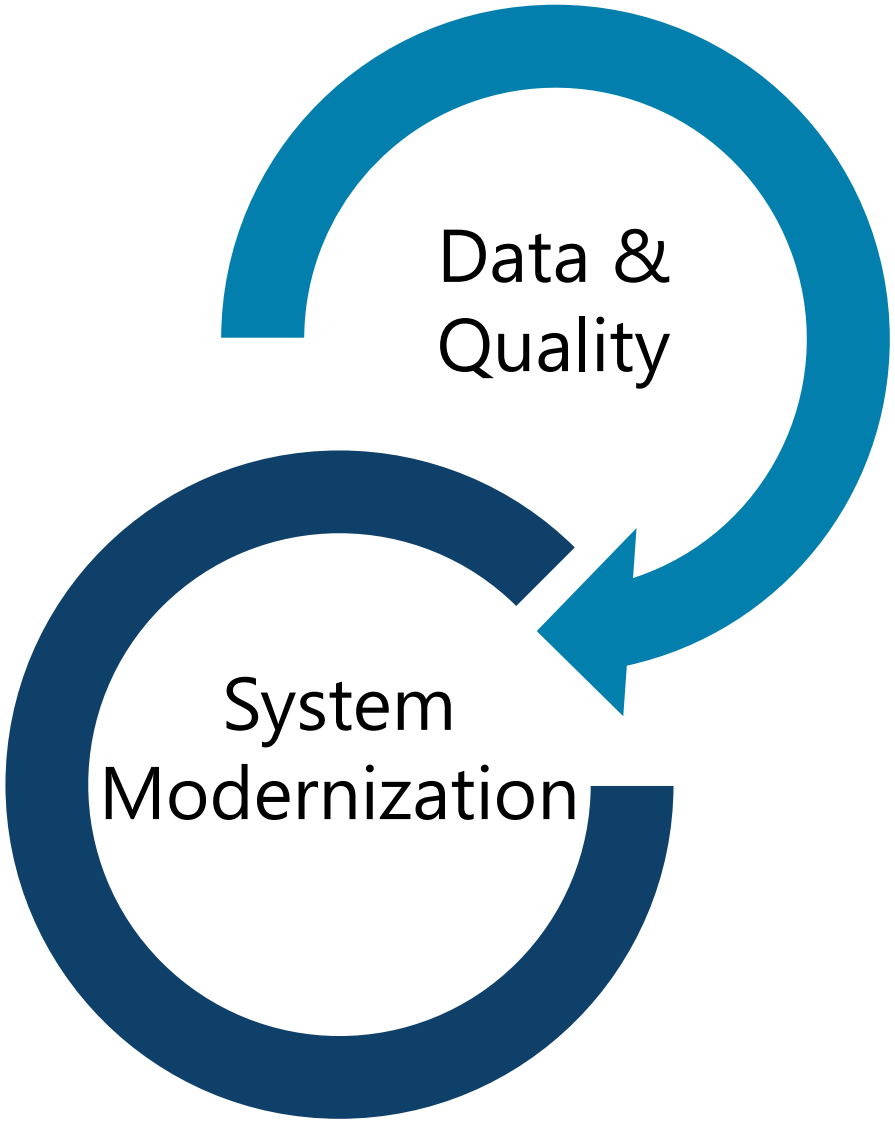
- Eligibility & Coverage Policy
- HCBS Operations & Oversight
- Managed Care Oversight
- Provider, Member & Tribal Engagement

CLINICAL REVIEW & PHARMACY MANAGEMENT

- Service Authorization & Certification of Need
- Non-Emergency Medical Transportation
- Hospital Complex Discharge Planning
- Drug Utilization Review
- Preferred Drug List (PDL) & Supplemental Drug Rebates

REIMBURSEMENT & RATE SETTING

- Research, calculate, and set provider rates and rate methodologies.
- Review & audit provider cost reports.
- Calculate Medicaid Upper Payment Limits.



DATA & QUALITY

- Data Analytics & Reporting
- Quality Strategy
- Health Tracks
- Value Based Programs

SYSTEM MODERNIZATION

- Implement Medicaid IT Roadmap to ensure systems are up to date.
- Responsible for submitting IAPD and OAPD for Medicaid systems to capture enhanced federal match.
- Current & Upcoming Modernization Projects:
  - Systems Integrator | Leidos | Kicked-Off May 2024
  - Module 1: Provider Enrollment | RFP Draft in Progress

2022 Single Audit
Findings and Programmatic Recommendations

- 2022-008 Medicaid Cluster. Develop a corrective action plan to address the errors identified in the audit and recover payments made on unsupported claims. *The Department recovered payments made on unsupported claims. HHS continues to educate providers about documentation requirements for Medicaid services.*
- 2022-009 Medicaid Cluster. Complete a risk analysis and security review of MMIS biennially. *A security review and penetration test was completed by NDIT in 2023. Another is scheduled for 2025.*
- 2022-010 Medicaid Cluster. Ensure the medical loss ratio report is finalized as outlined in the contract and all required documentation is properly maintained. *The Department re-procured the Medicaid Expansion Managed Care Organization contract with a January 1, 2022 start date. As part of that process, the contract was revised and more specific terms related to the MLR requirements were included in the contract.*
- 2022-011 Medicaid Cluster. Review access rights to the Medicaid Management Information System (MMIS) fee schedule and all major Medicaid information systems on a regular basis. *HHS and NDIT have implemented a quarterly review of all security roles associated to each user within MMIS. These are sent to the individual's manager to either retain or remove their current access. If no response is received, the security roles are automatically removed. The most recent review was completed in December 2024.*
- 2022-019 Children's Health Insurance Program. Review the SPACES system edit checks and ensure eligibility determinations made for the CHIP programs are proper. We also recommend corrections to payments and Federal reimbursement of CHIP. *With the end of the continuous enrollment requirement in April 2023, system edits checks were put back in place as part of the Department's Unwinding activities.*

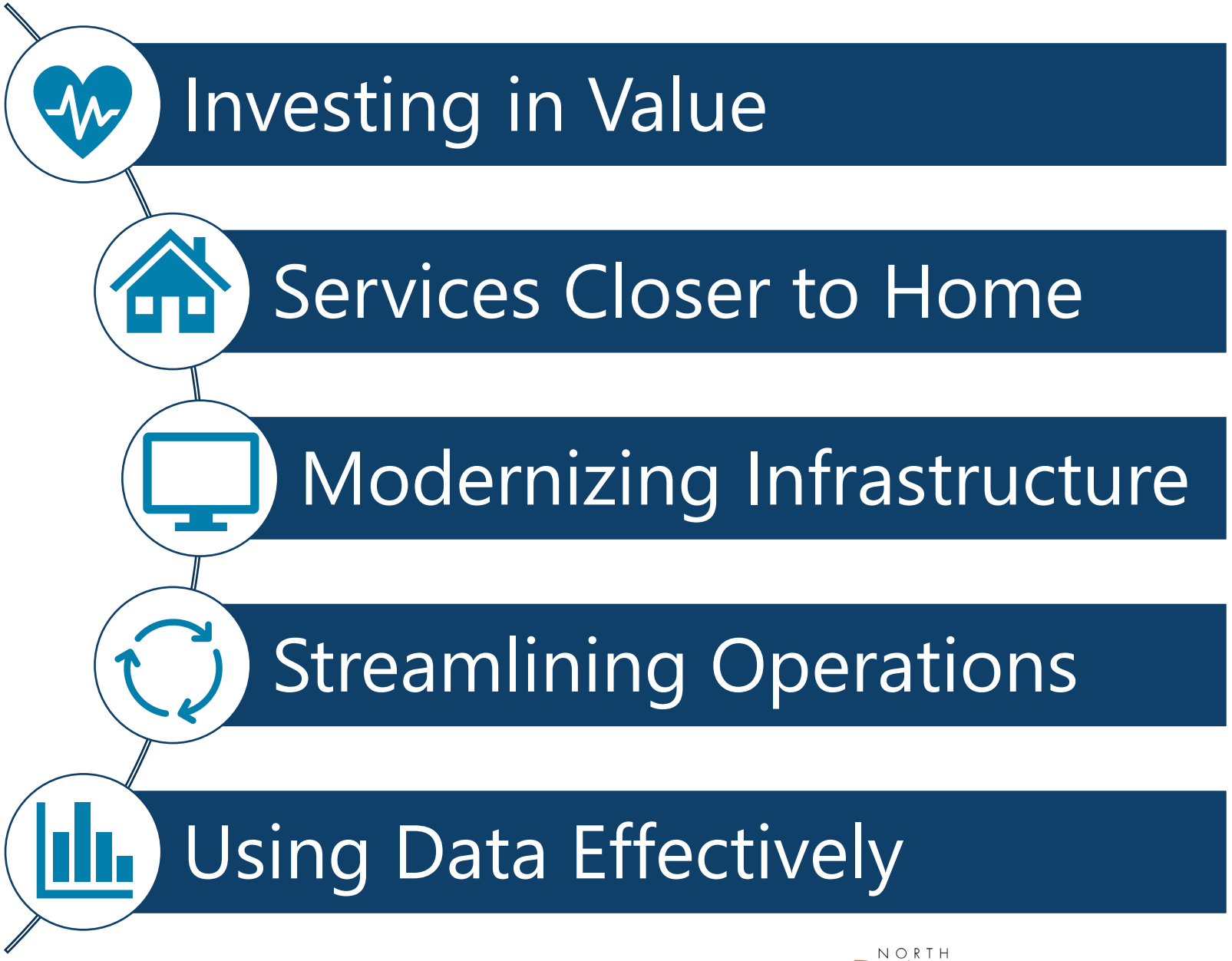
Successes

- Value Based Purchasing Implementation
- Unwinding
- Systems Integrator Procurement
- D-SNP Implementation
- Medicaid School Based Administrative Claiming Implementation
- Member, Provider, & Tribal Engagement
- Complex Discharge Coordination
- Increased Customer Support
  - QSP Provider Enrollment Portal
- Collaboration Across HHS & State Agencies
  - ND HIN OAPD Funding
  - Cross Disability Waiver Planning
  - Data Sharing with DPI

Challenges, Opportunities, & Areas of Risk

- Federal Regulations & Limitations
- Community vs. Institutional Care
- Barriers to Discharge & Complex Patients
- Access to Certain Services
- Data & System Limitations
- Vendor & Provider Accountability
- Provider Partnerships
- Rate Strategy
- Competing Priorities & Finite Resources

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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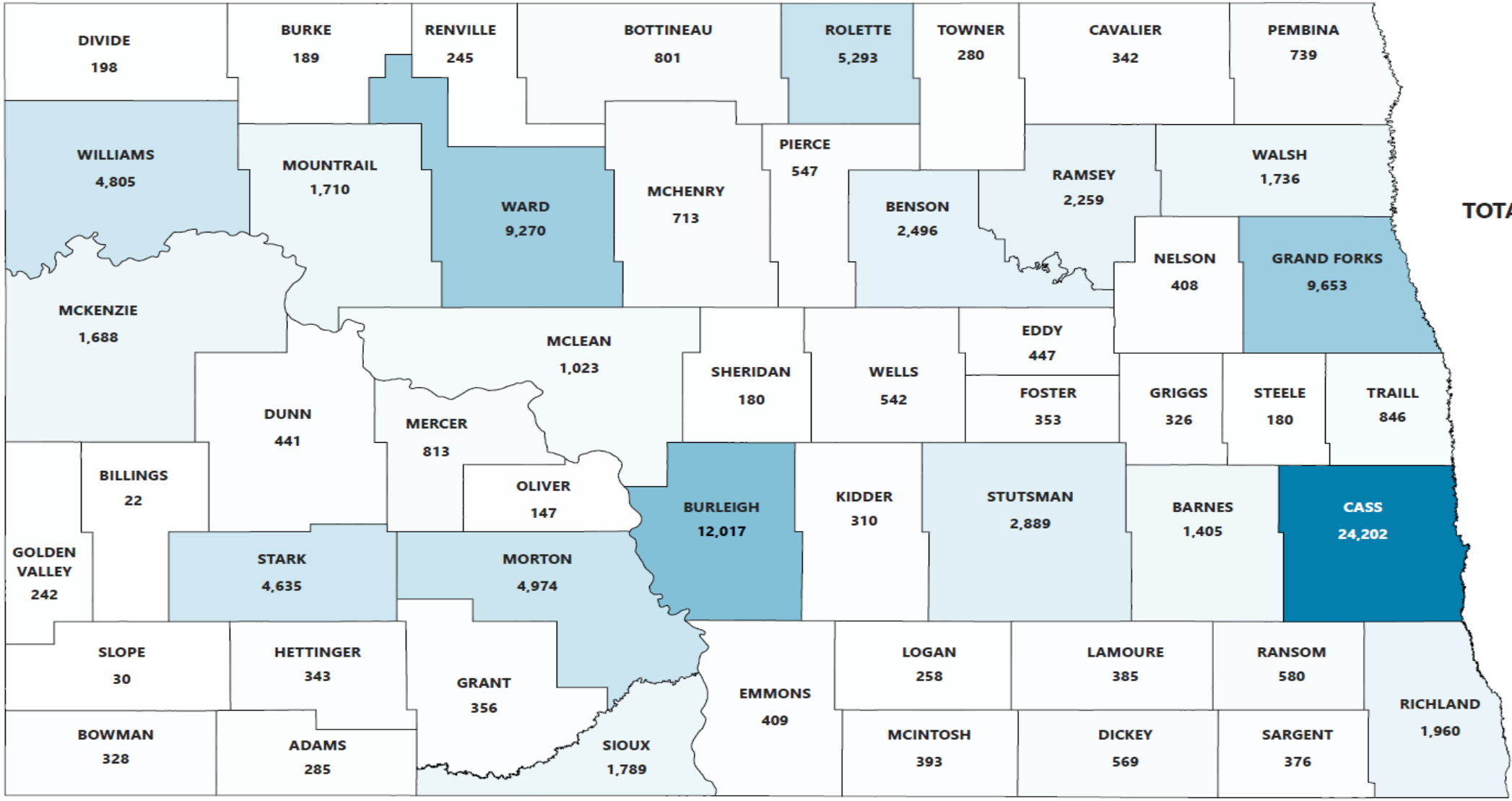
Last updated: 01/04/2024

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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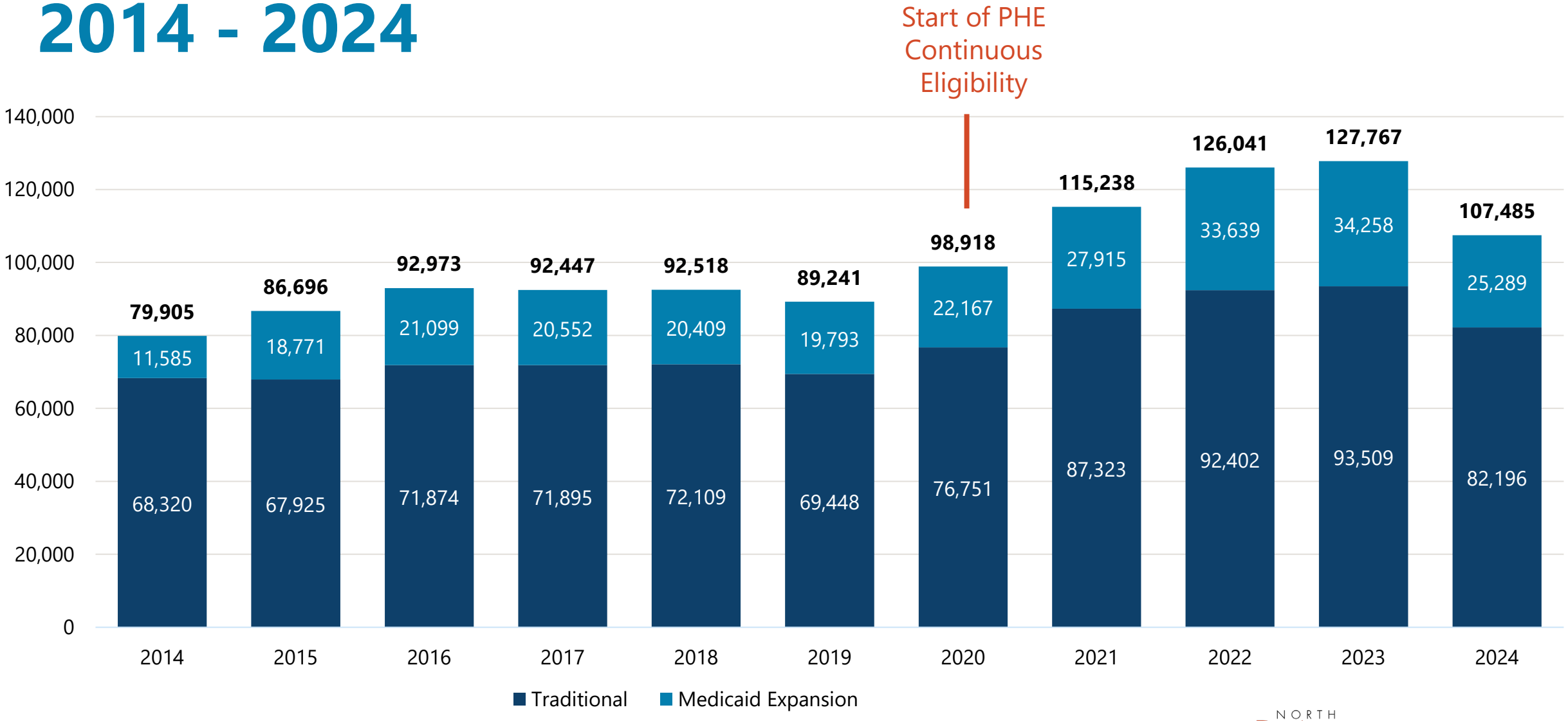
ND Medicaid Average Monthly Enrollment 2014 - 2024



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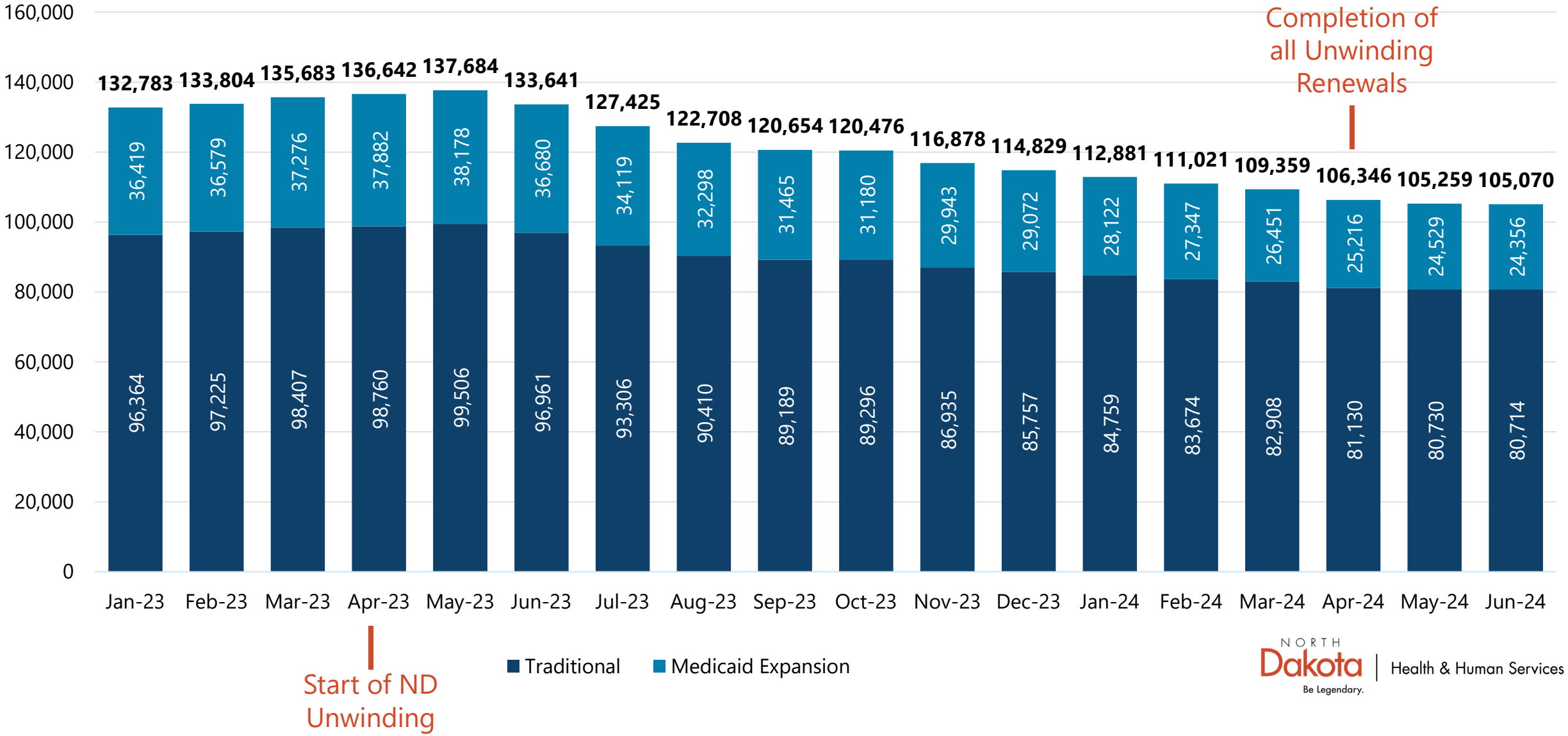
Monthly Enrollment
January 2023 – June 2024



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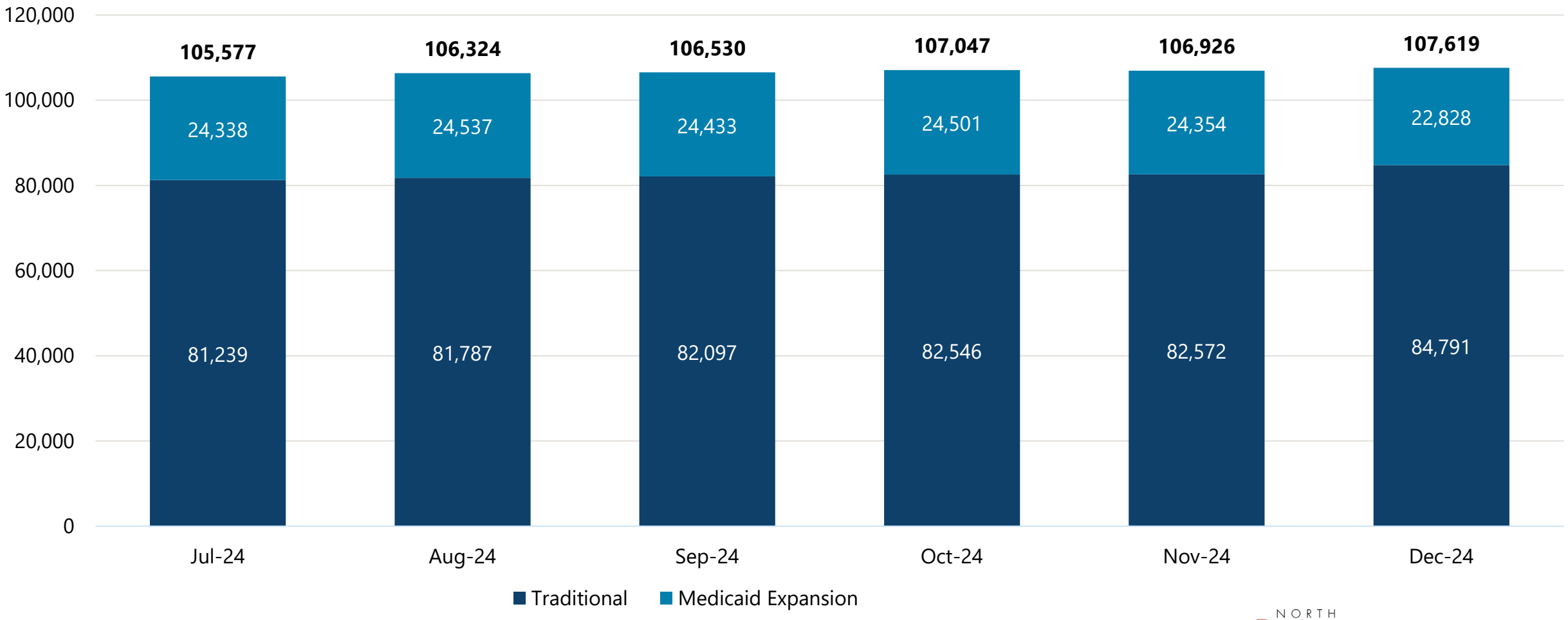
Monthly Enrollment
July 2024 – December 2024



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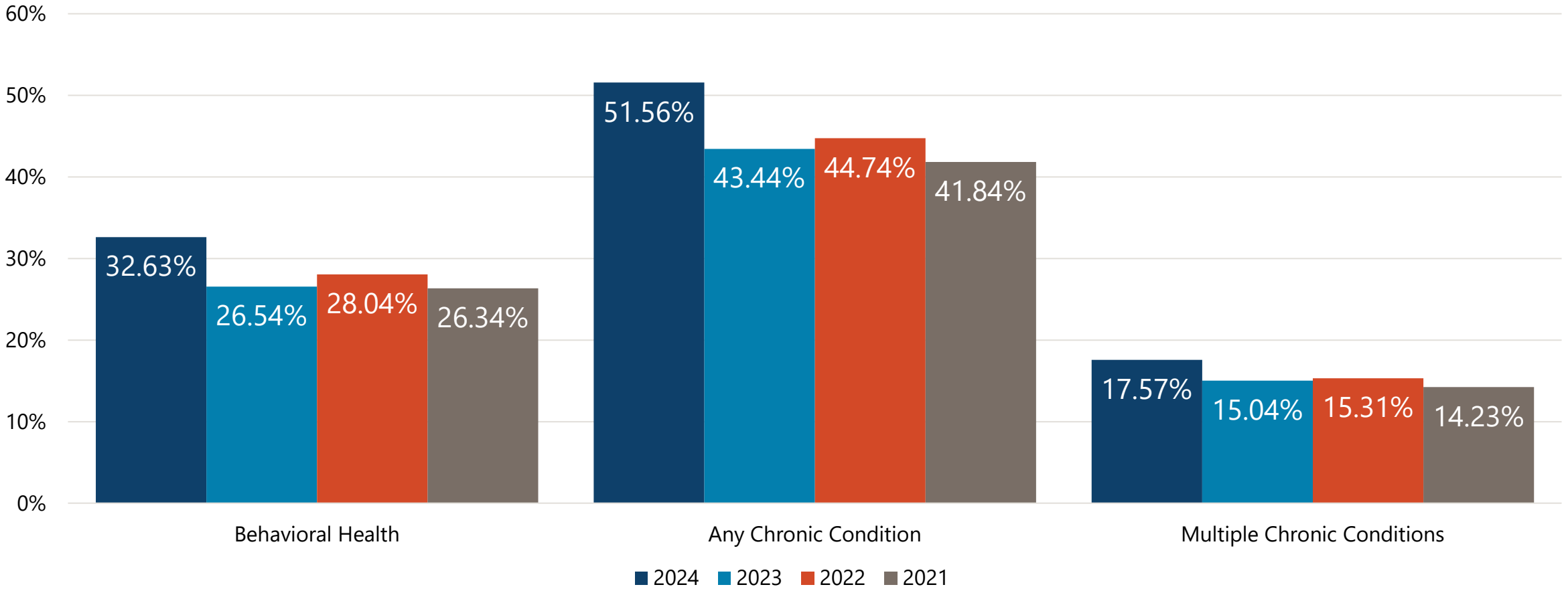
Traditional Medicaid: Chronic Conditions
Percent of Members with Diagnosis



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

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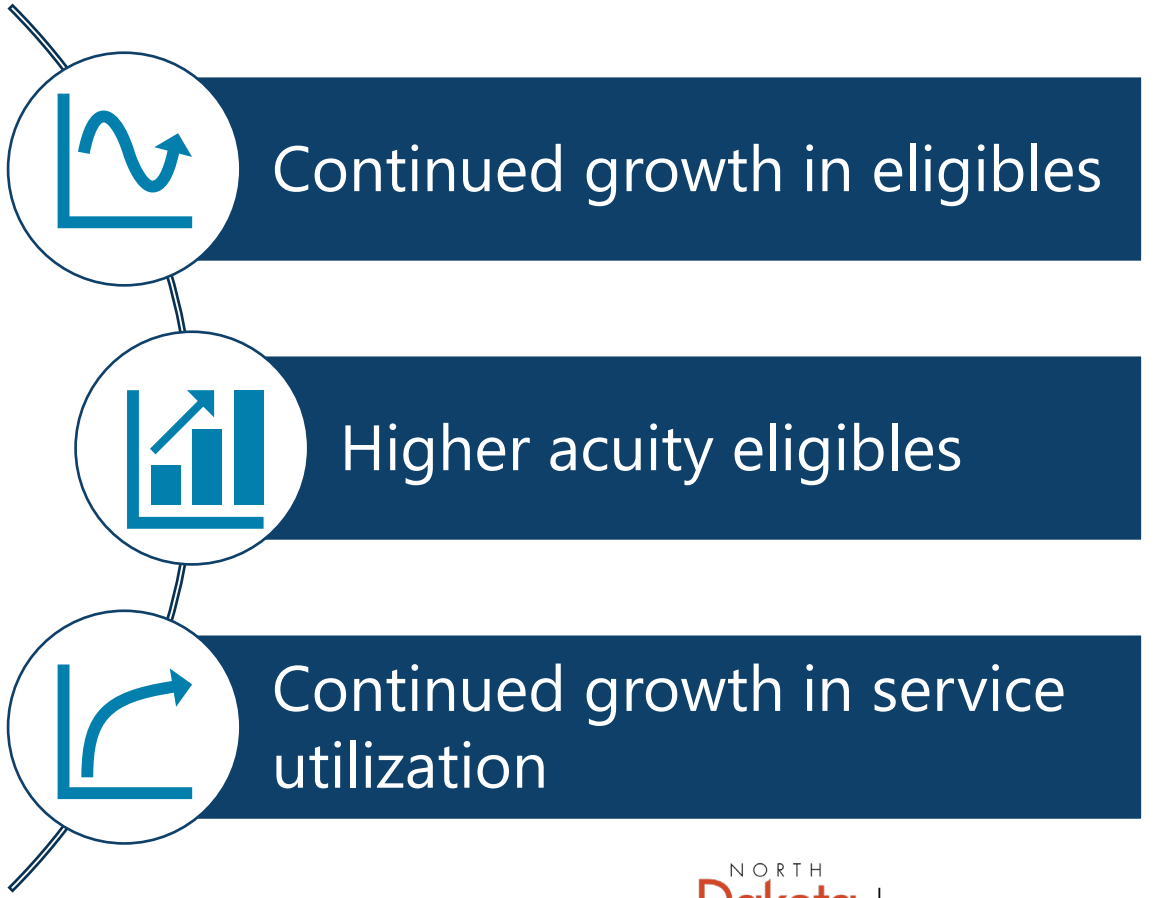
Unwinding Impact on ND Medicaid Budget

- Lower Enrollment
- Higher Utilizers

Eligibility Assumptions for 2025 – 2027 Biennium Base Budget



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Medicaid Financing

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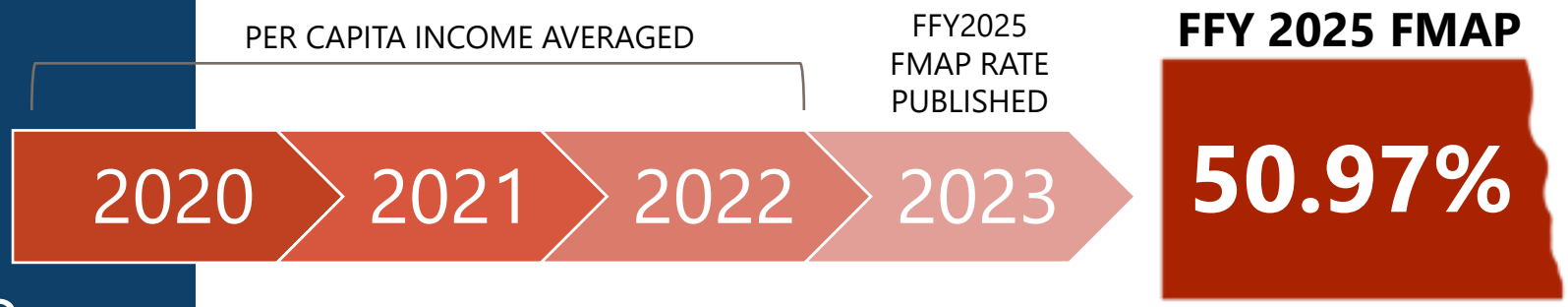
What is the FMAP?

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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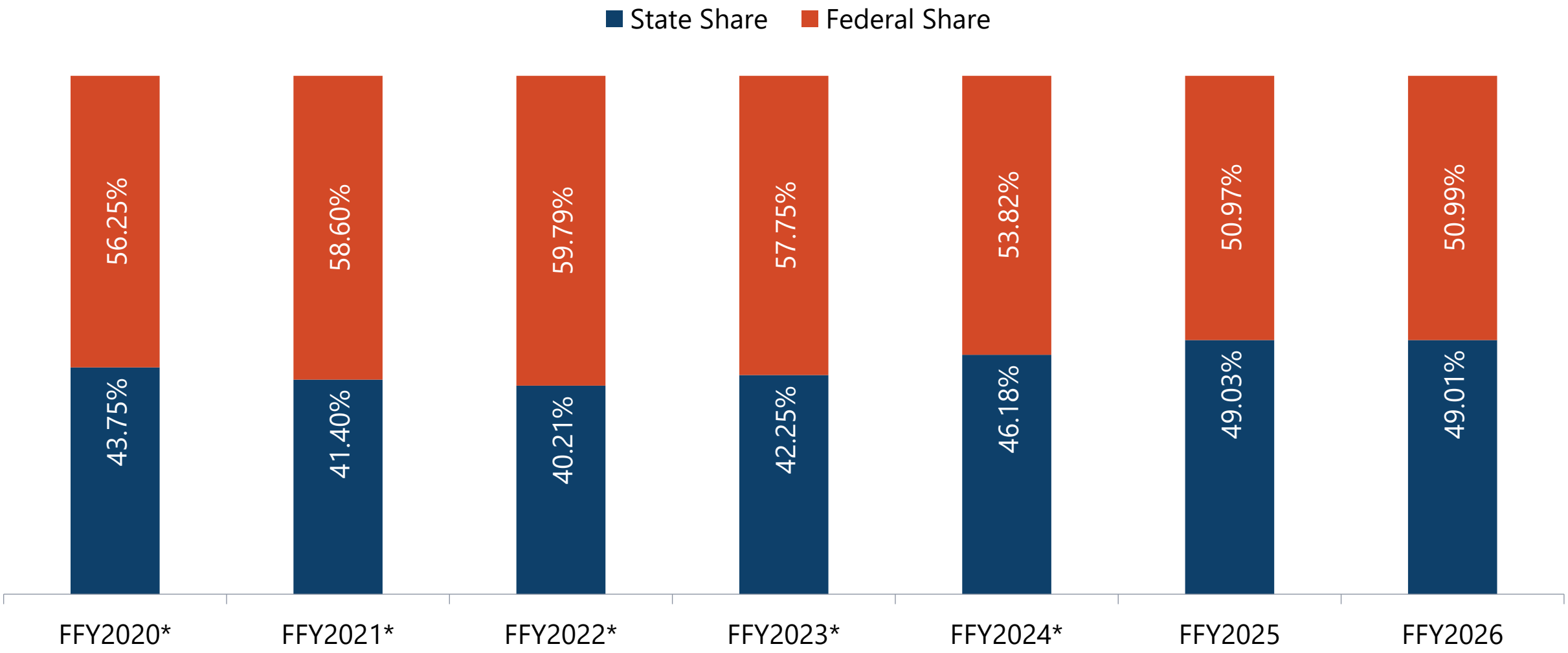
FMAP



*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

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

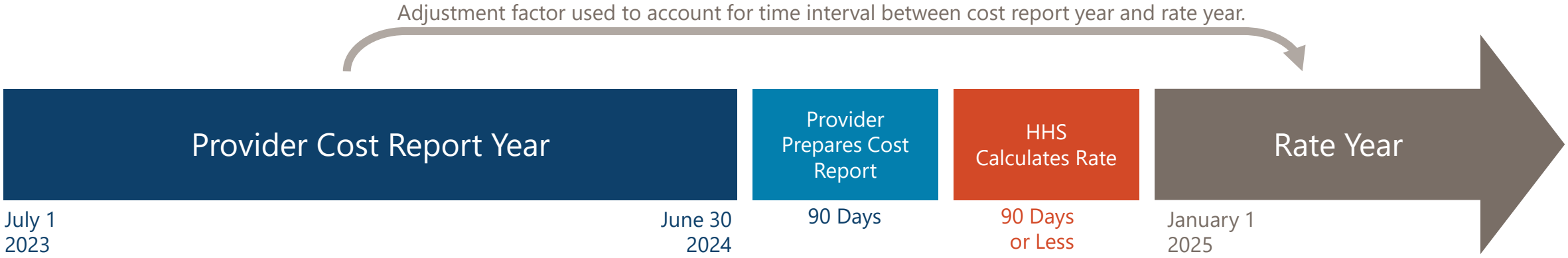
- **Cost Based Per Diem** – Uses cost reports as the basis for setting individual facility per diem payments. Per diem payments may be adjusted to account for patient acuity.
- **Classification System** – Defines an episode (ex. inpatient admission or outpatient visit) and assigns a classification based 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

Costs & Outcomes

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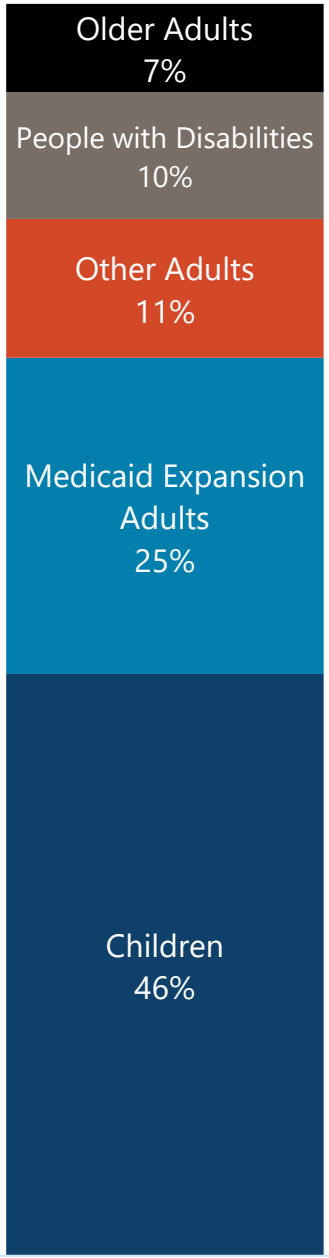
How do we measure results in Medicaid?

Expenditures & Outcomes

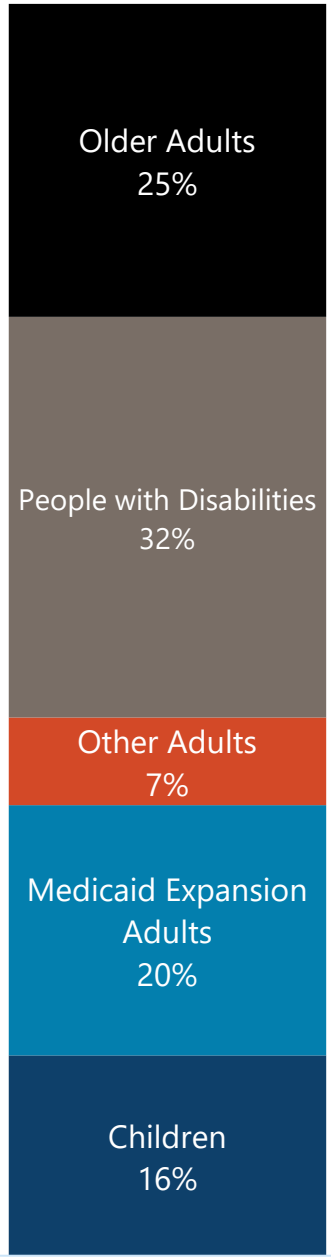
The Center for Medicare and Medicaid Services (CMS) collects and publishes data related to both expenditures and outcomes on the Medicaid & CHIP Scorecard.

- 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

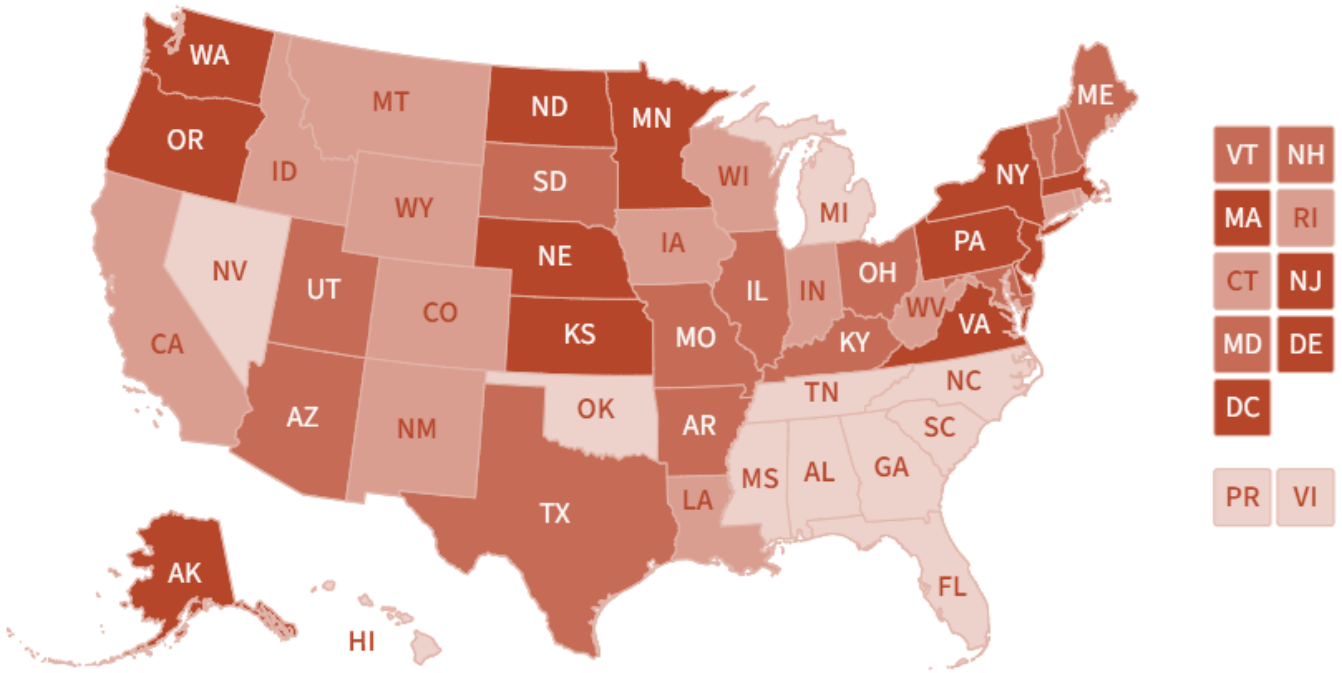


Enrollment



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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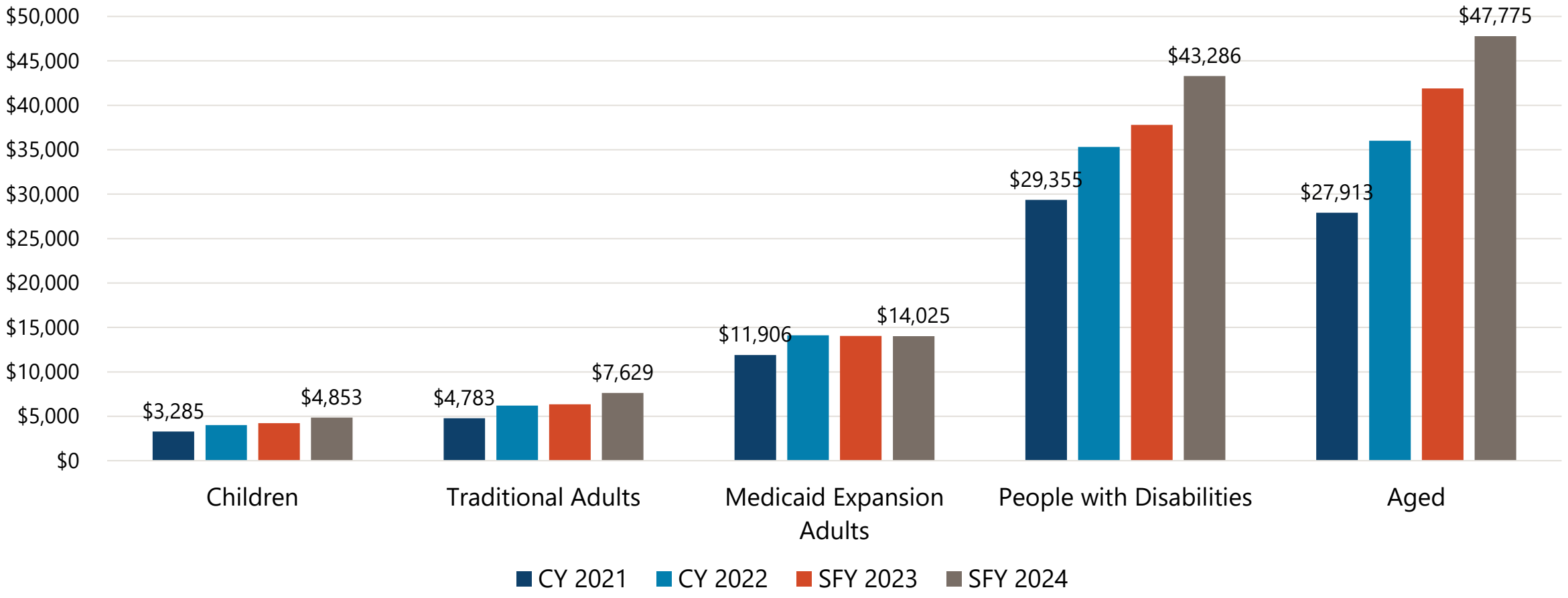
Medicaid and CHIP Scorecard - Medicaid Per Capita Expenditures

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

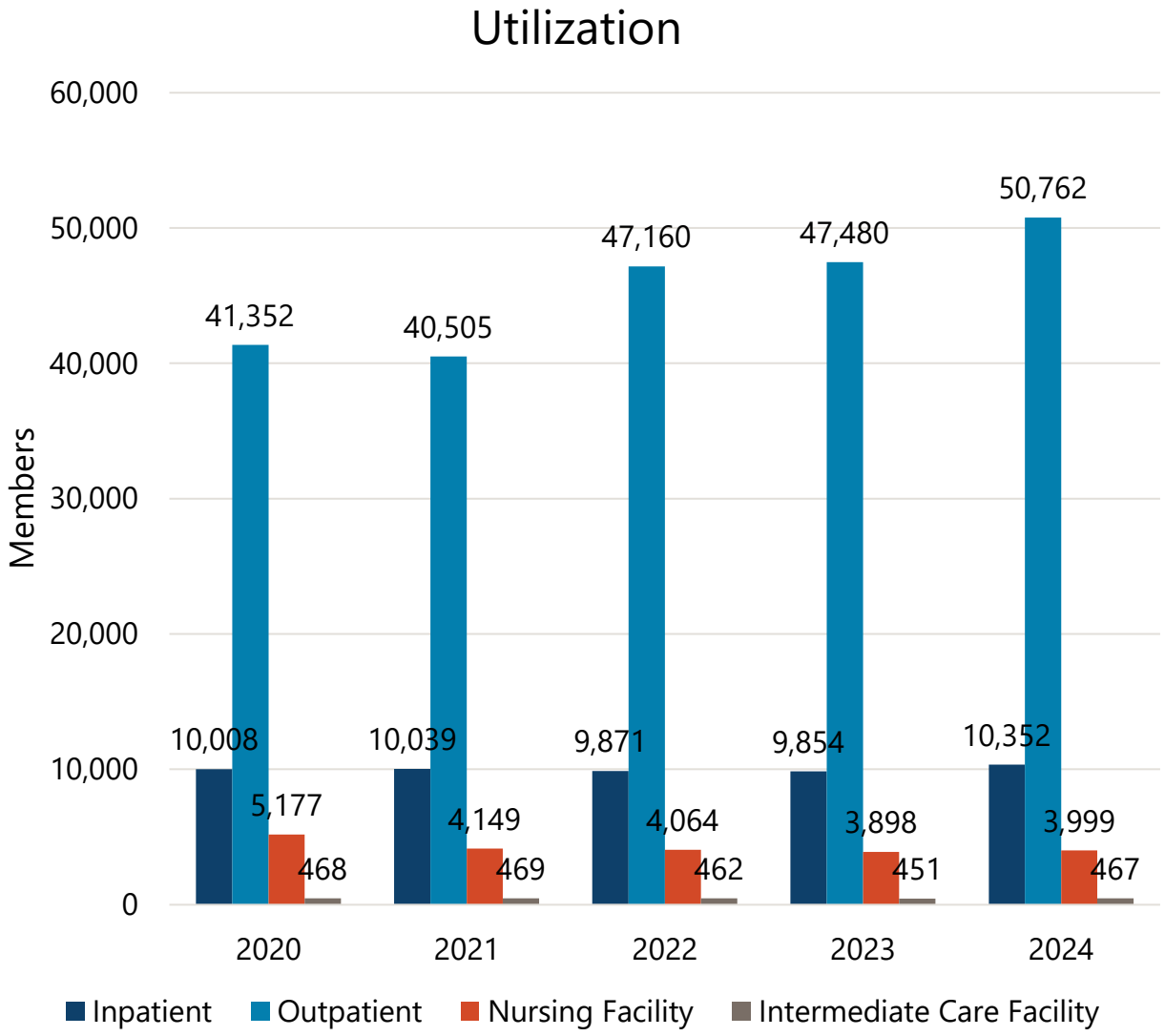
Top 25 Claims

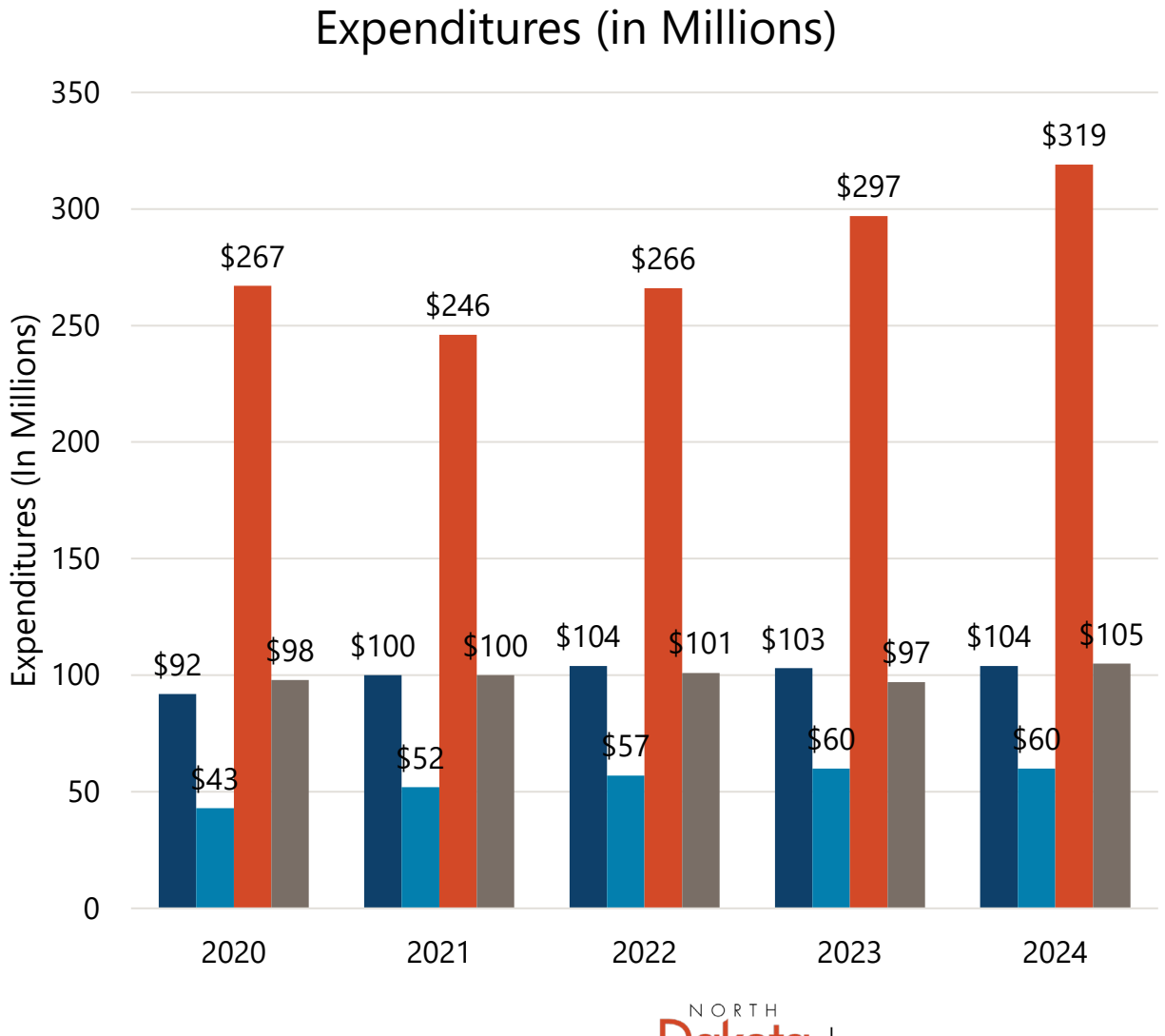
- Average Amount: $309,949
- 64% were for infants
- 60% related to cardiovascular disorders or disease
- Other diseases included: Cancer, End Stage Renal Disease (ERSD), and other rare conditions

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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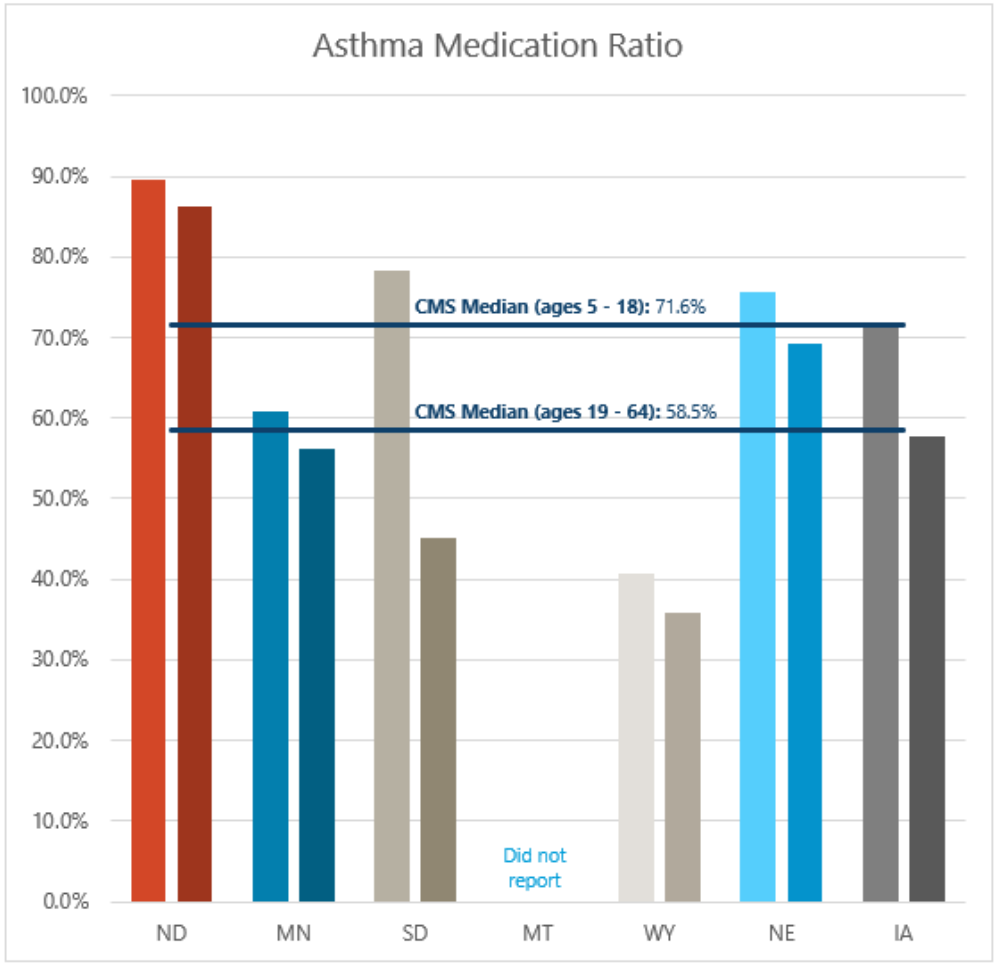
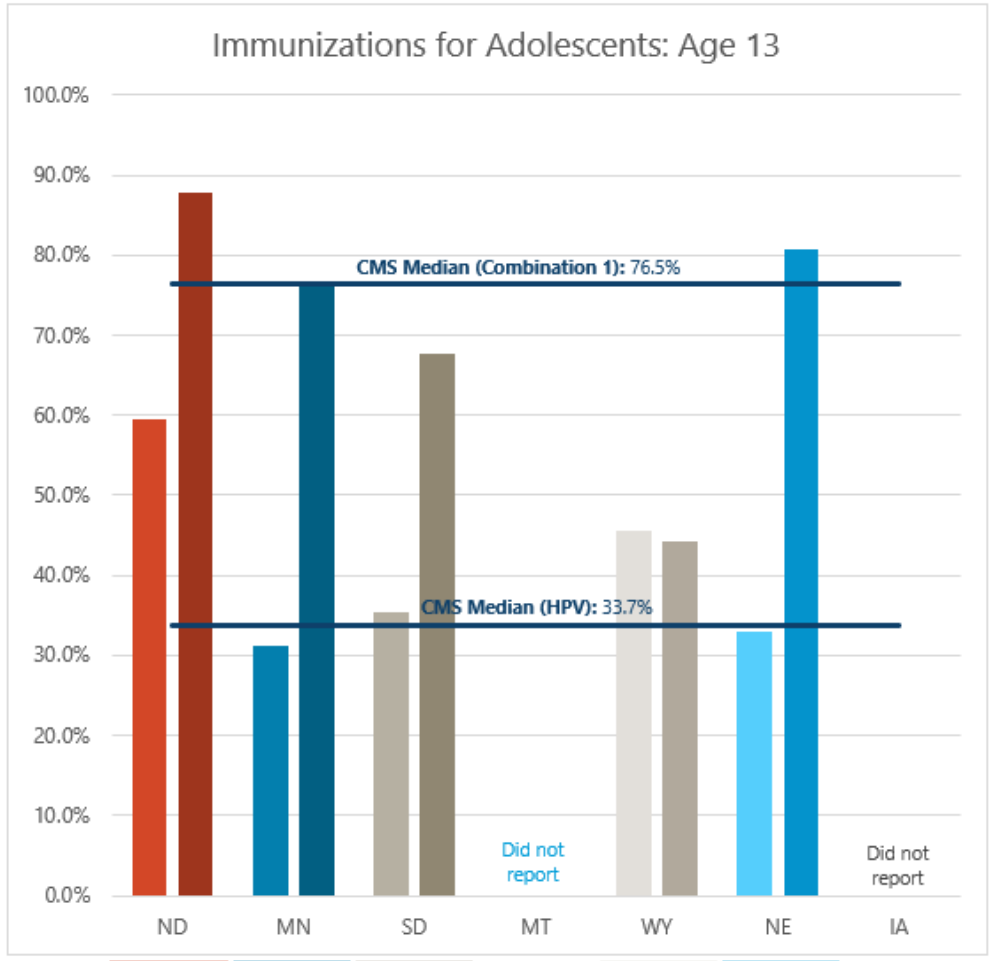
Outcomes: Medicaid and CHIP Scorecard

- 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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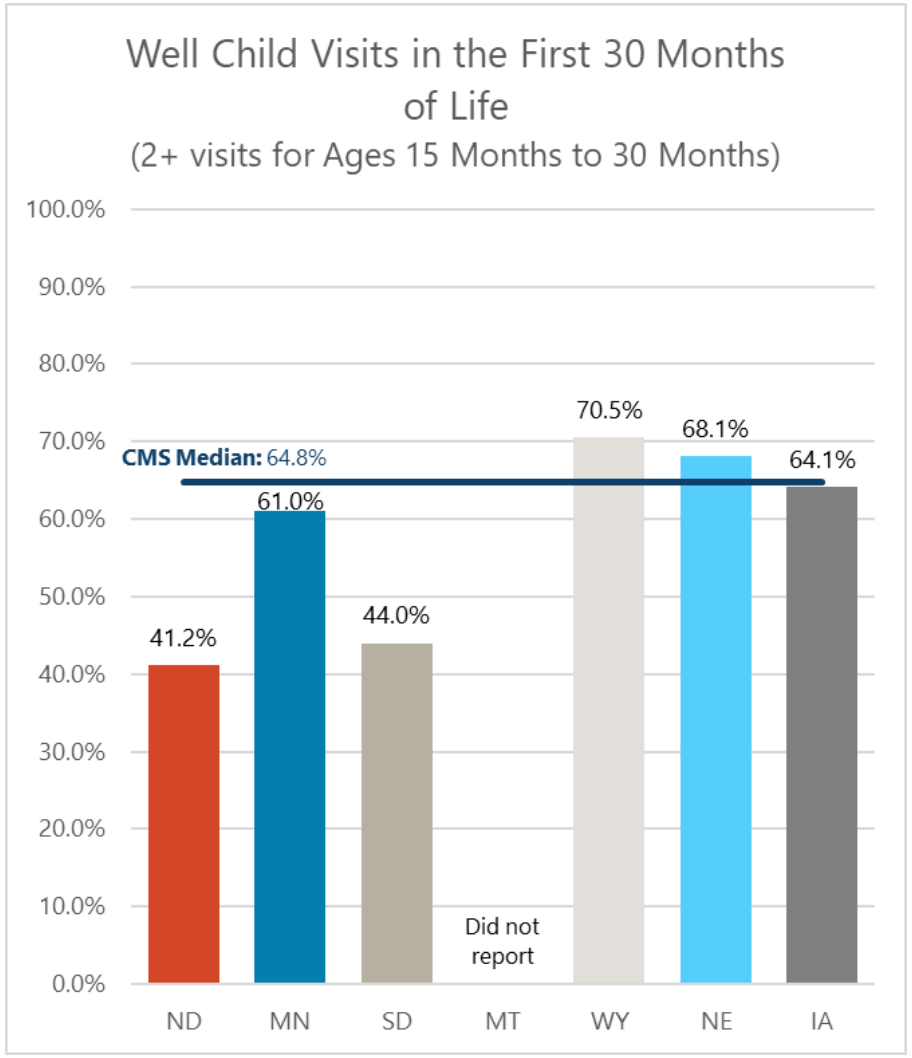
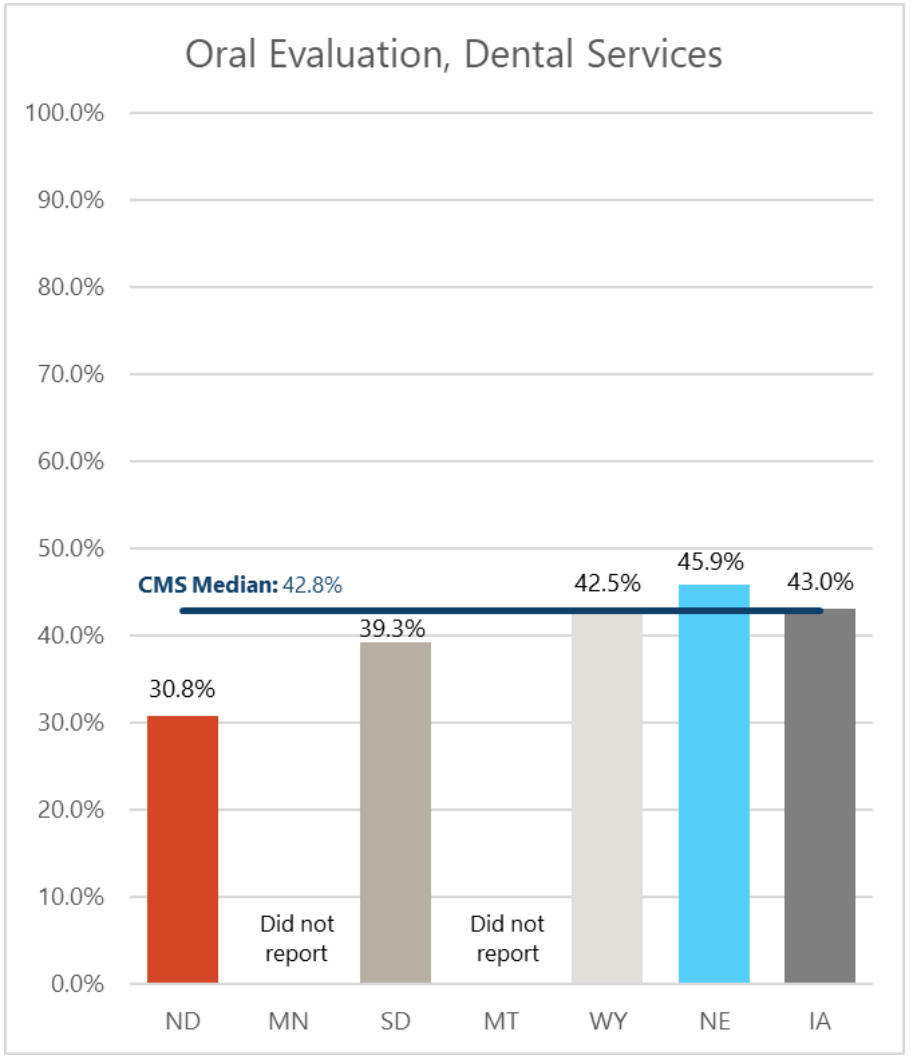
Bottom Quartile Outcomes: FFY 2023





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Value Based Programs

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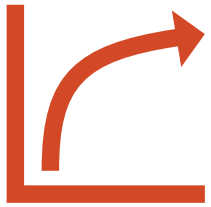
Why Value Based Care?

Accountability for Enhanced Care Delivery

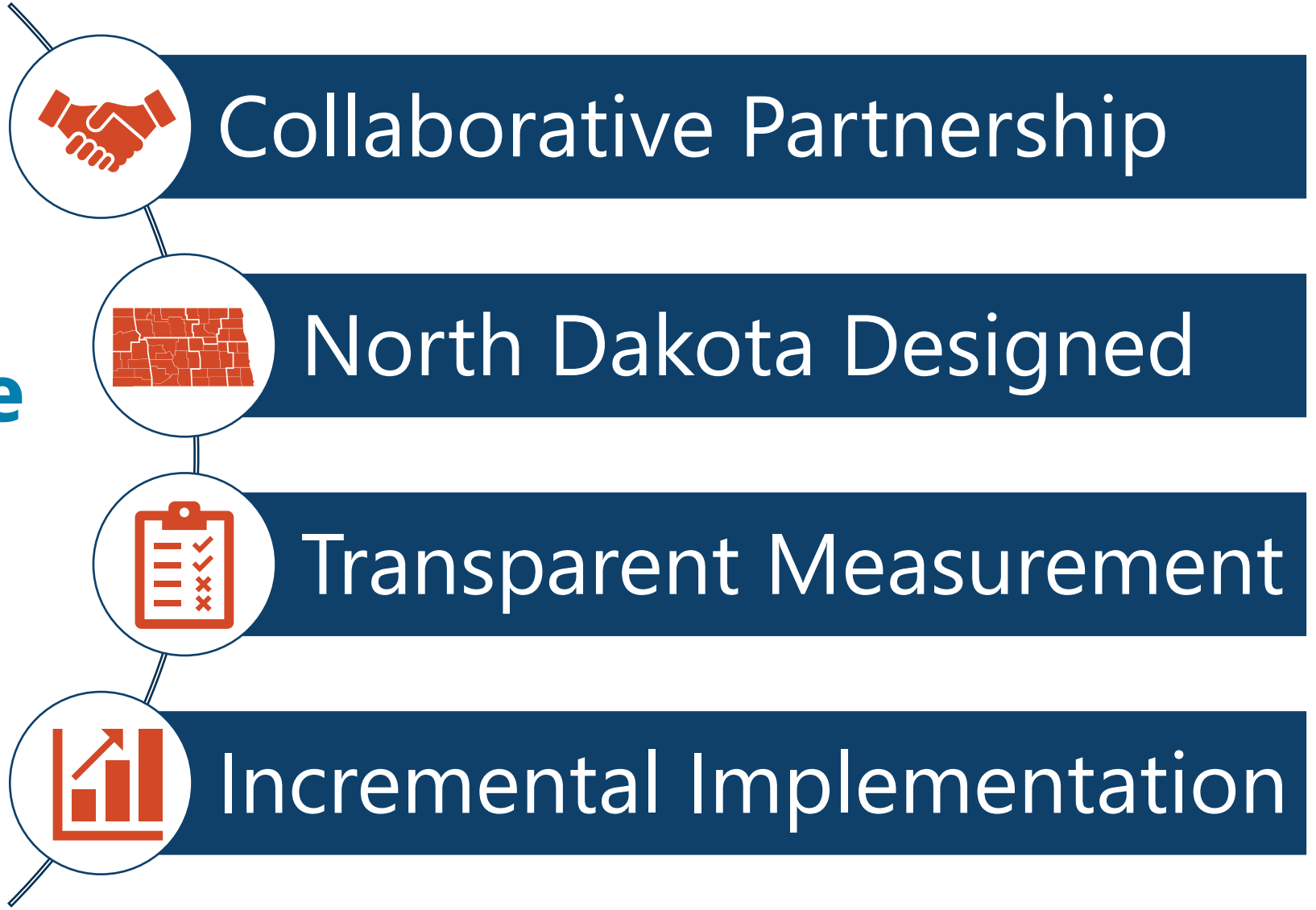
Improved Patient Experiences & Outcomes

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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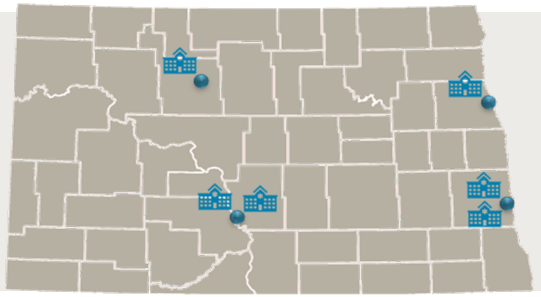
Health System Value-Based Purchasing

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) 1. Prenatal Care: Prenatal Care & Postpartum Care 2. Contraceptive Care: Postpartum Women 3. Structural Measure: Perinatal Collaborative Participation
Behavioral Health Services Optional Measures: (systems must select 1) 1. Follow-up After Emergency Department Visit for Alcohol & Other Drugs Abuse or Dependence 2. Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment

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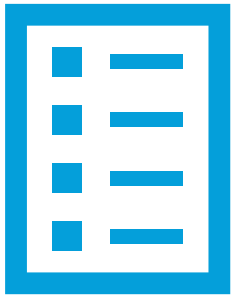
2024 Pay for Reporting Components



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

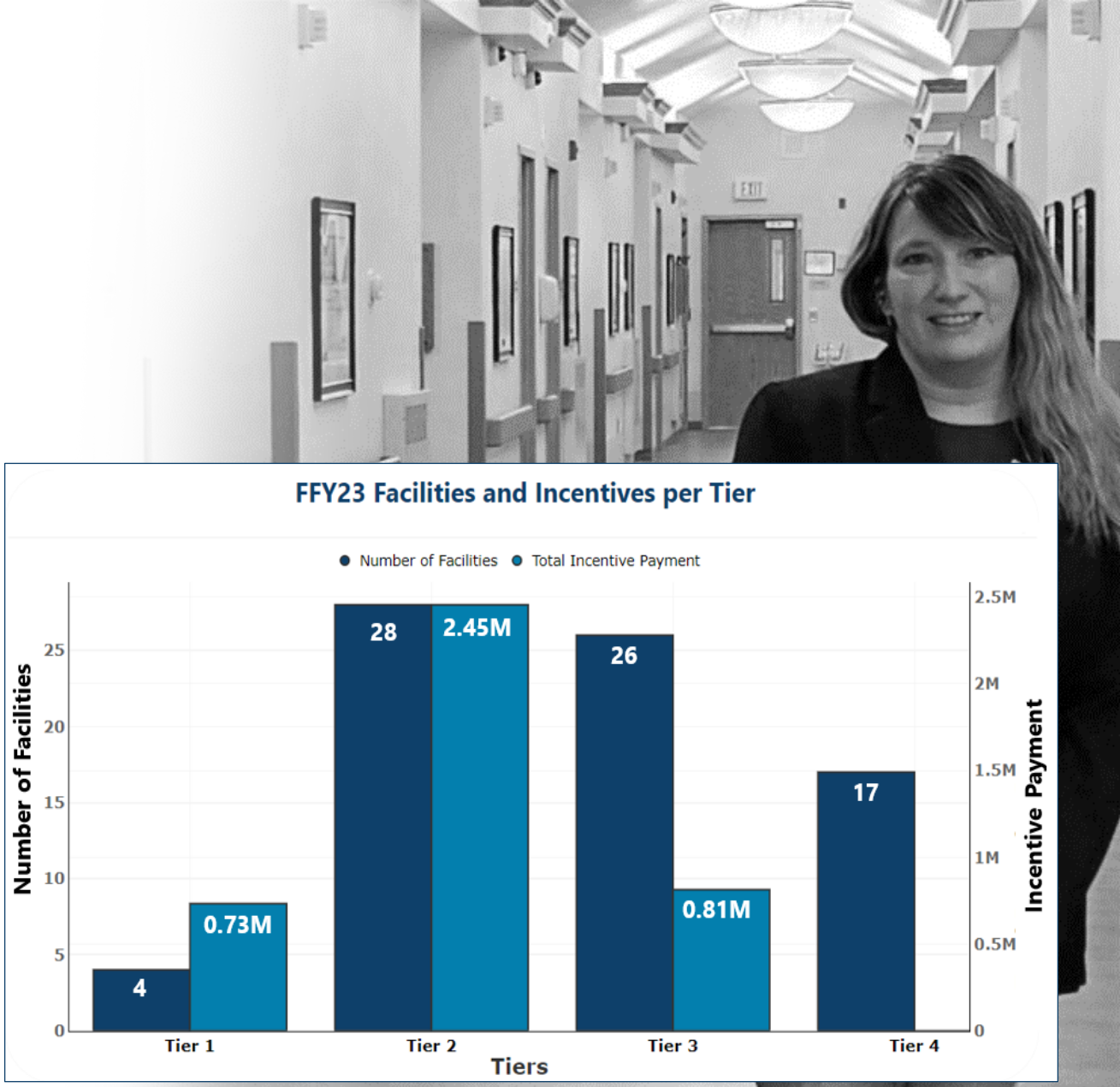
Improve resident outcomes through an incentive payment based on specific quality measures.

- 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

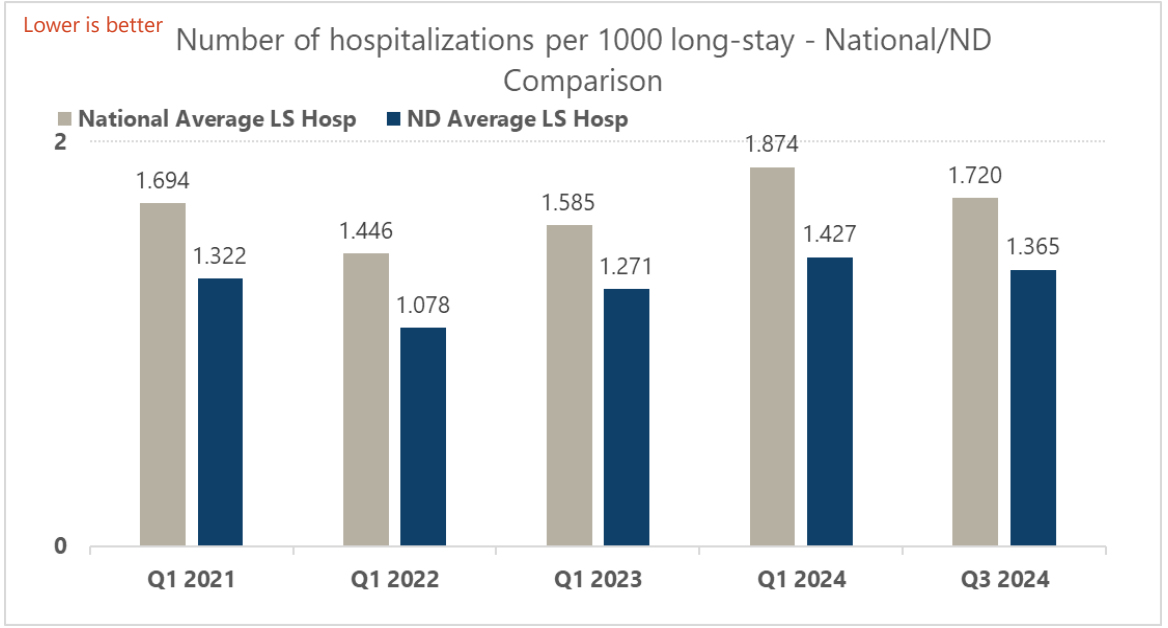
- $4 million dollars distributed in June 2024
- 58 out of 75 Nursing Facilities received incentives to improve quality of care for residents
- Examples of reported use of funds include
  - New mattresses for entire facility
  - Staff bonuses
  - Building renovation
  - Staff training



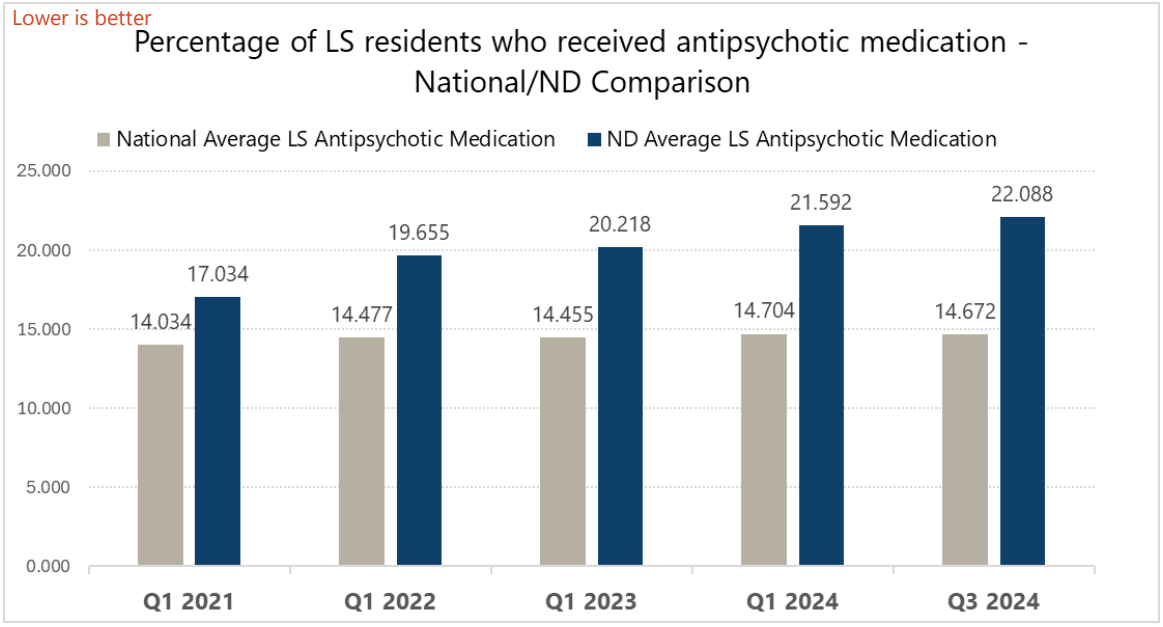
Carrie Zazeski, Administrator, Elm Crest Manor, New Salem

Nursing Facility Incentive Program Initial Outcomes

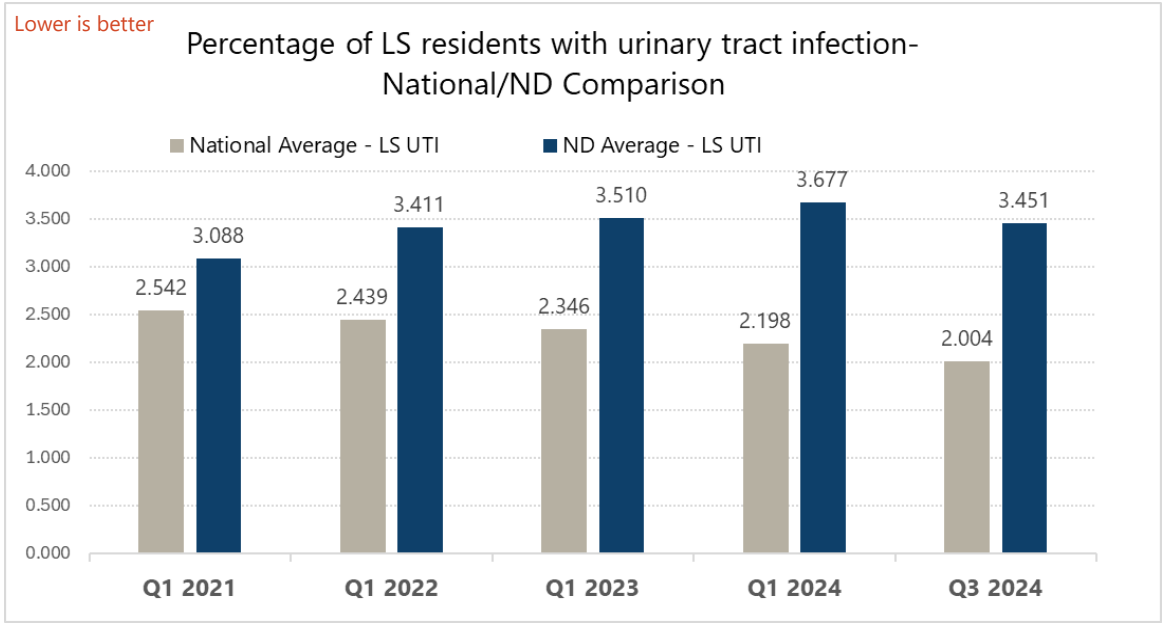
Lower is better



Lower is better



Lower is better



Long Term Care

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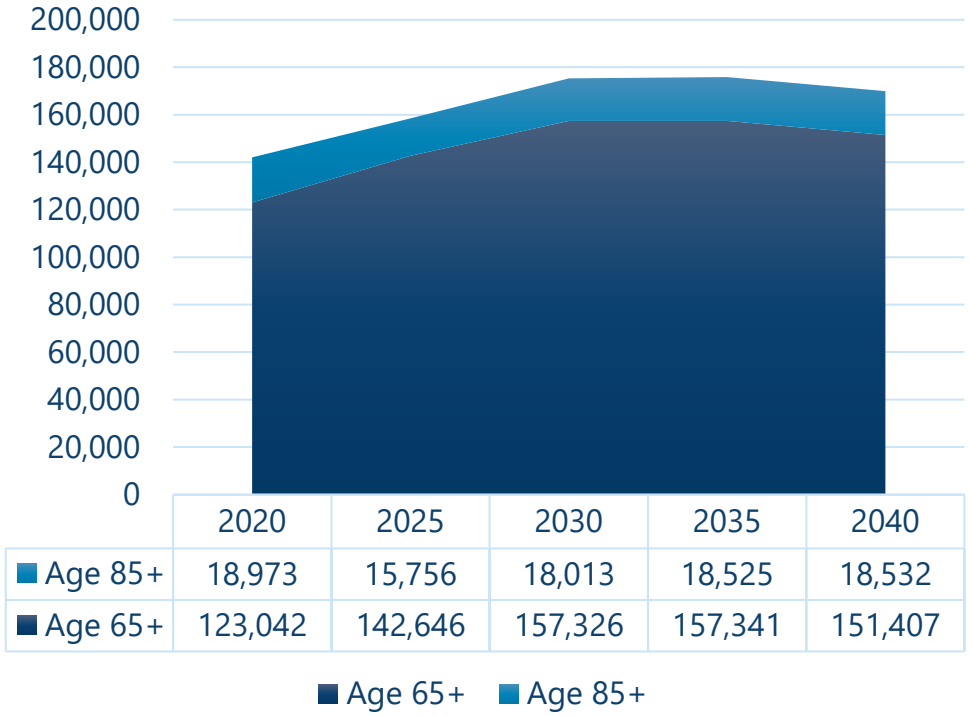
Long Term Care Outlook

Changing Demographics



	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

2024 ND State Data Center Projections

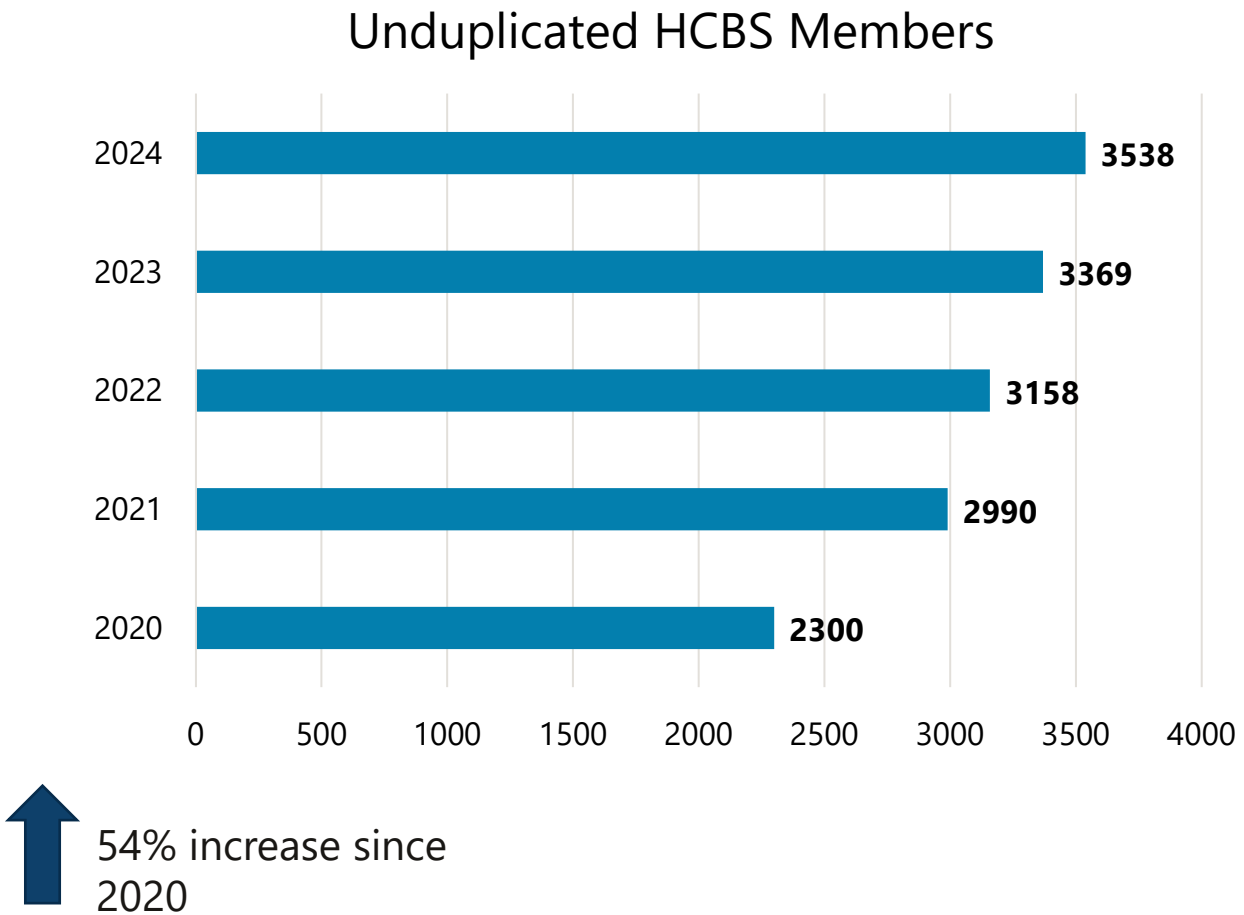
- The population age 65+ is expected to grow significantly between now and 2035
- 16% of ND population is 65+
- 15% of that group is 85+

7 in 10

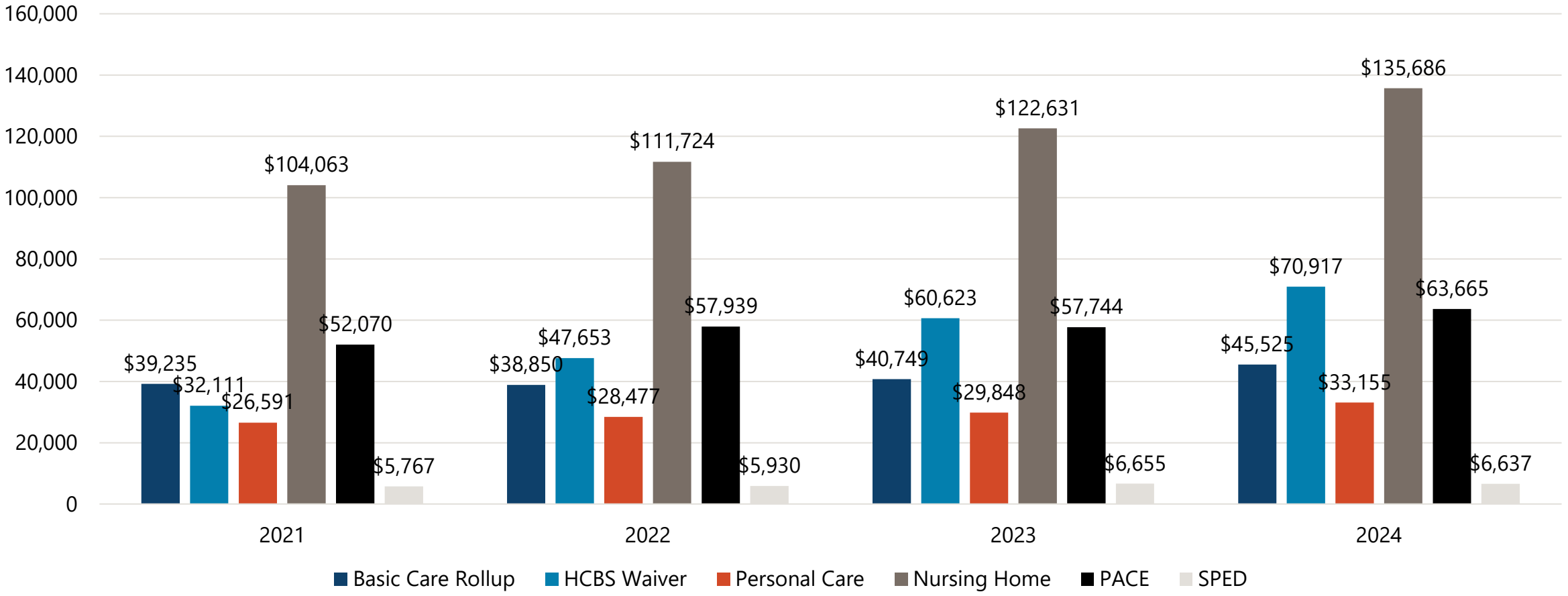
Americans 65+ will need LTC services for an average of 5 years

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 needs) 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.



Where the Long-Term Care Budget Goes



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

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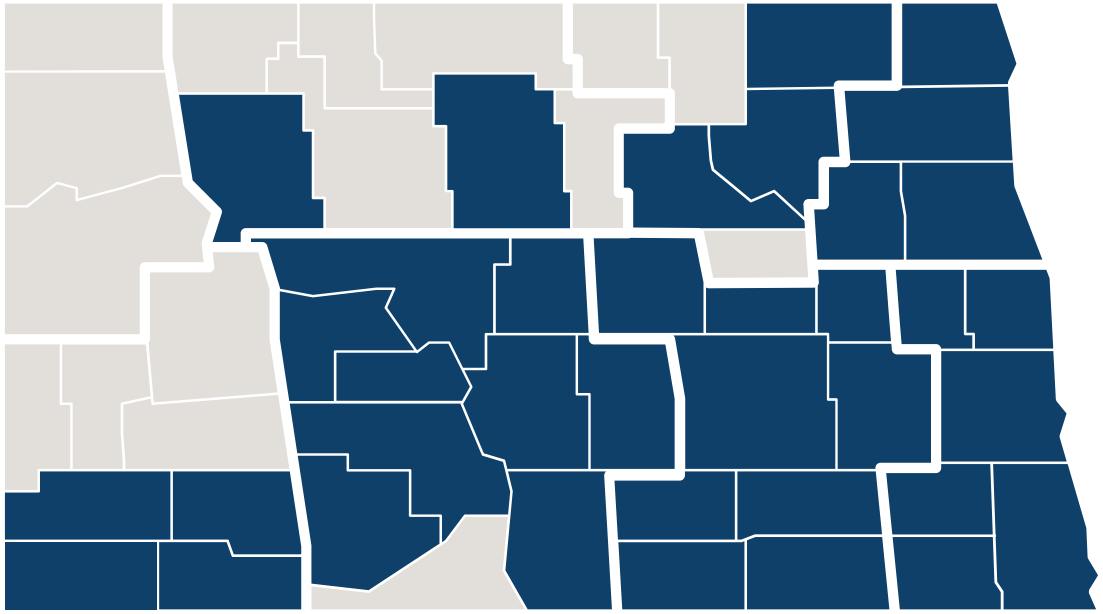
Dual Special Needs Plans (D-SNPs)

- **D-SNP enrollment is limited to "Full-Benefit" Dual Eligibles**
- **ND D-SNPs:**
  - **Humana**
  - **Medica**
  - **Sanford Health**
  - **United Healthcare**

- D-SNPs are offered in 37 North Dakota counties
- 76% of ND dual eligibles have at least 1 DSNP option
- Approximately 1200 members currently enrolled in a DSNP.



Counties with a D-SNP

Counties without a D-SNP

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Complex Discharge Coordination

Common barriers to discharge:

- Transitioning to long term care
- Extensive medical and behavioral health issues
- Homeless patients
- History of aggressive behaviors
- Need community resources

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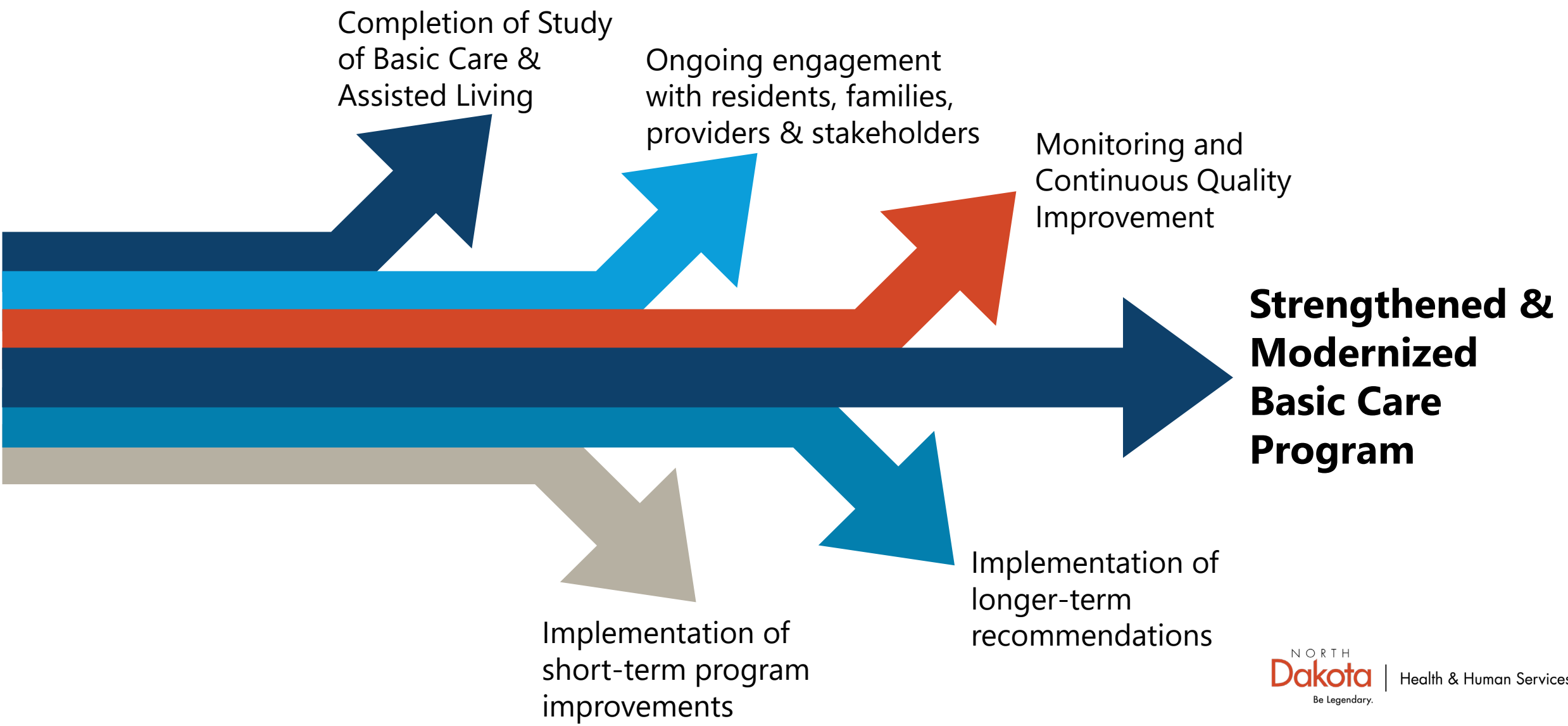
Basic Care Strategy



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Managed Care & Medicaid Expansion

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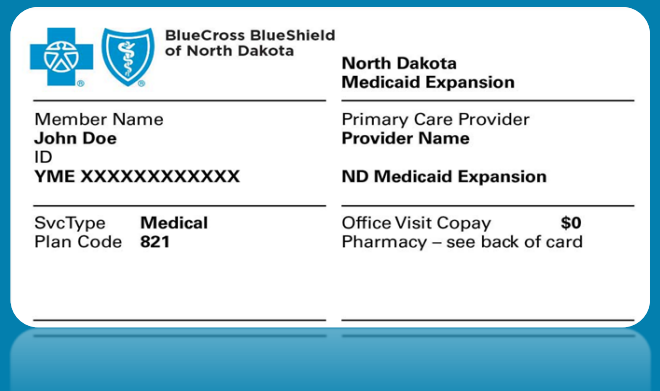
Medicaid Expansion Coverage

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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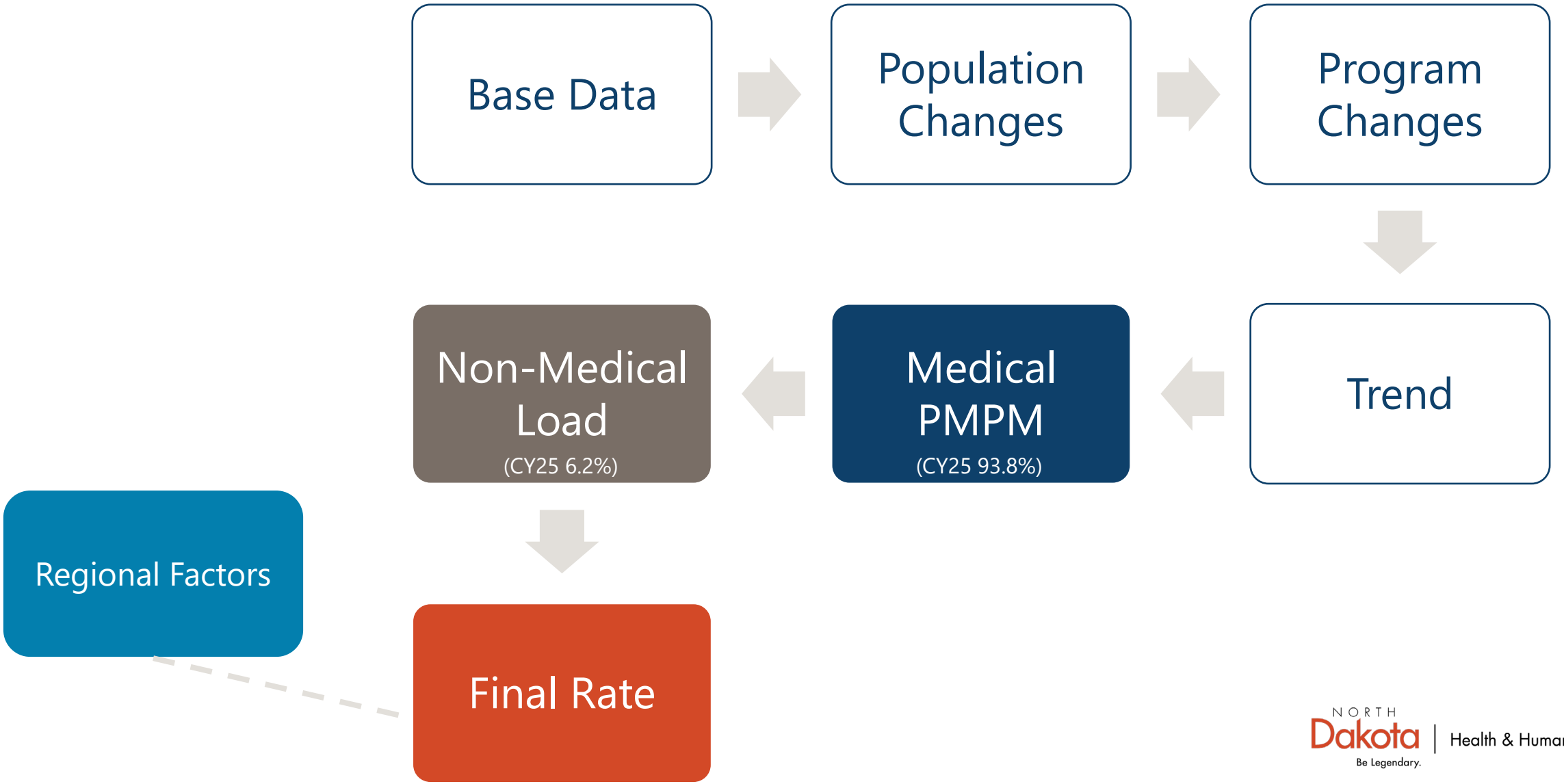
Managed Care

- **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

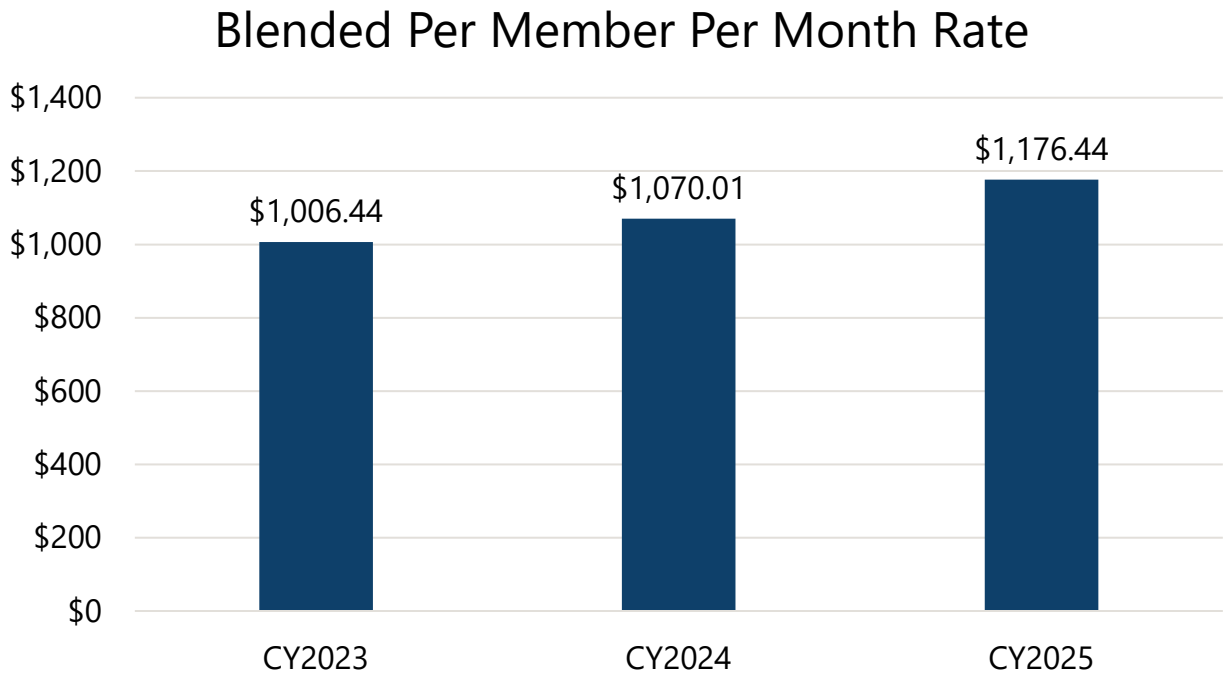


2025 Capitation Rates

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, 9.5% increase in rates for CY2025.



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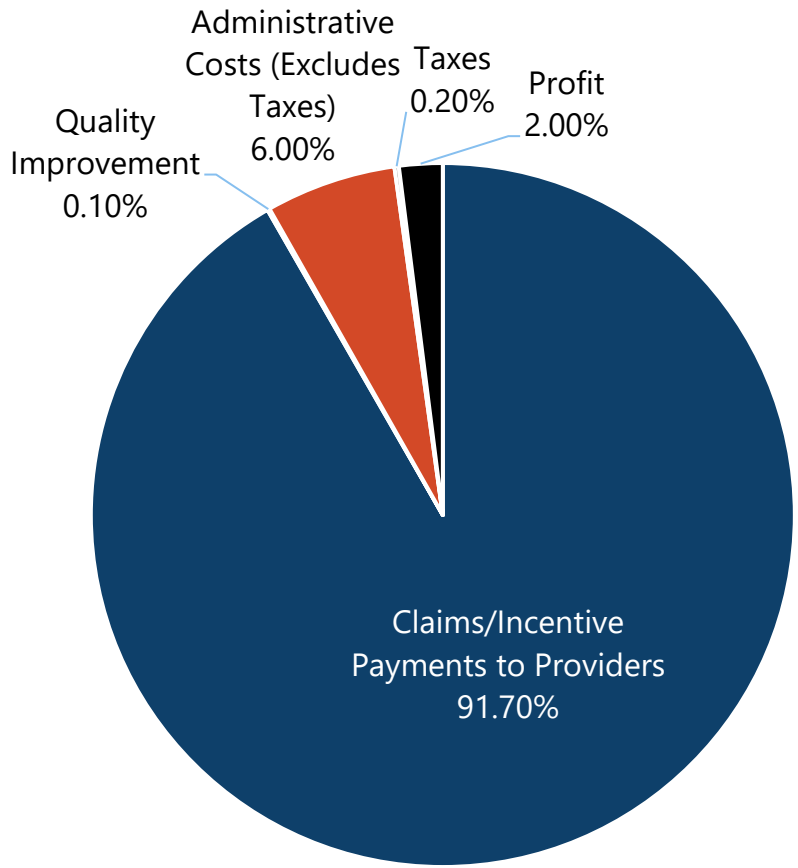
Medical Loss Ratio (MLR) & Profit Cap

- 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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Drugs

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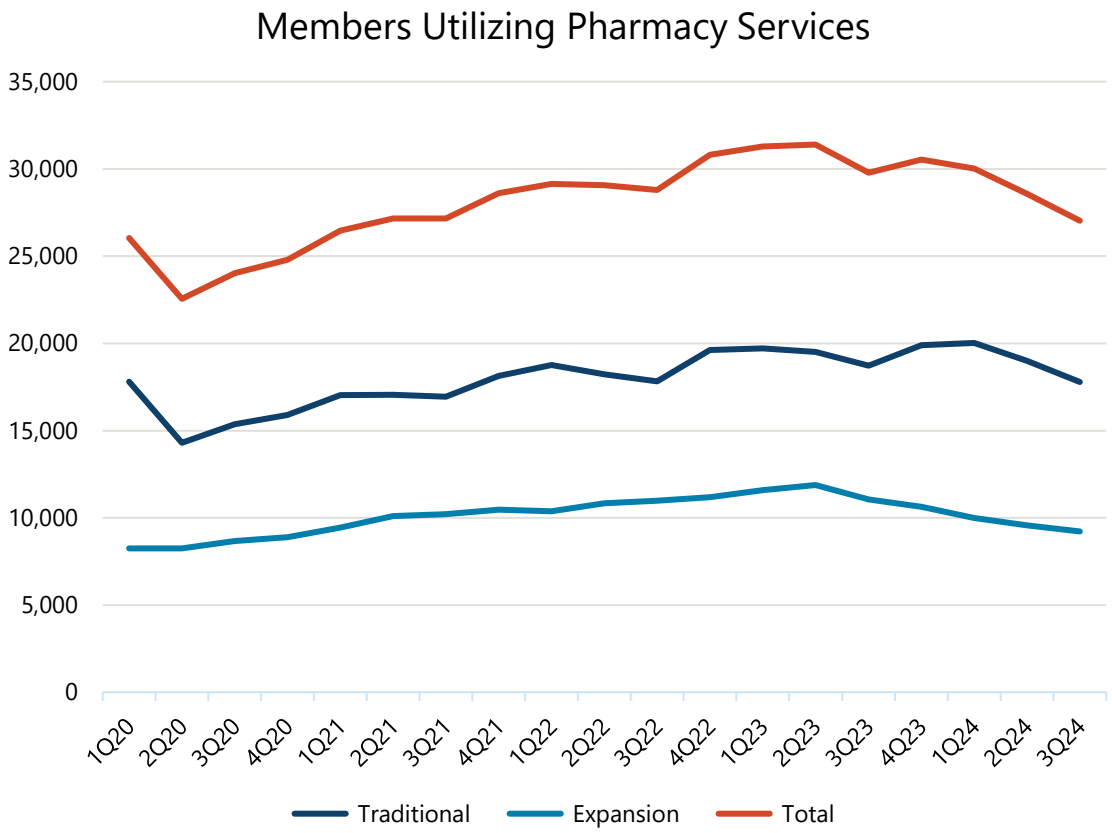
Coverage

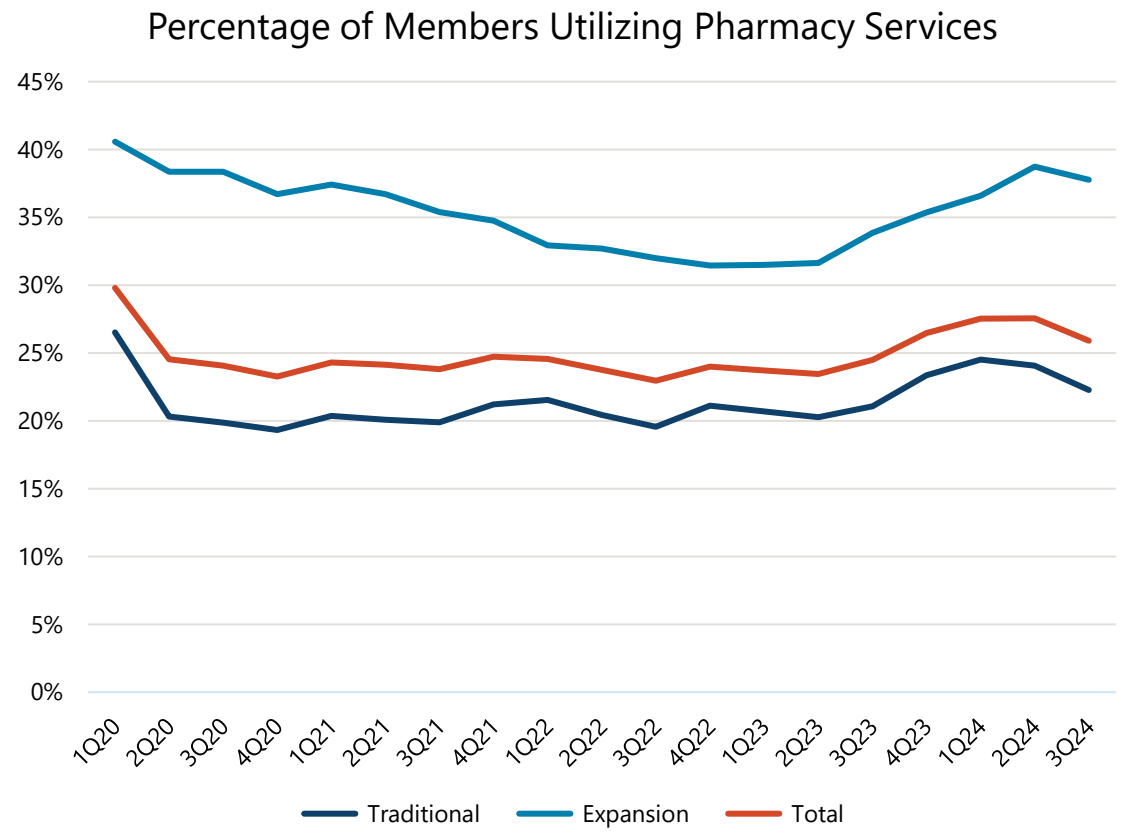
- **Prescription Only/Legend Drugs:** federal law requires Medicaid to cover all legend drugs of manufacturers who have signed a Medicaid Drug Rebate Agreement (MDRP)
  - Essentially all legend drugs are covered as most manufacturers participate in the MDRP
- **Over-the-Counter Drugs:** some are covered 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

Utilizers of Pharmacy Services





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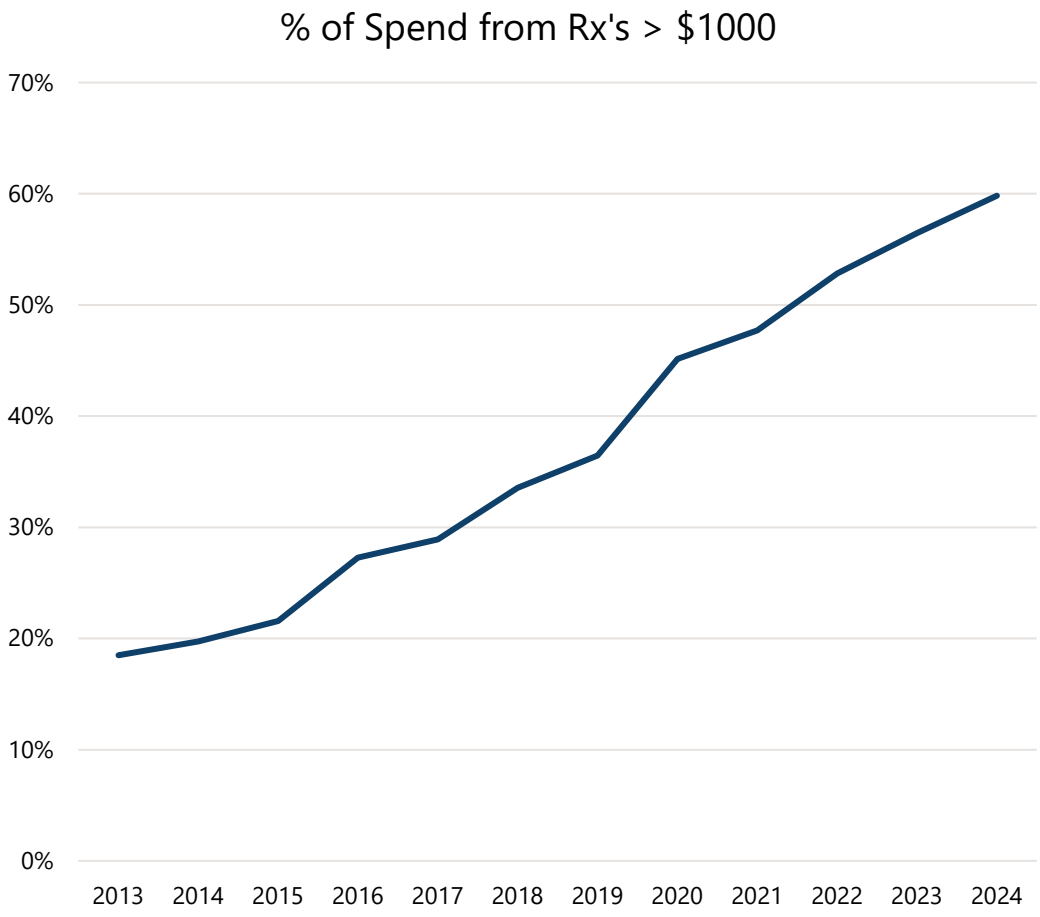
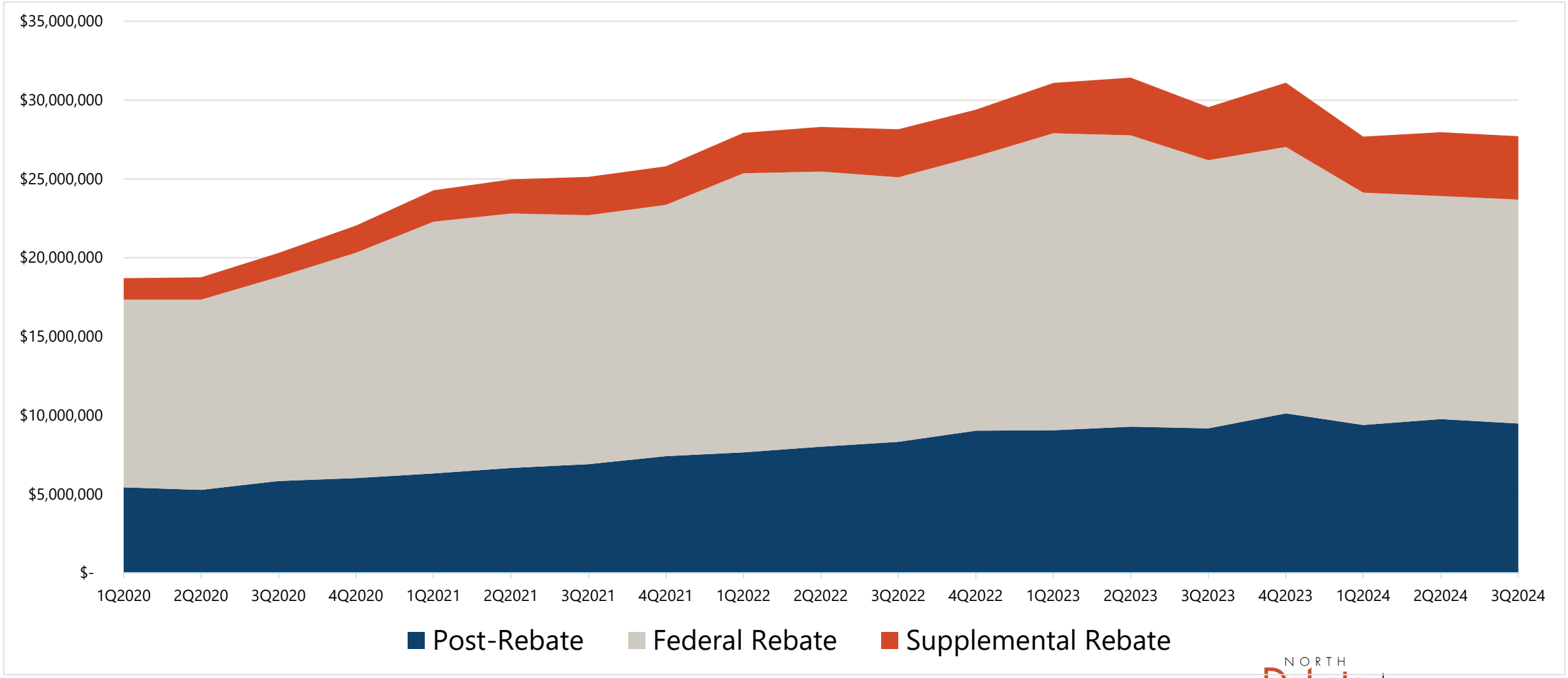
Cost Drivers

- **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



Rebates are Increasingly Important



2025 – 2027 Budget & Other Resource Requirements

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Comparison of budgets and funding

By Major Expense

Description	2023-25 Budget Base	Increase/ (Decrease)	2025-27 Executive Budget
Salaries and Benefits	$ 21,072,281	$ 2,528,269	$ 23,600,550
Operating	70,793,645	17,336,681	88,130,326
IT Services	61,578,286	6,515,475	68,093,761
Capital Asset Expense	-	-	-
Capital Assets	-	-	-
Grants	2,684,129,807	(102,087,611)	2,582,042,196
Total	**$ 2,837,574,019**	**$ (75,707,186)**	**$ 2,761,866,833**
General Fund	**$ 973,425,702**	**$ 28,379,563**	**$ 1,001,805,265**
Federal Funds	**1,804,099,685**	**(97,802,656)**	**1,706,297,029**
Other Funds	**60,048,632**	**(6,284,093)**	**53,764,539**
Total Funds	**$ 2,837,574,019**	**$ (75,707,186)**	**$ 2,761,866,833**

Comparison of budgets and funding

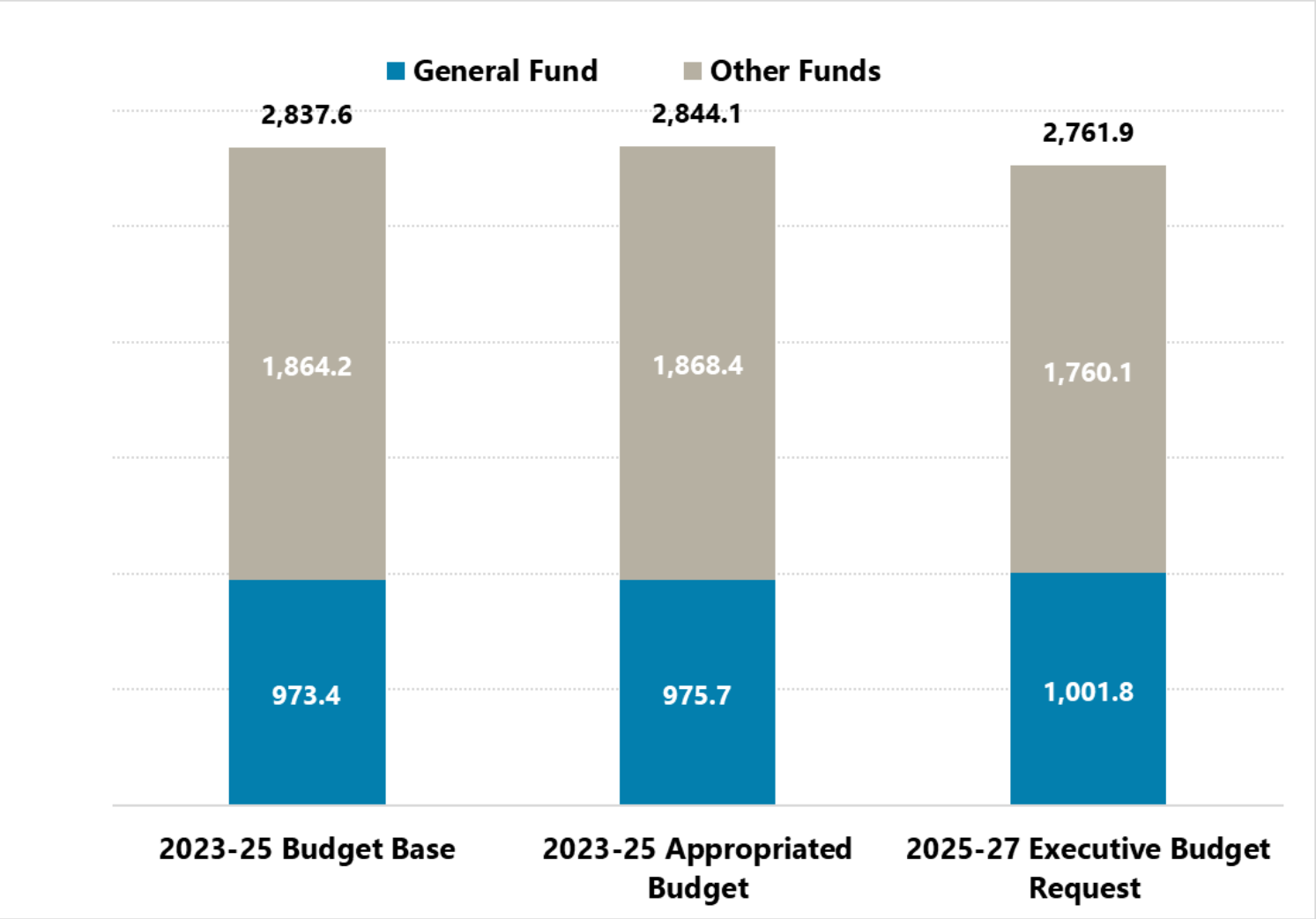
By Base Budget, Current Appropriated Budget, and Requested Budget

2023-25 Appropriated Budget

- $4.5M One-time funding for Program Integrity Audits
- $.6M One-time funding for Basic Care Rate Study
- $1.4M in One-time funding for Cross-Disability Advisory Council

2025-27 Executive Request

- $3.0M Cost to Continue Salary
- ($56.6M) Cost/Caseload Changes
- ($29.5M) Underfunding Medical Assistance Grants to meet base budget target



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.
- SB 2096 – creates regional acute psychiatric treatment and residential supportive housing services.

Summary

Key Budget Drivers & Take Aways

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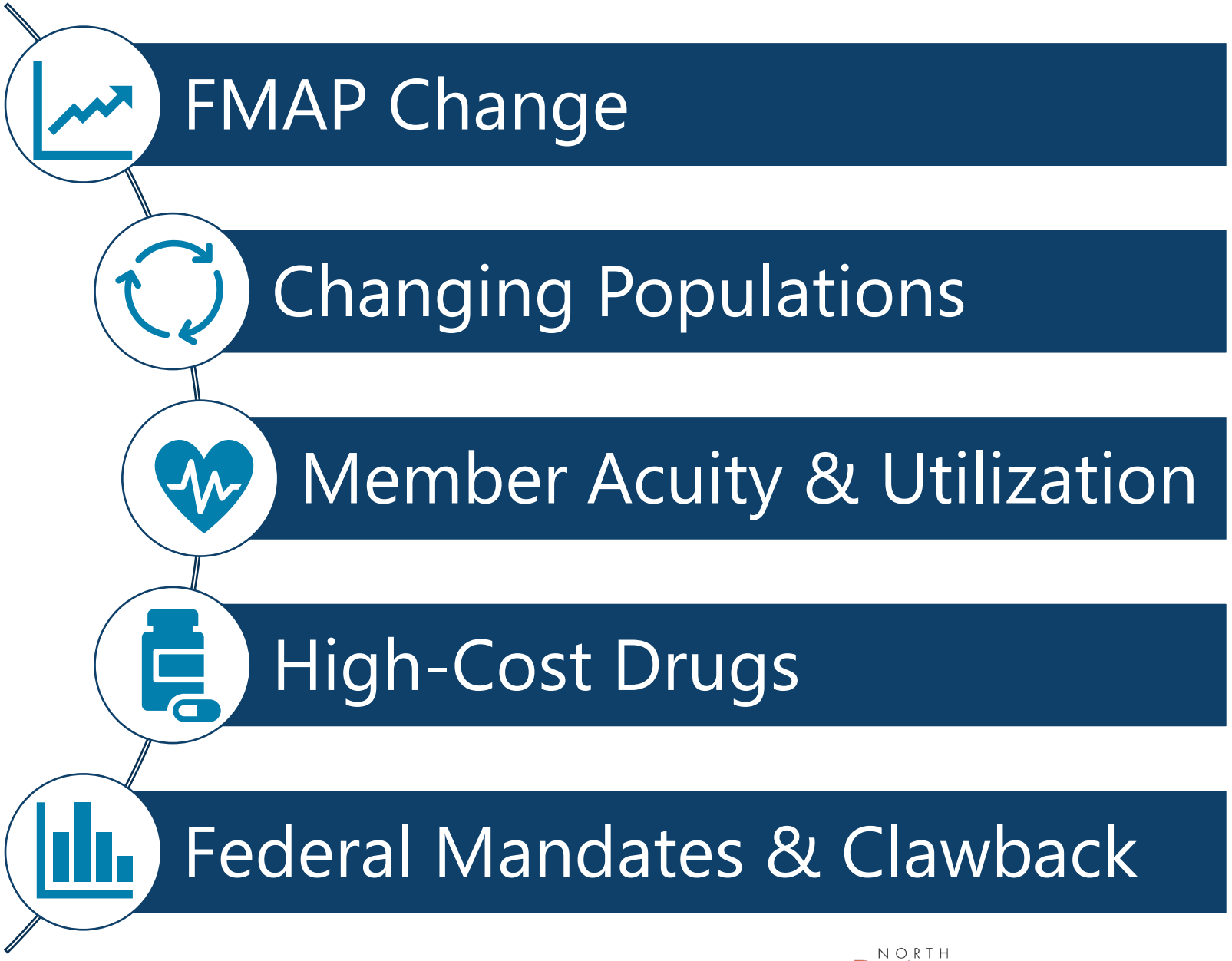
Key Budget Drivers



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Take-Aways

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

Contact information

Sarah Aker

Executive Director, Medical Services
saker@nd.gov

hhs.nd.gov

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