House Bill 1012

Senate Appropriations | Human Resources Division
Senator Dever, Chairman

Medical Services Detail | Sarah Aker | Executive Director

March 12, 2025

NORTH Dakota | Health & Human Services

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Acronyms

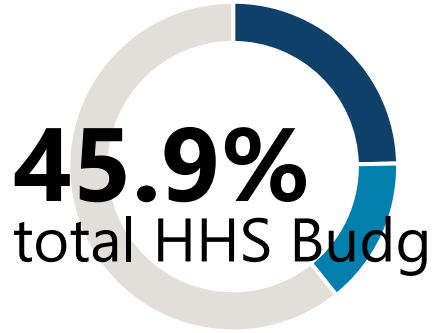
ADL – Activity of Daily Living
AMP - Average Manufacturer Price
BCBS ND – Blue Cross Blue Shield of North Dakota
CAH – Critical Access Hospital
CCBHC – Certified Community Behavioral Health Clinic
CFR – Code of Federal Regulation
CMS – Centers for Medicare & Medicaid Services
CON – Certificate of Need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

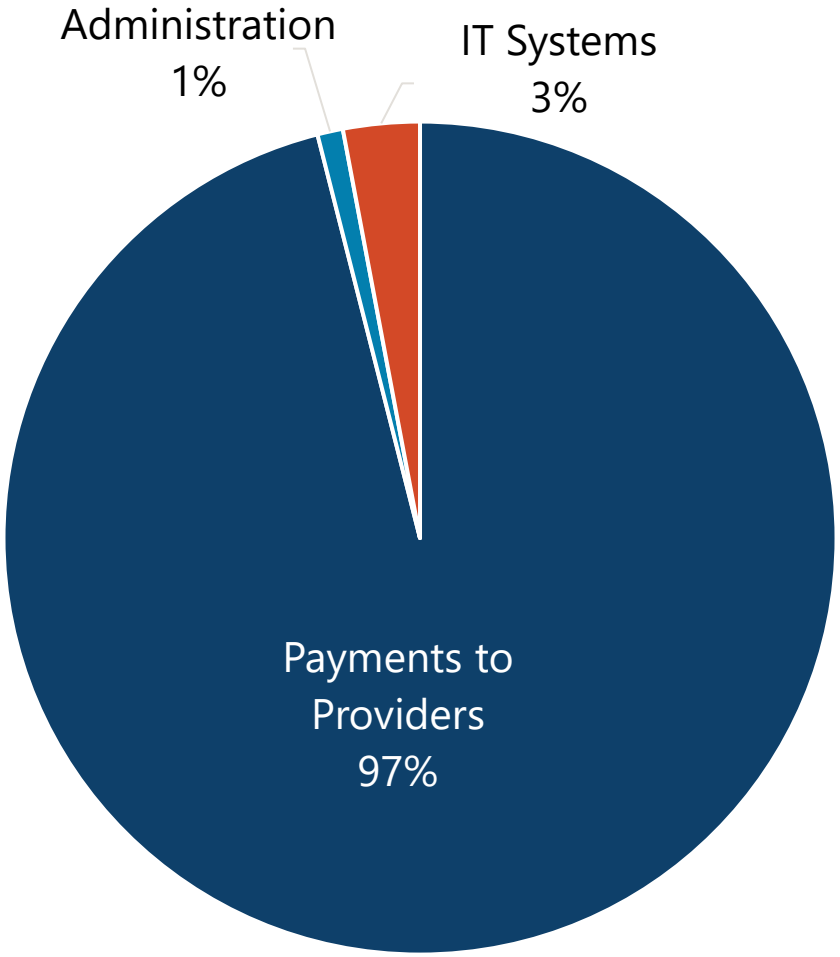
Medical Services Presentation Roadmap

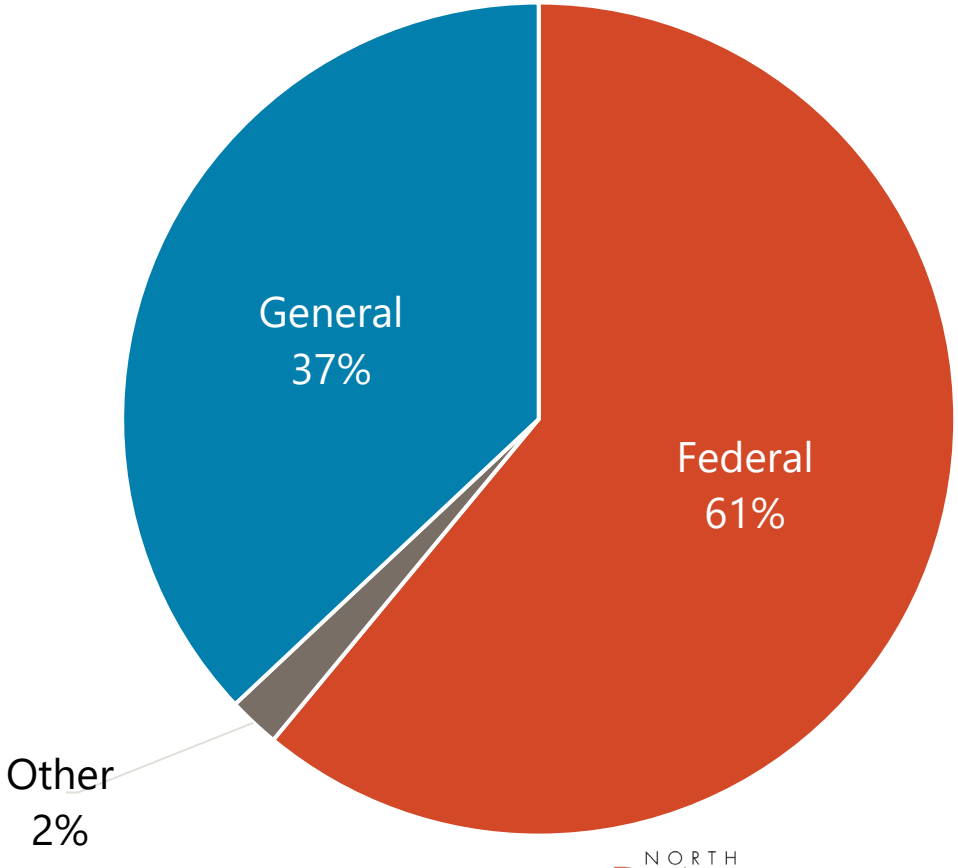
- Budget Overview & Key Medicaid Tenets
- Medical Services
  - Who We Serve
  - Who We Are
  - 2025 – 2027 Budget & Other Resource Requirements
- Long Term Care
  - 2025 – 2027 Budget & Other Resource Requirements
- Summary

Budget Overview

Medical Services & Long-Term Care: $2.9 Billion Total Budget







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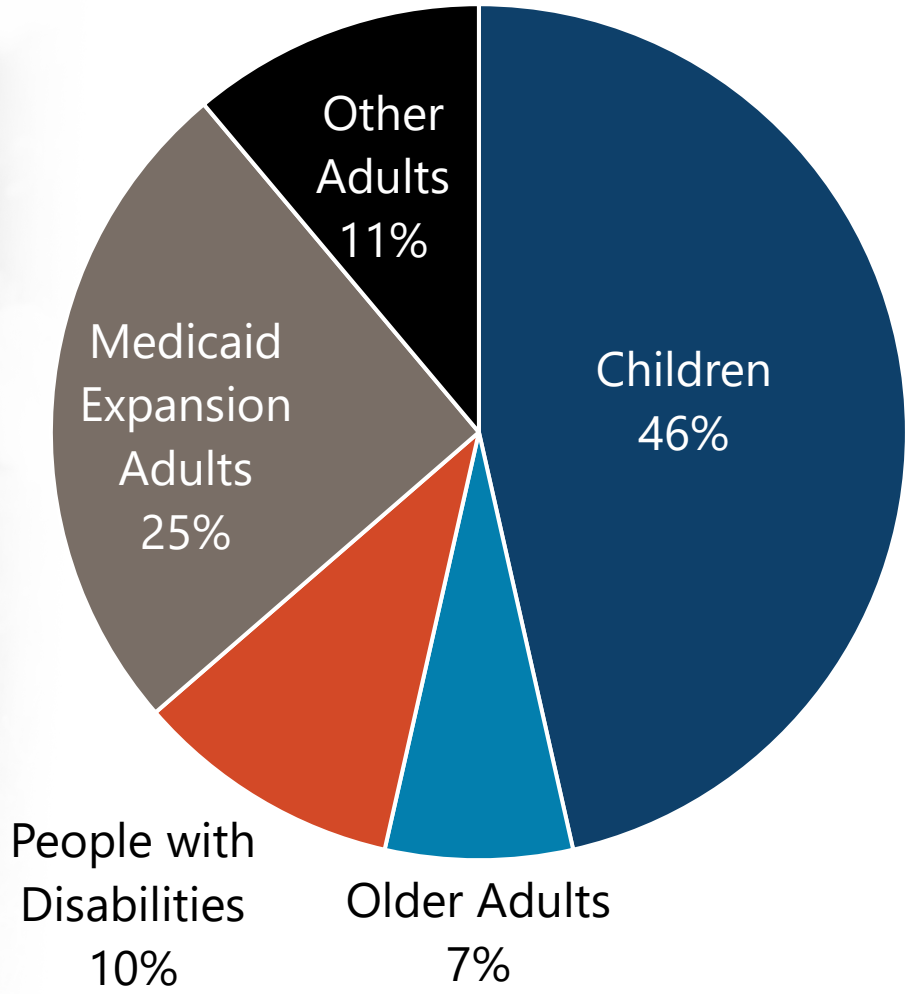
Key Medicaid Tenets

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

Who We Serve

Medical Services

Who is covered by North Dakota Medicaid?



State Fiscal Year 2024

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

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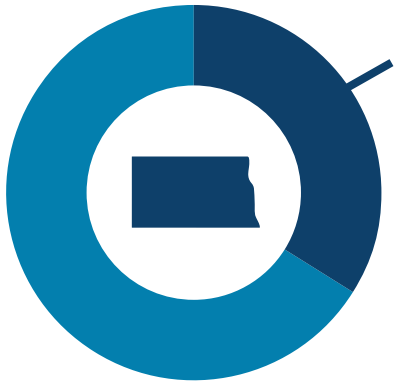
Who We Serve

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

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

52.5% nursing facility residents are paid by Medicaid



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

Federal Poverty Level & HHS Programs

2025 CALENDAR YEAR FEDERAL POVERTY GUIDELINES

Annual Amount at Various Income Percentage Levels

Family Size	34%	100%	130%	138%	175%	185%	205%
1	$5,321	$15,650	$20,345	$21,597	$27,388	$28,953	$32,083
2	$7,191	$21,150	$27,495	$29,187	$37,013	$39,128	$43,358
3	$9,061	$26,650	$34,645	$36,777	$46,638	$49,303	$54,633
4	$10,931	$32,150	$41,795	$44,367	$56,263	$59,478	$65,908
5	$12,801	$37,650	$48,945	$51,957	$65,888	$69,653	$77,183
6	$14,671	$43,150	$56,095	$59,547	$75,513	$79,828	$88,458
7	$16,541	$48,650	$63,245	$67,137	$85,138	$90,003	$99,733
8	$18,411	$54,150	$70,395	$74,727	$94,763	$100,178	$111,008

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

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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.

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.

Home and Community Based Services

Programs and Populations

	Intellectual and Developmental Disabilities	Physical Disabilities	Behavioral Health
Adults	Medicaid State Plan		
	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)
Children	Medicaid State Plan		
	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

Serving Children with Disabilities

2021

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

2022

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

2023

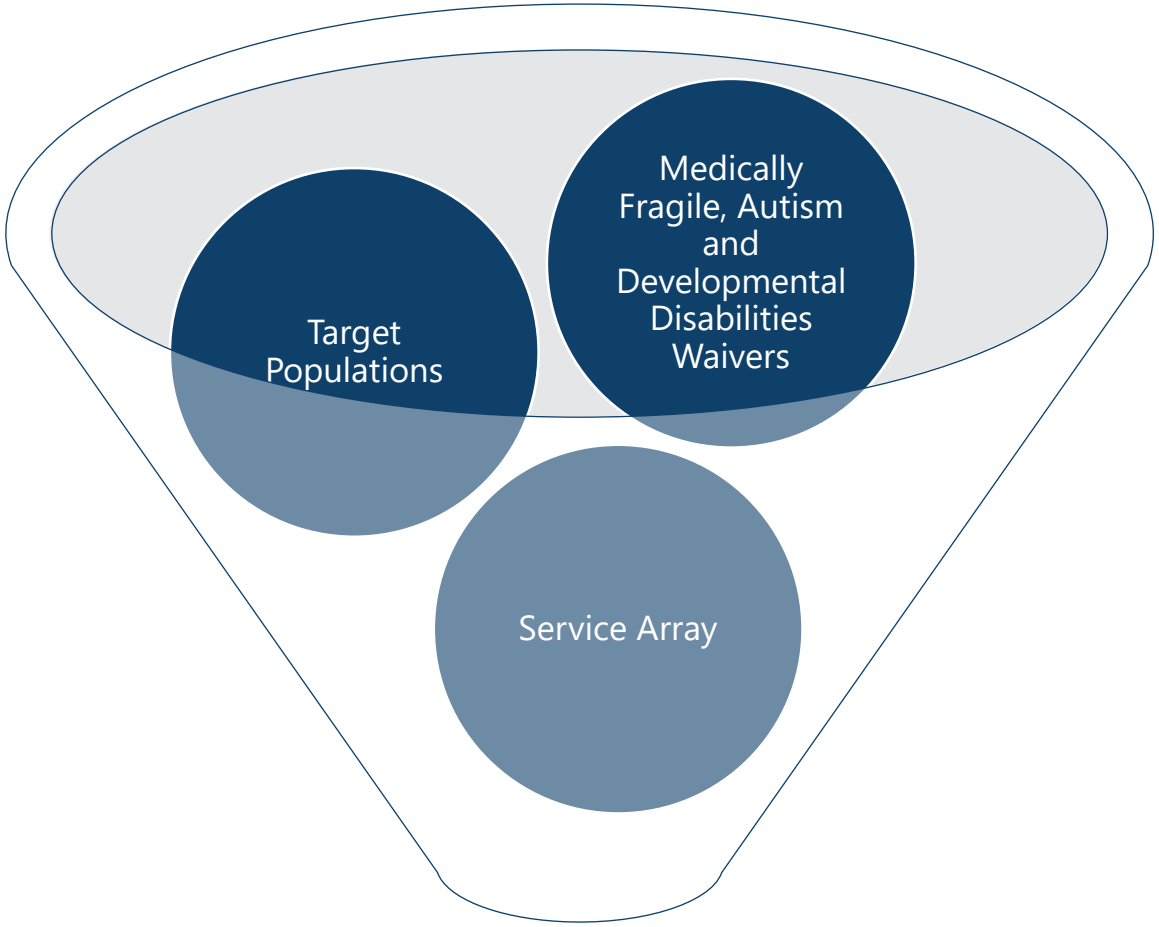
SB 2276: Established Cross Disability Advisory Council

2024

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

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

2025



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

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Cross Disability Advisory Council

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

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

Cross Disability Waiver Implementation

Ongoing

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

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

2023-2025 Biennium Activities:

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

Funding will support:

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

Who We Are

Medical Services Division

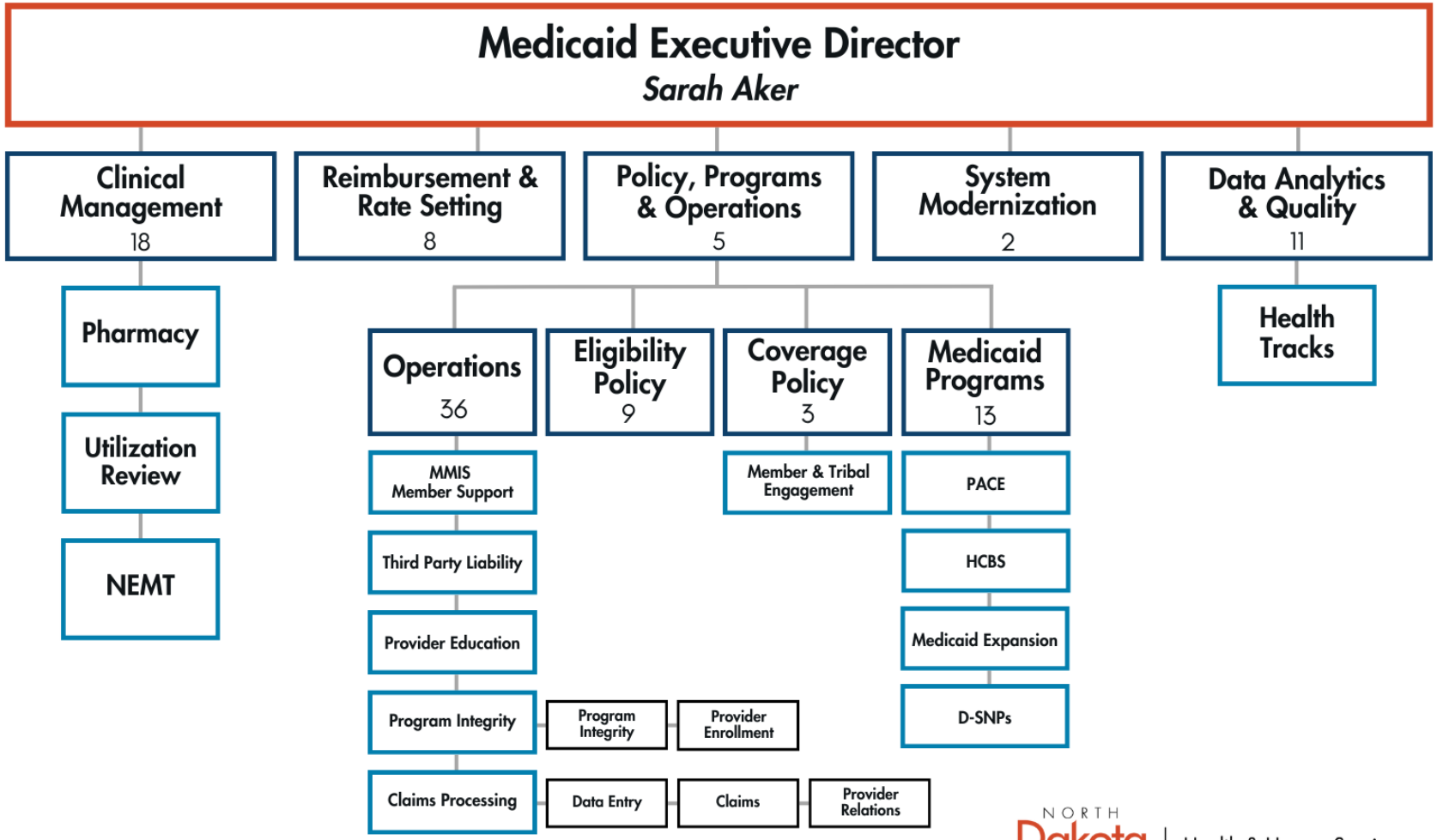
Medical Services Division

Team Structure and Function

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

*As of 12/01/2024

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



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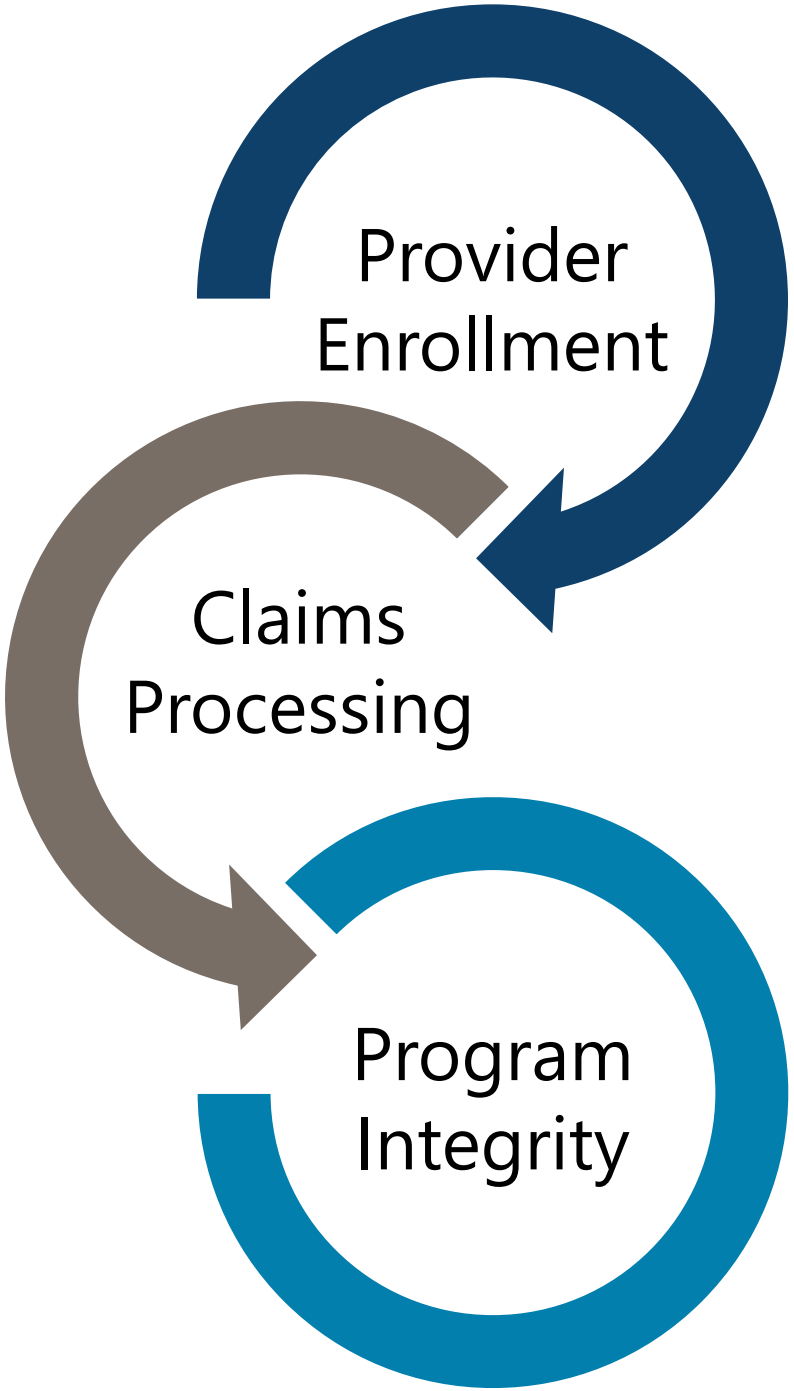


PROVIDER ENROLLMENT

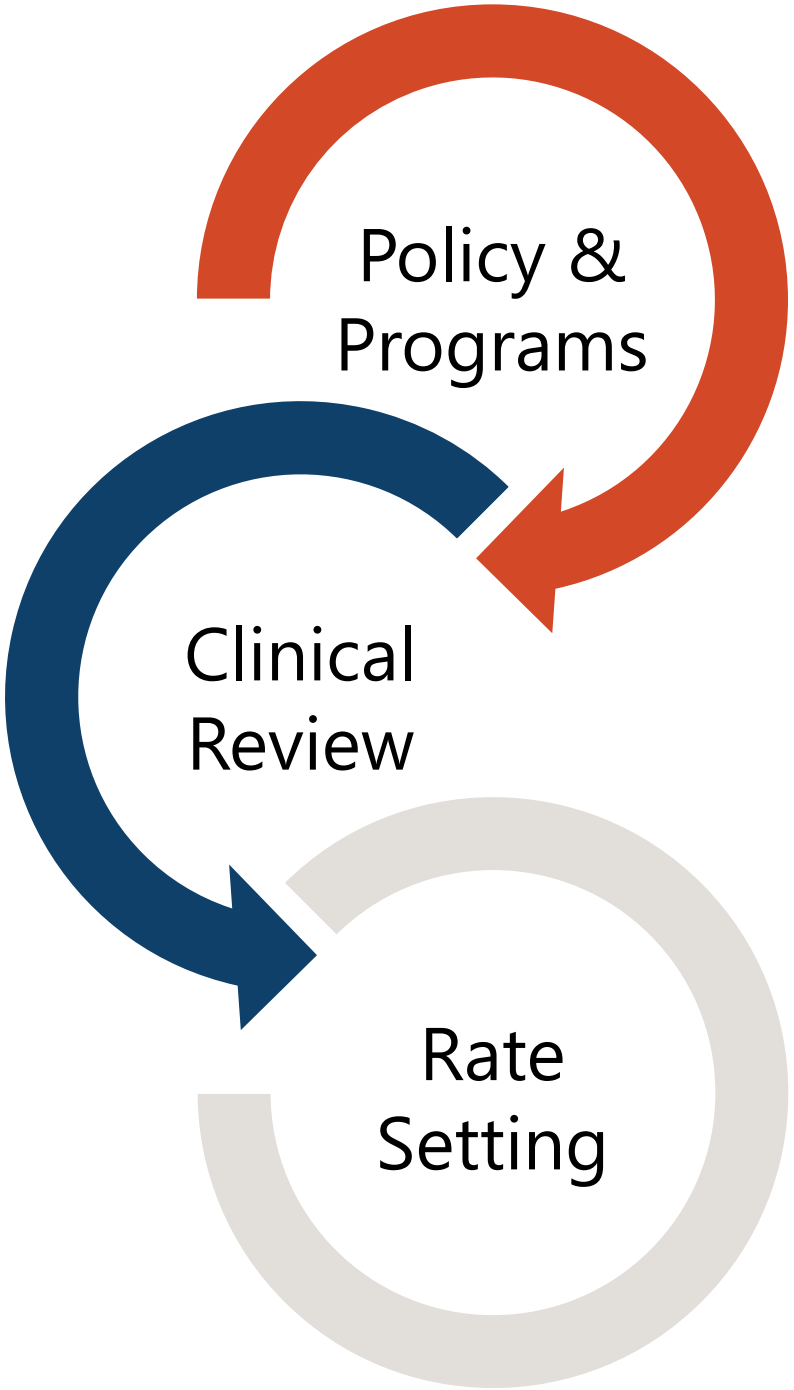
- Ensures providers meet all federal and state standards to enroll as a Medicaid provider and remain an eligible provider.
- ND Medicaid has over 24,000 enrolled providers.
- On average, new enrollments were processed within 11 days.

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.



POLICY & PROGRAM ADMINISTRATION

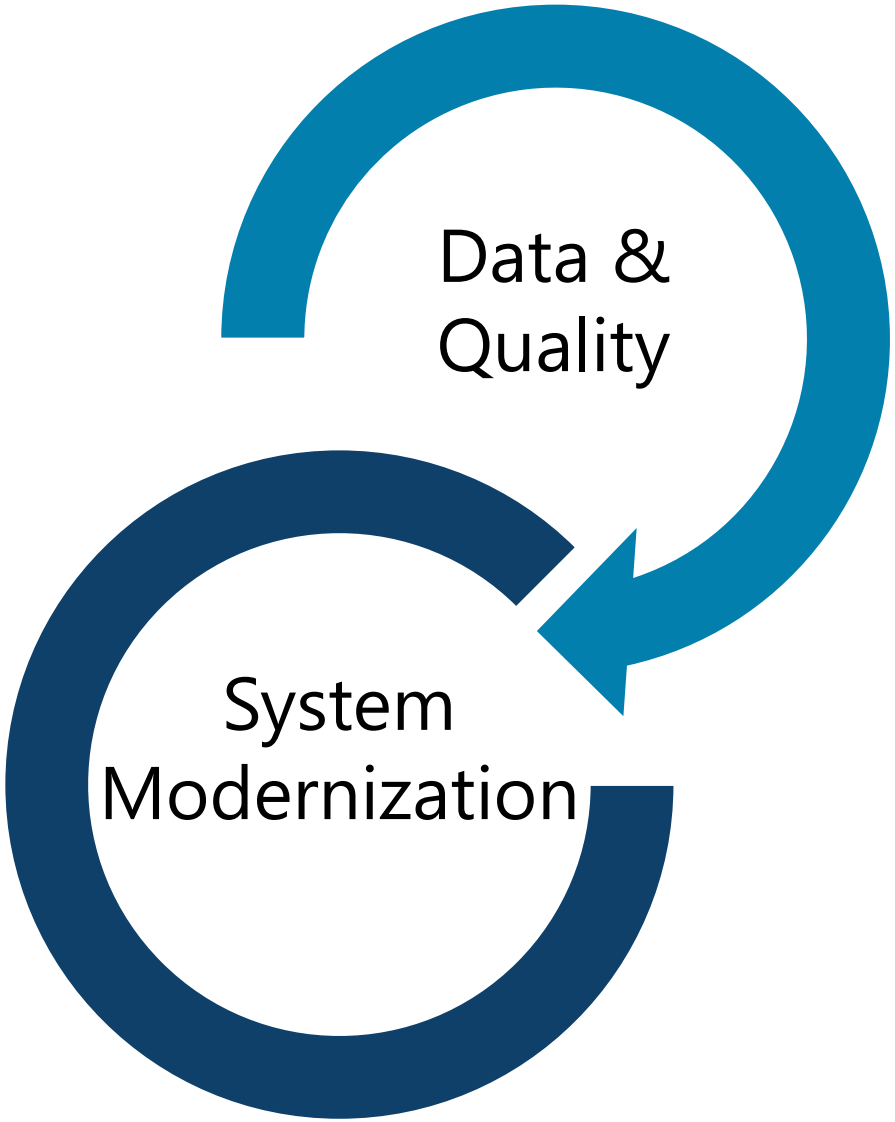
- Eligibility & Coverage Policy
- HCBS Operations & Oversight
- Managed Care Oversight
- Provider, Member & Tribal Engagement

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

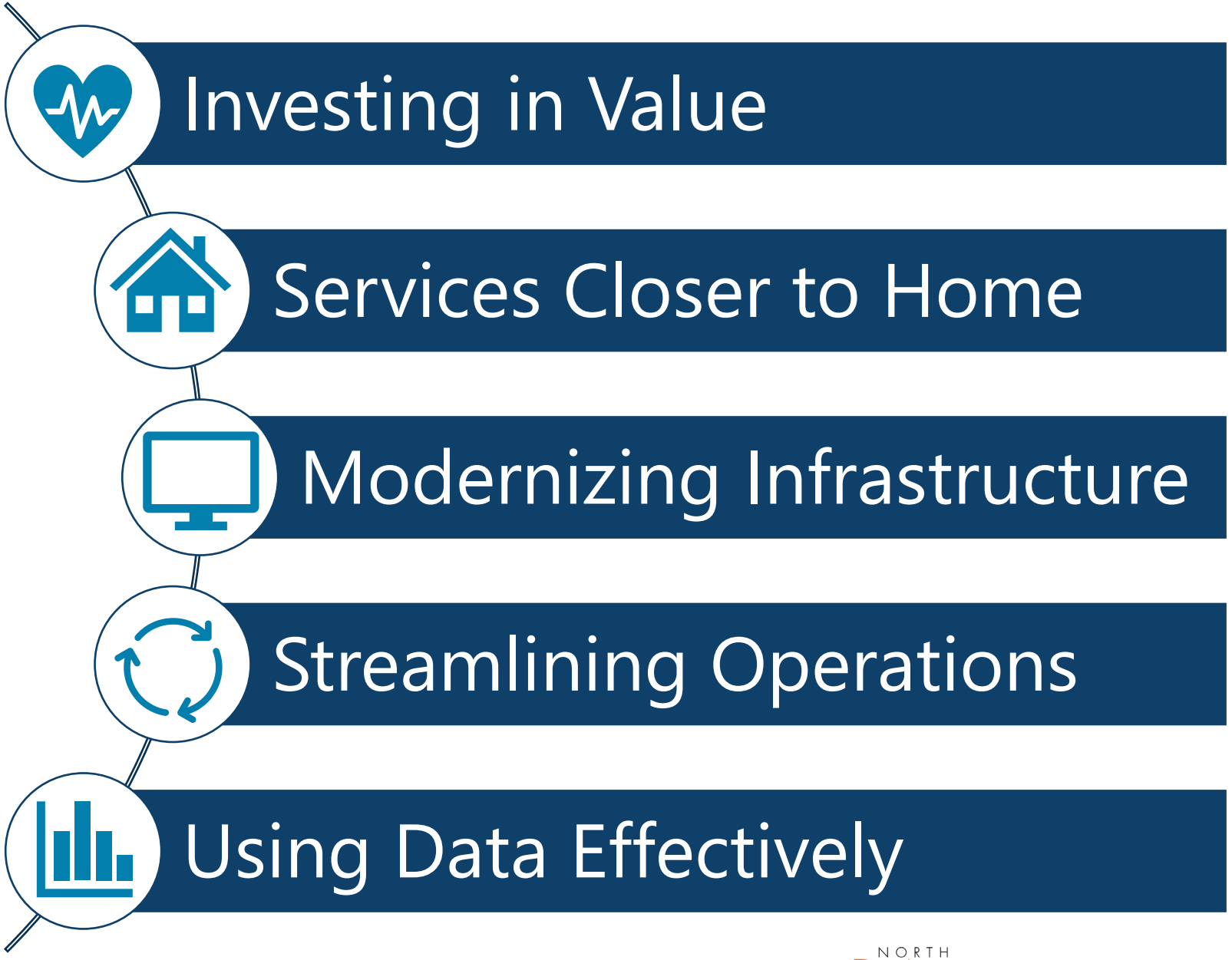
Successes

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

Challenges, Opportunities, & Areas of Risk

- Federal Regulations & Limitations
- Community vs. Institutional Care
- Complex Patients
- Data & System Limitations
- Vendor & Provider Accountability and Partnerships
- Rate Strategy
- Competing Priorities & Finite Resources

Our Key Priorities



Goals for the Next Biennium

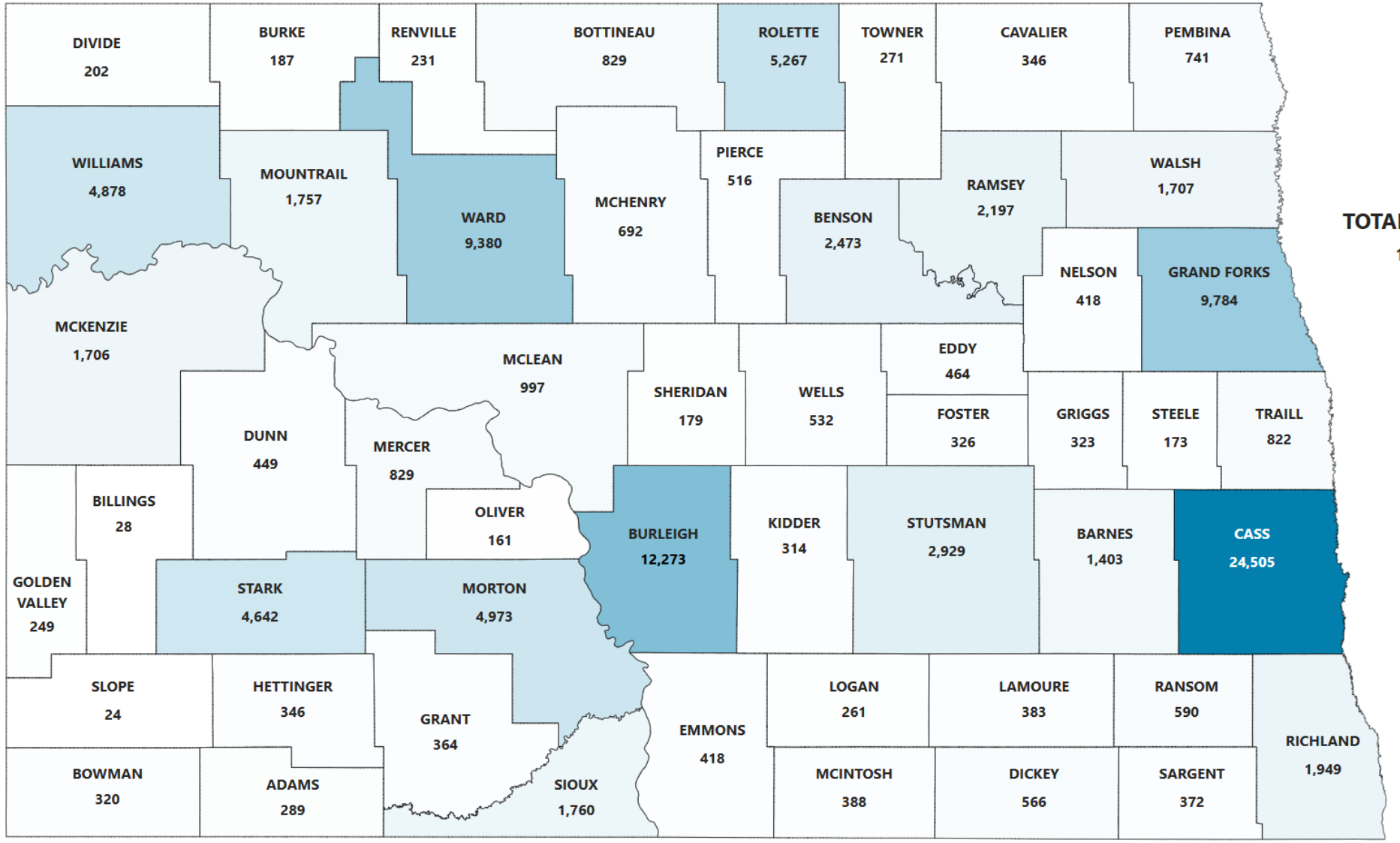
- Bending the Cost Curve
- Delivering Whole Person Care
- Promoting Sustainability & Value
- Improving the Member & Provider Experience

Eligibles & Unwinding

Last updated: 03/06/2024

MEDICAID ELIGIBLES BY COUNTY

February 2025



TOTAL ELIGIBLES

108,345

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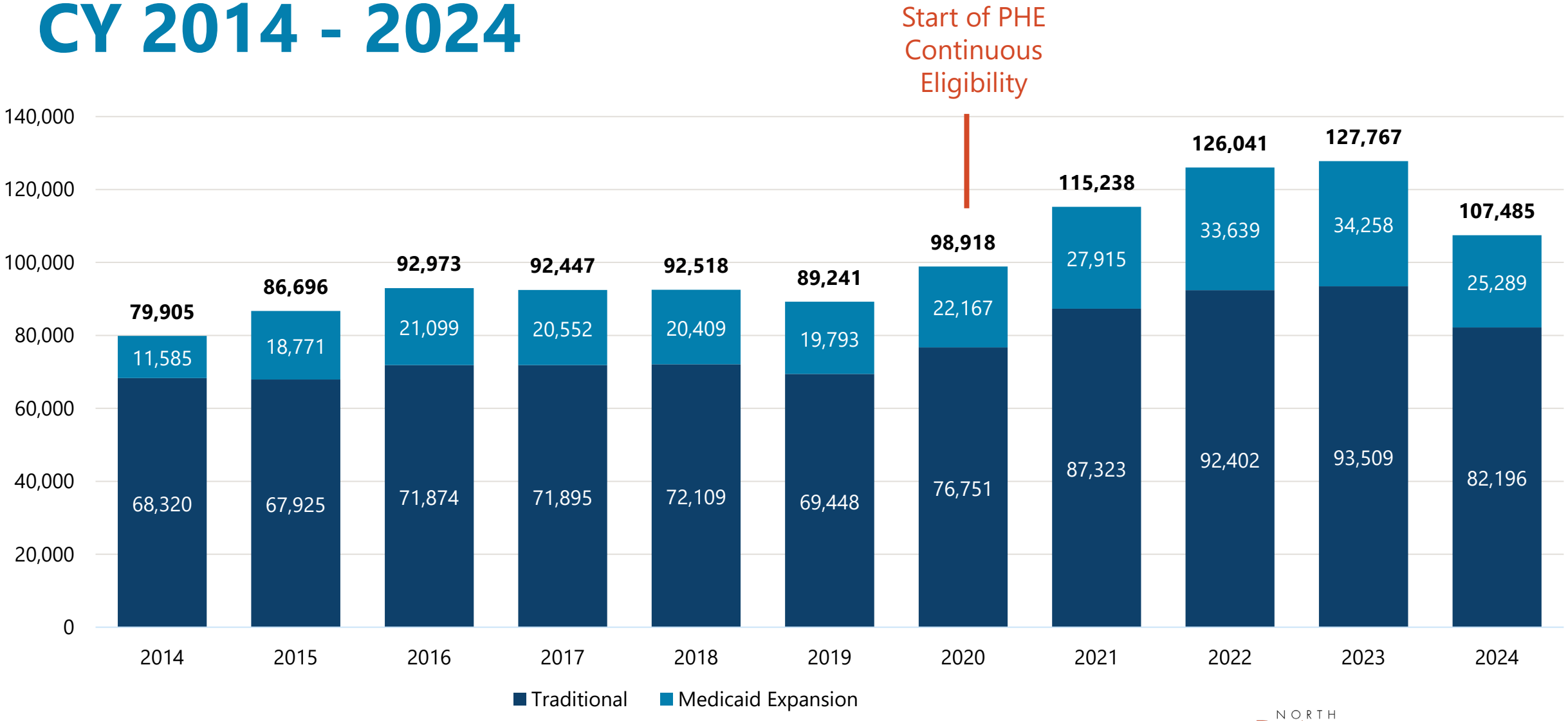
Public Health Emergency Continuous Eligibility Requirement

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.

ND Medicaid Average Monthly Enrollment CY 2014 - 2024



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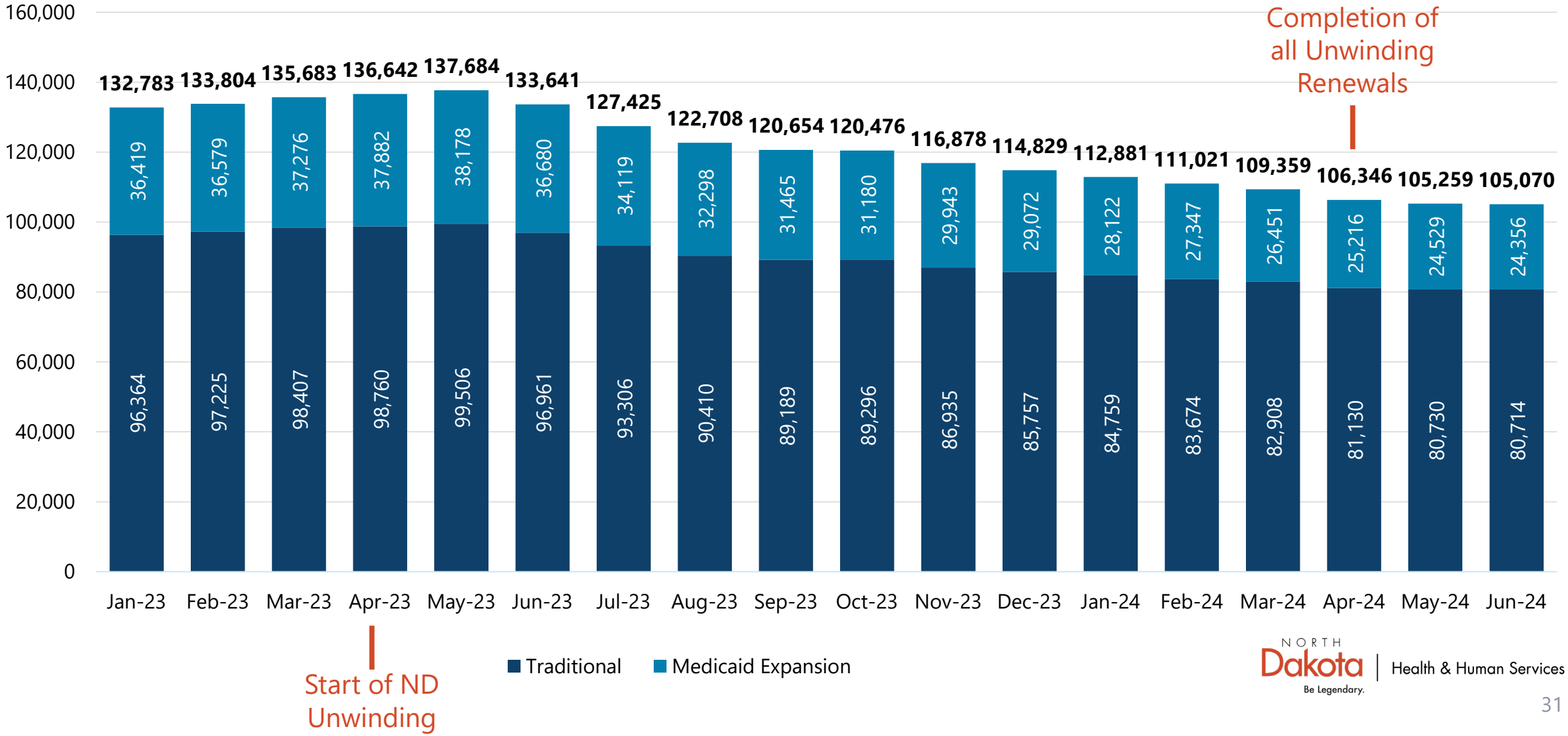
Monthly Enrollment
January 2023 – June 2024



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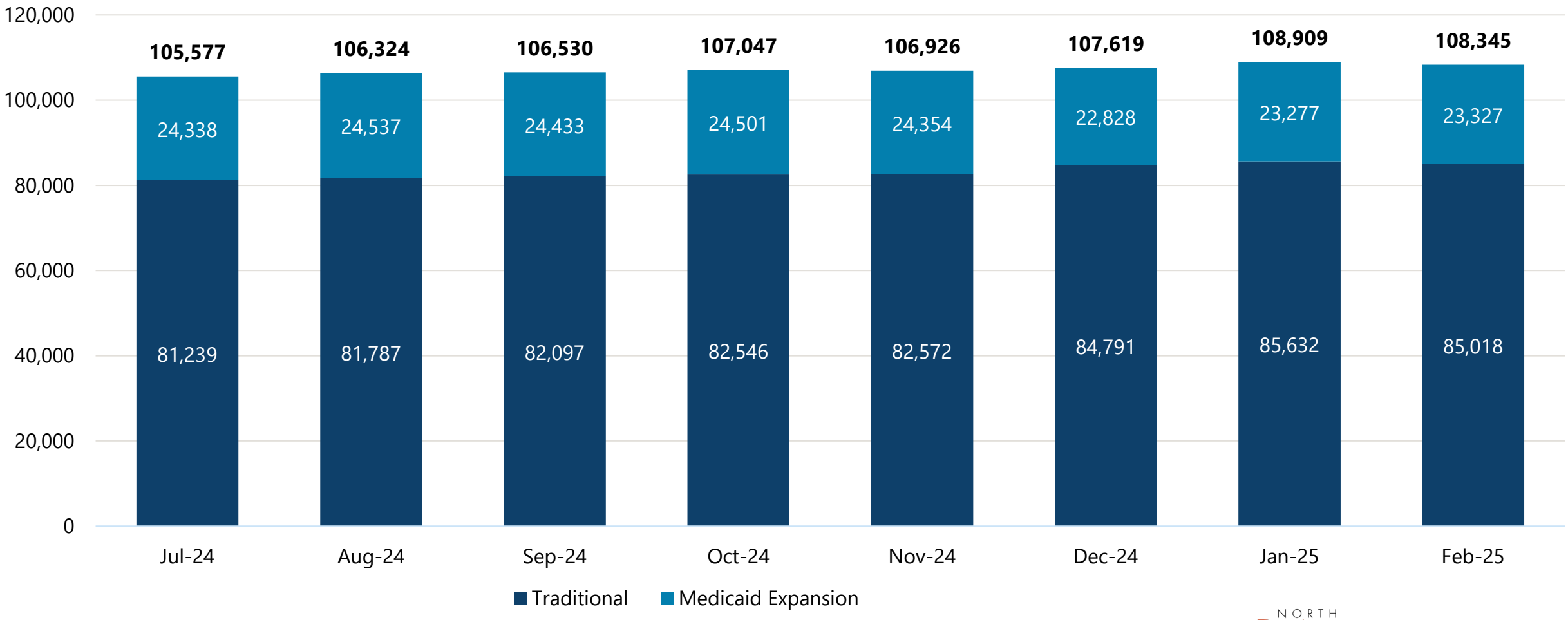
Monthly Enrollment
July 2024 – February 2025



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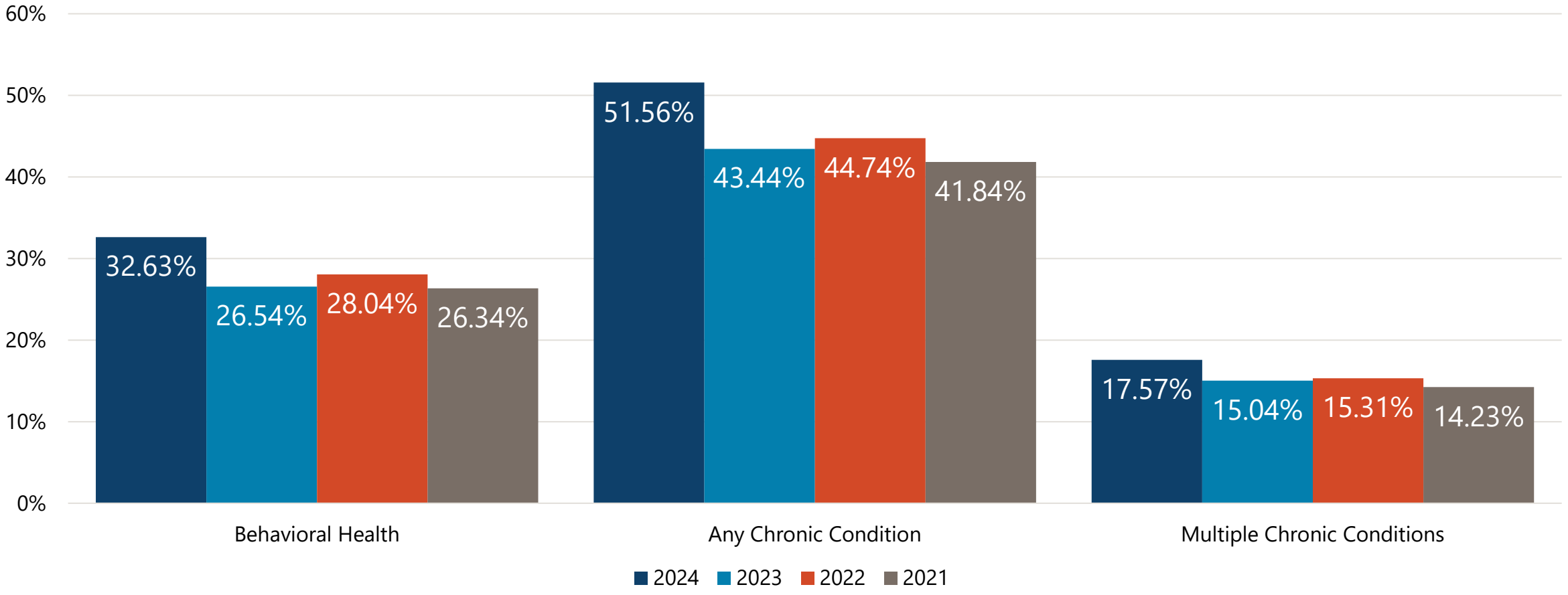
Traditional Medicaid: Chronic Conditions

Percent of Members with Diagnosis



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

Medicaid & Incarceration

Federal Fund Restrictions for Inmates

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

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

Youth and Young Adults in Carceral Settings

Section 5121 of the Consolidated Appropriations Act, 2023

Requires states to:

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

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

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

Federal Grant

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

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

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

Costs & Outcomes

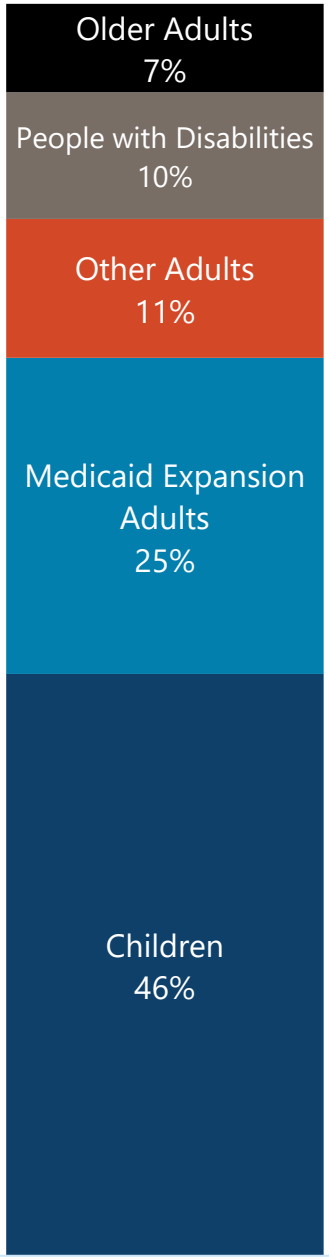
How do we measure results in Medicaid?

Expenditures & Outcomes

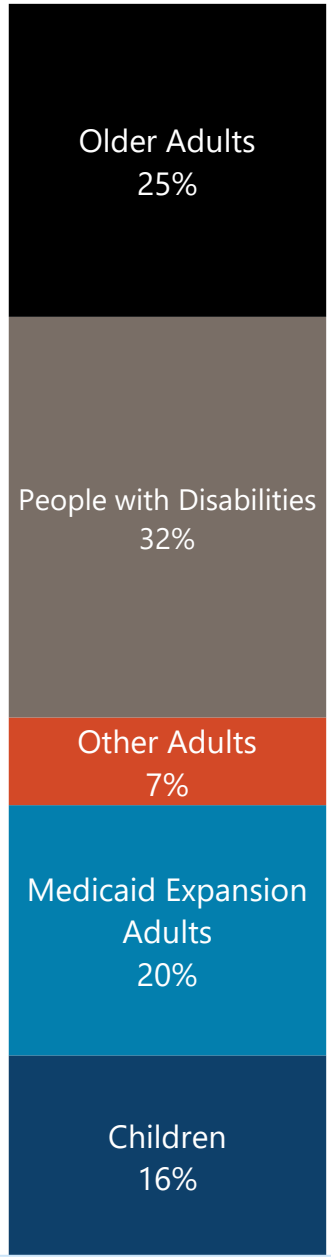
The Center for Medicare and Medicaid Services (CMS) collects and publishes data related to both expenditures and outcomes on the Medicaid & CHIP Scorecard.

- 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

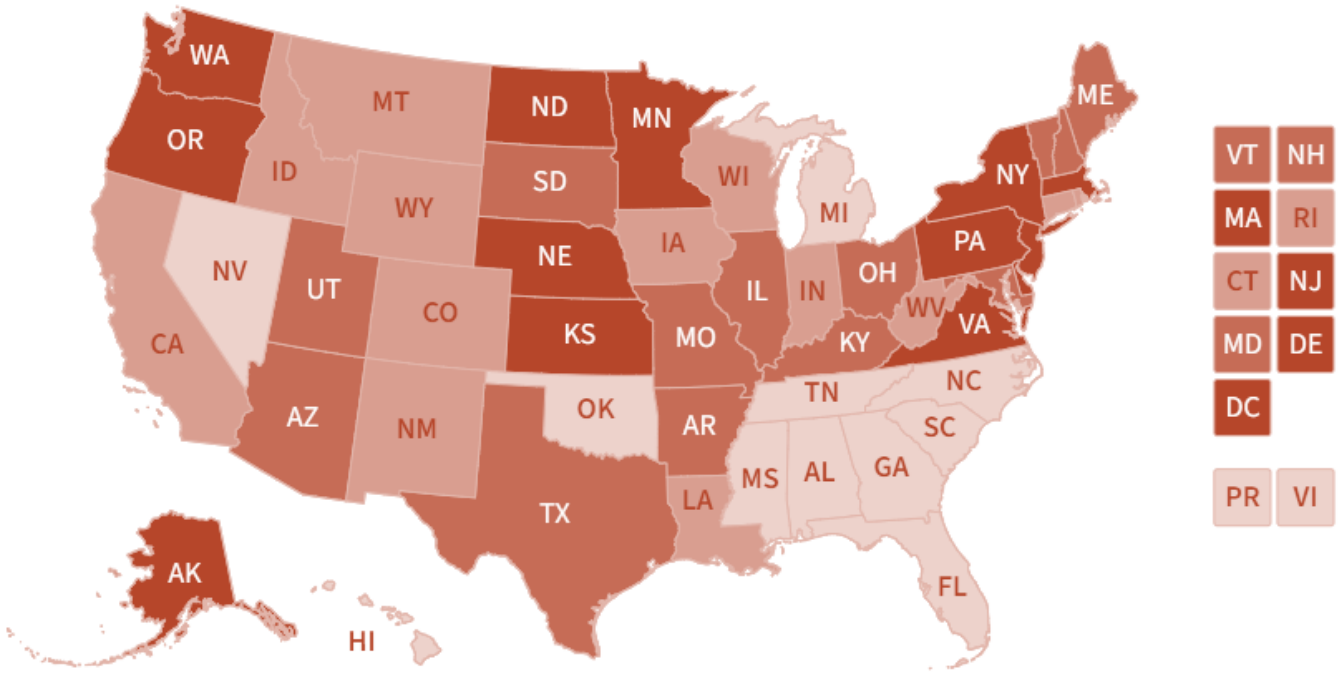


Enrollment



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** per capita 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

Medicaid and CHIP Scorecard - Medicaid Per Capita Expenditures

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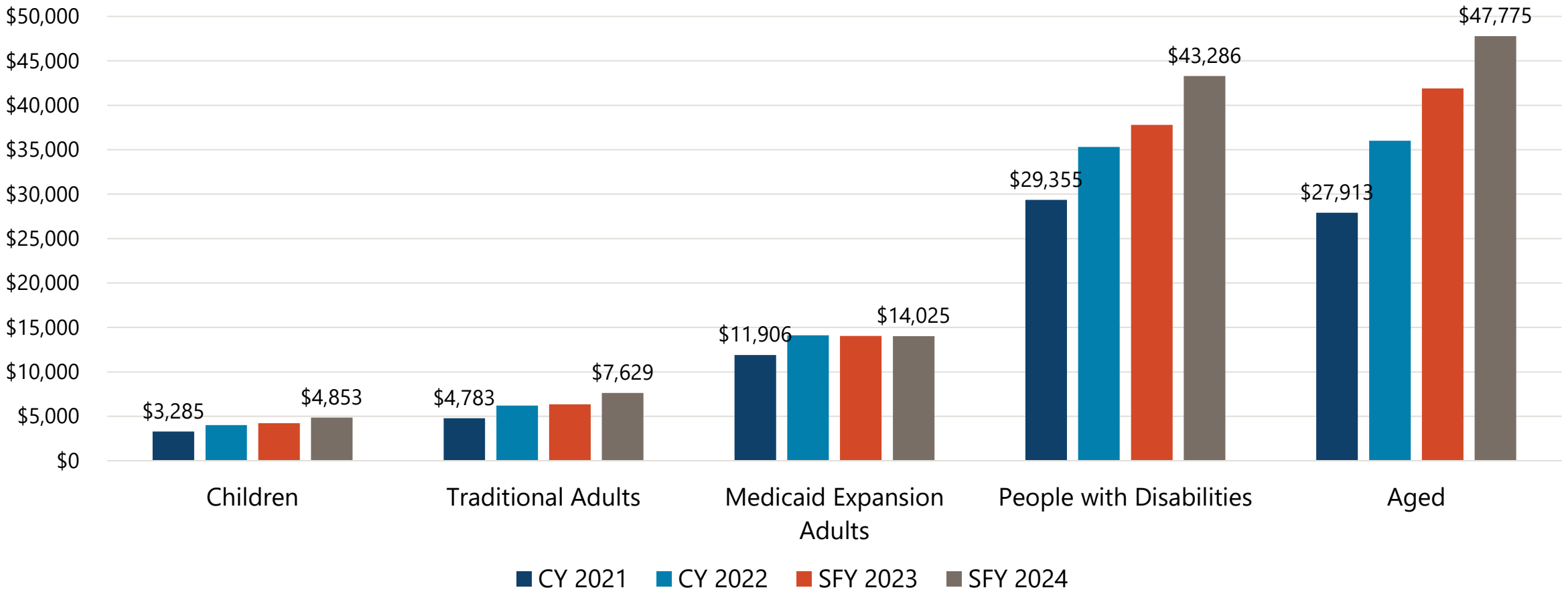
Per Capita Expenditures



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

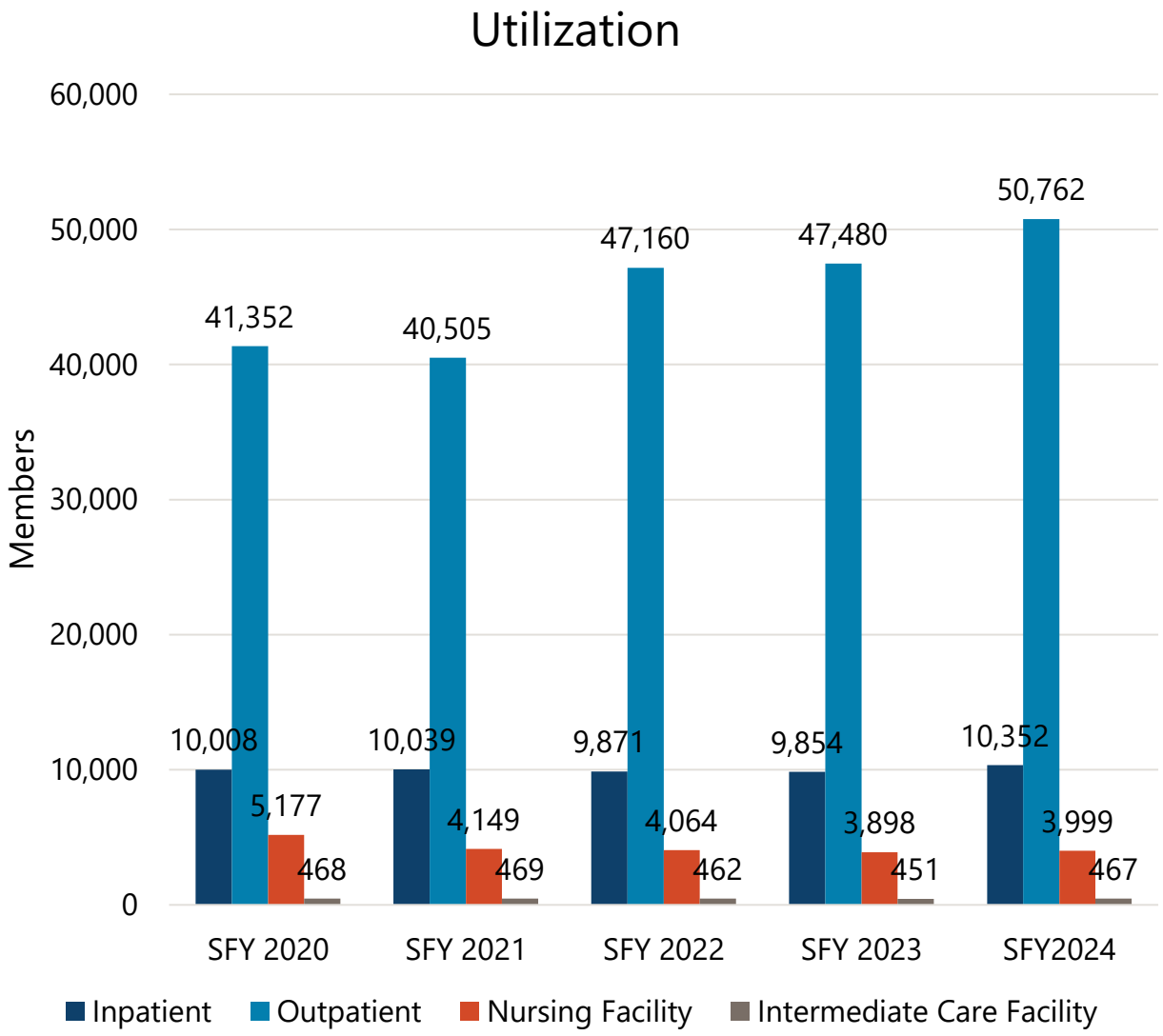
Top 25 Claims

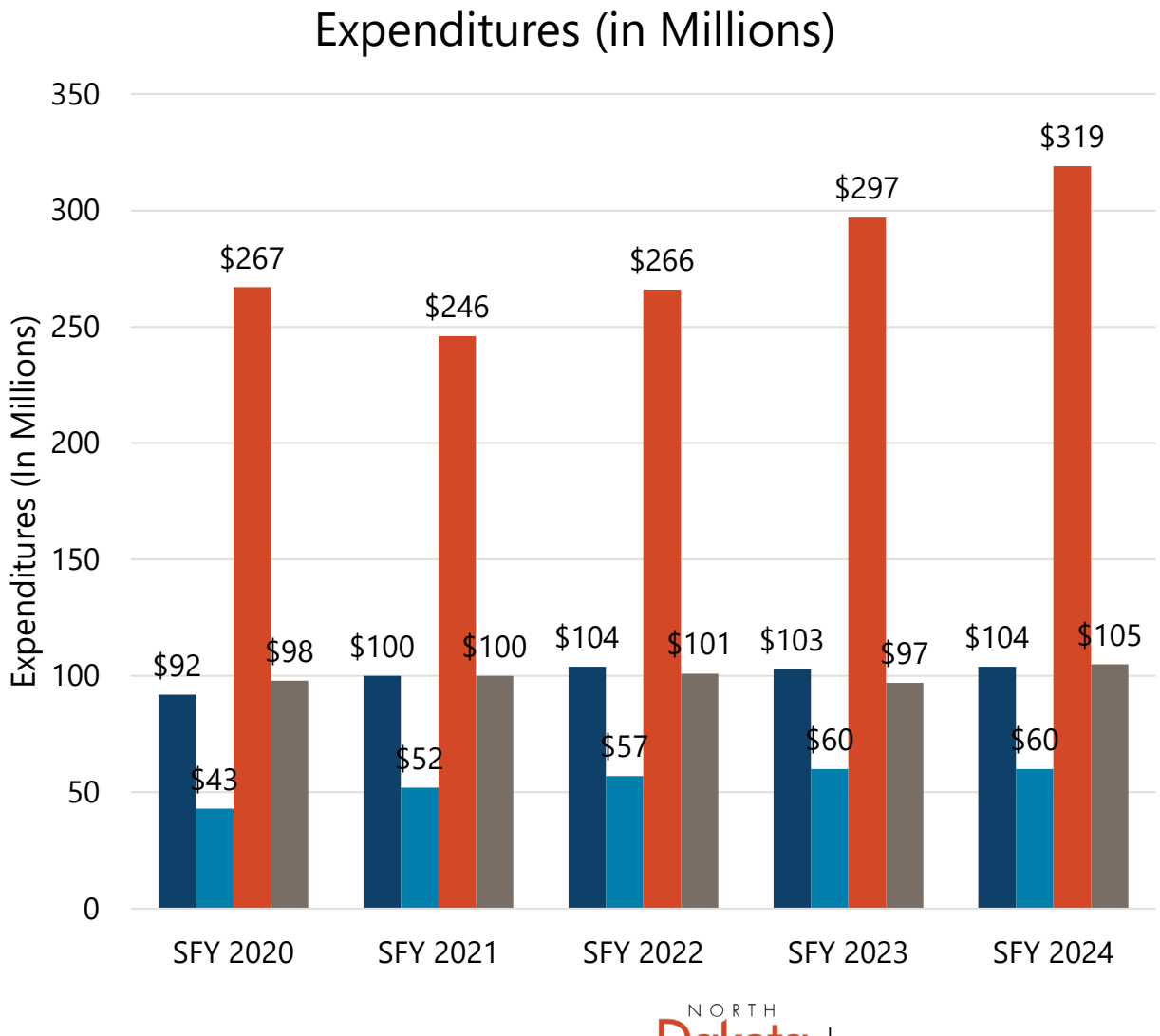
- Average Amount: $309,949
- 64% were for infants
- 60% related to cardiovascular disorders or disease
- Other diseases included: Cancer, End Stage Renal Disease (ERSD), and other rare conditions

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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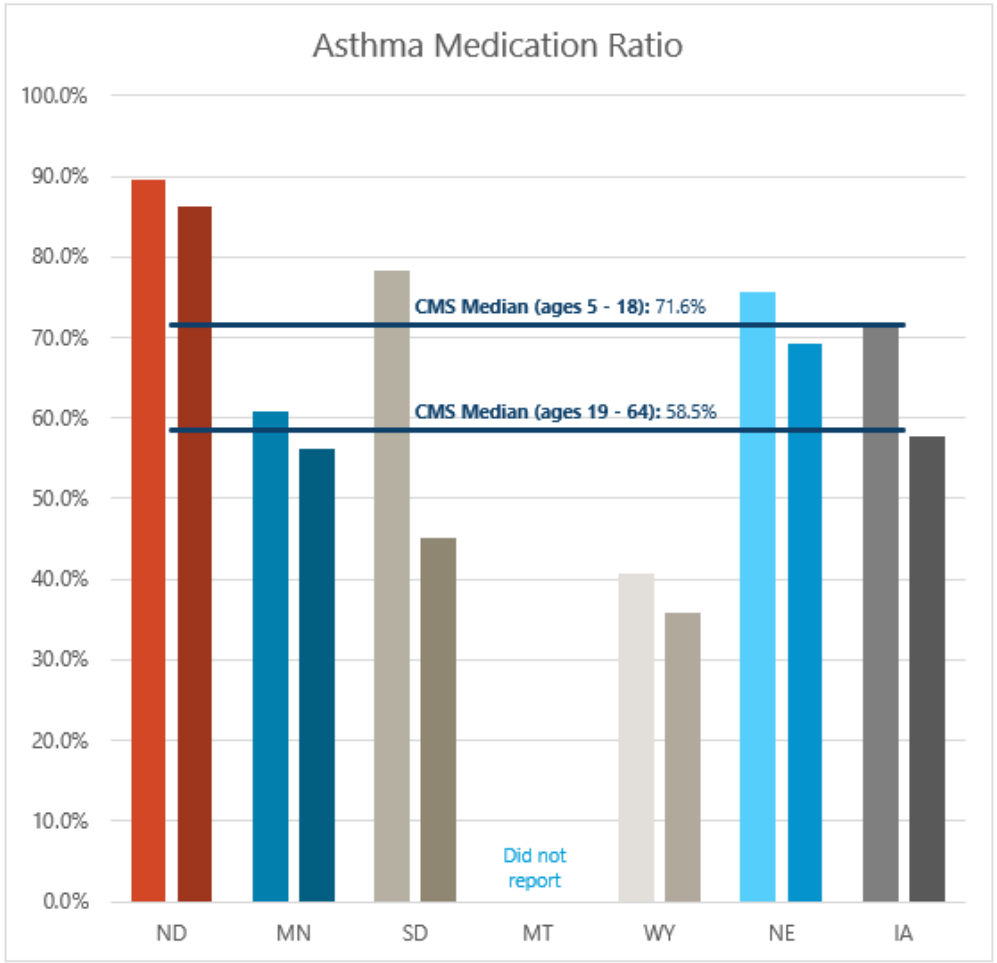
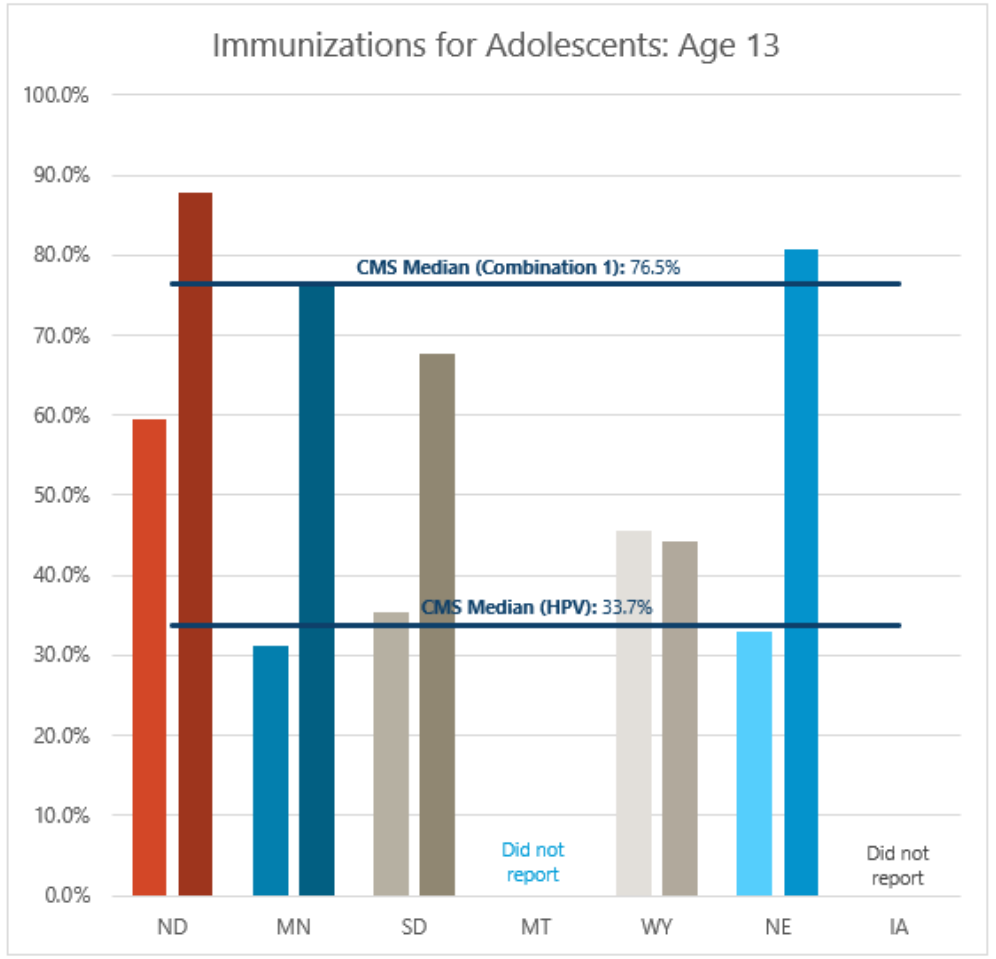
Outcomes: Medicaid and CHIP Scorecard

- 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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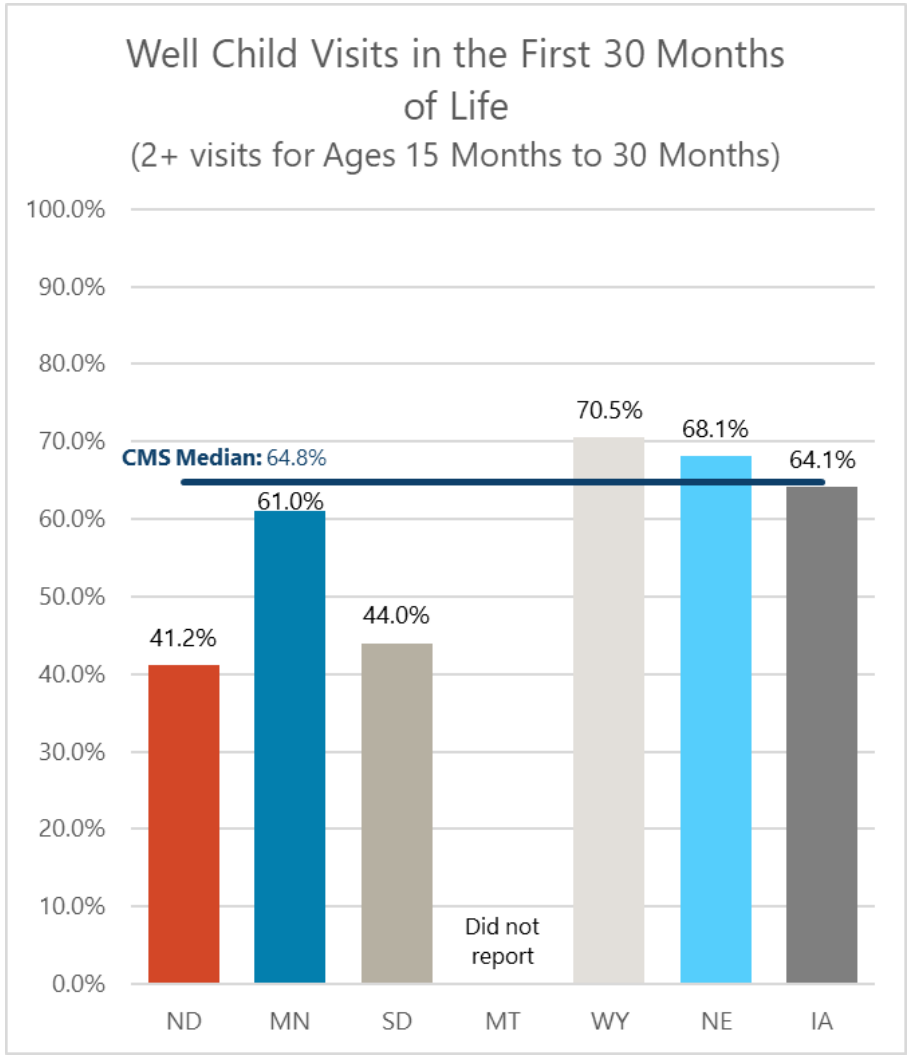
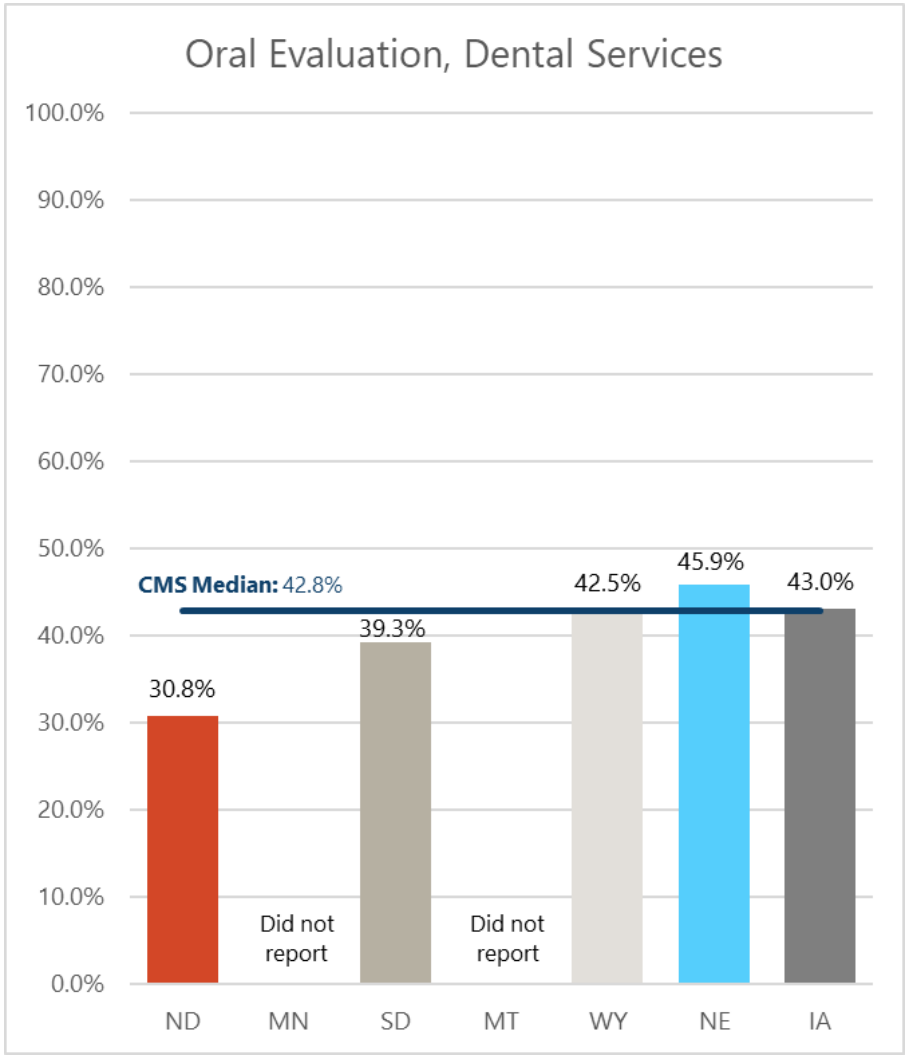
Bottom Quartile Outcomes: FFY 2023





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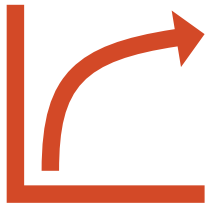
Value Based Programs

Why Value Based Care?

Accountability for Enhanced Care Delivery

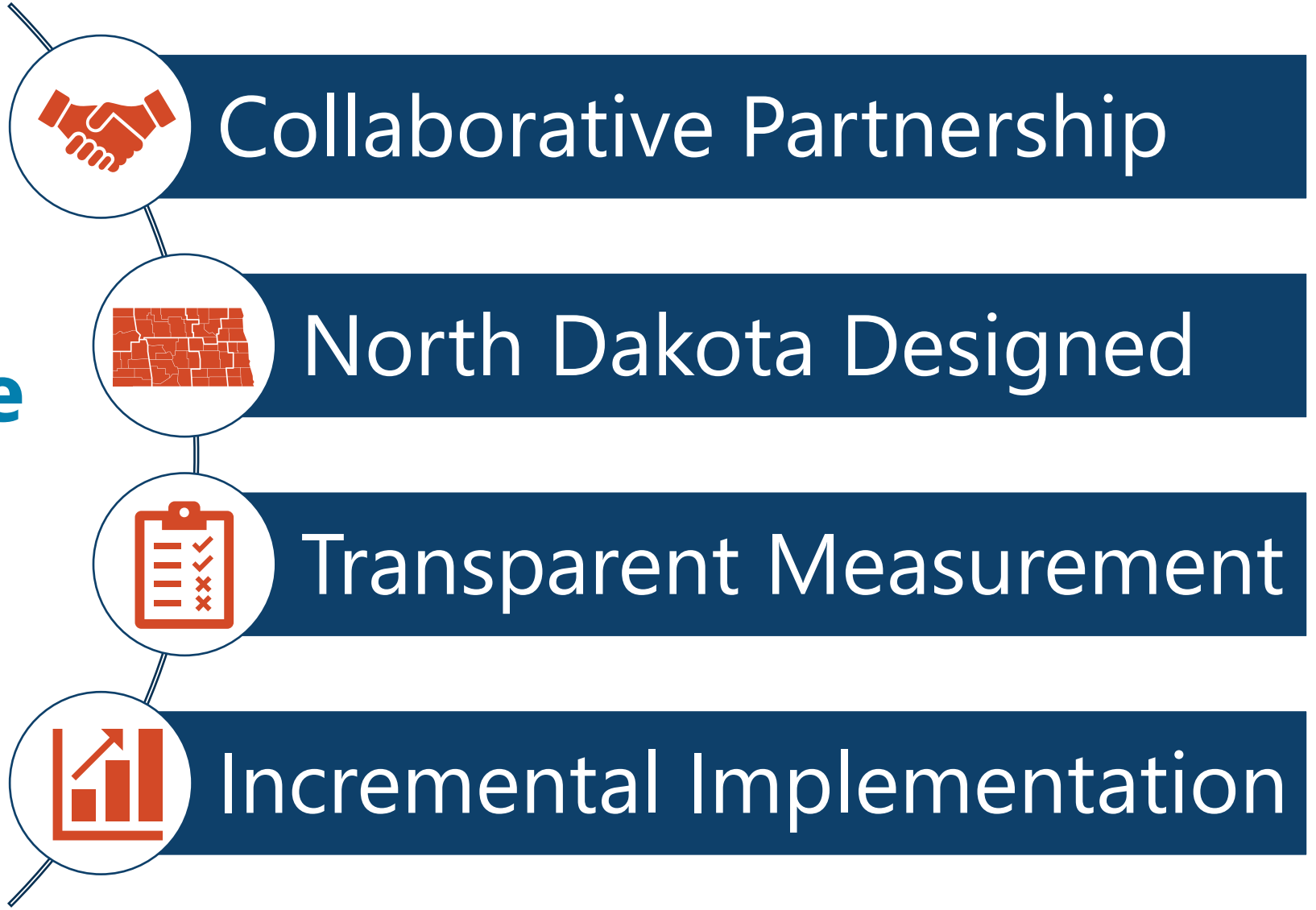
Improved Patient Experiences & Outcomes

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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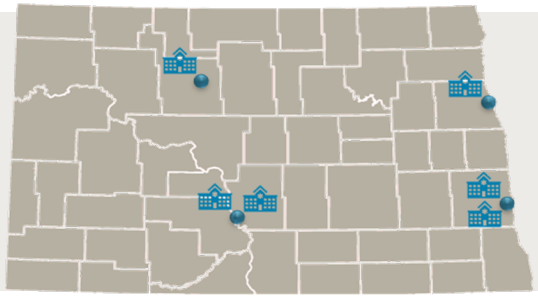
Health System Value-Based Purchasing

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

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	28.29	28.89	40.25	41.35	36.42	32.85	33.45
Breast Cancer Screening (BCS-AD)	52.20%	29.97%	44.51%	35.14%	34.38%	48.29%	31.83%	35.69%
Child & Adolescent Well-Care Visits (WCV-CH)	48.07%	47.29%	47.51%	39.20%	34.72%	53.95%	48.86%	46.61%
* Plan All-Cause Readmissions (PCR-AD)	0.9850	0.7701	1.2557	0.8469	1.1143	0.8098	0.7860	0.8454
Postpartum Care: Prenatal and Postpartum Care (PPC)	78.10%	73.37%	58.87%	62.07%	54.95%	58.36%	76.95%	66.02%
Screening for Depression & Documented Follow-up Plan (CDF)	72.60%	7.68%	0.13%	8.35%	1.75%	62.83%	6.40%	14.41%
Topical Fluoride for Children (TFL-CH)	19.30%	13.08%	16.22%	9.17%	8.95%	13.44%	13.95%	12.91%
Well-Child Visit First 15 Months (W30-CH)	66.76%	43.02%	51.26%	52.21%	47.44%	61.50%	44.50%	48.85%
Well-Child Visit 15 – 30 Months of Life (W30-CH)	58.38%	55.99%	65.84%	61.18%	44.16%	64.93%	55.94%	58.68%

Performance Timeframe: January 2024 – November 2024 (11-month performance snapshot)
2024 final performance will be produced in May 2025 which allows the systems 12 months to close care gaps & final inclusion of supplemental data.

Meeting State Goal	13 metrics	Improvement from CY 2023	25 metrics

** Lower Performance is better*

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Nursing Facility Incentive Program

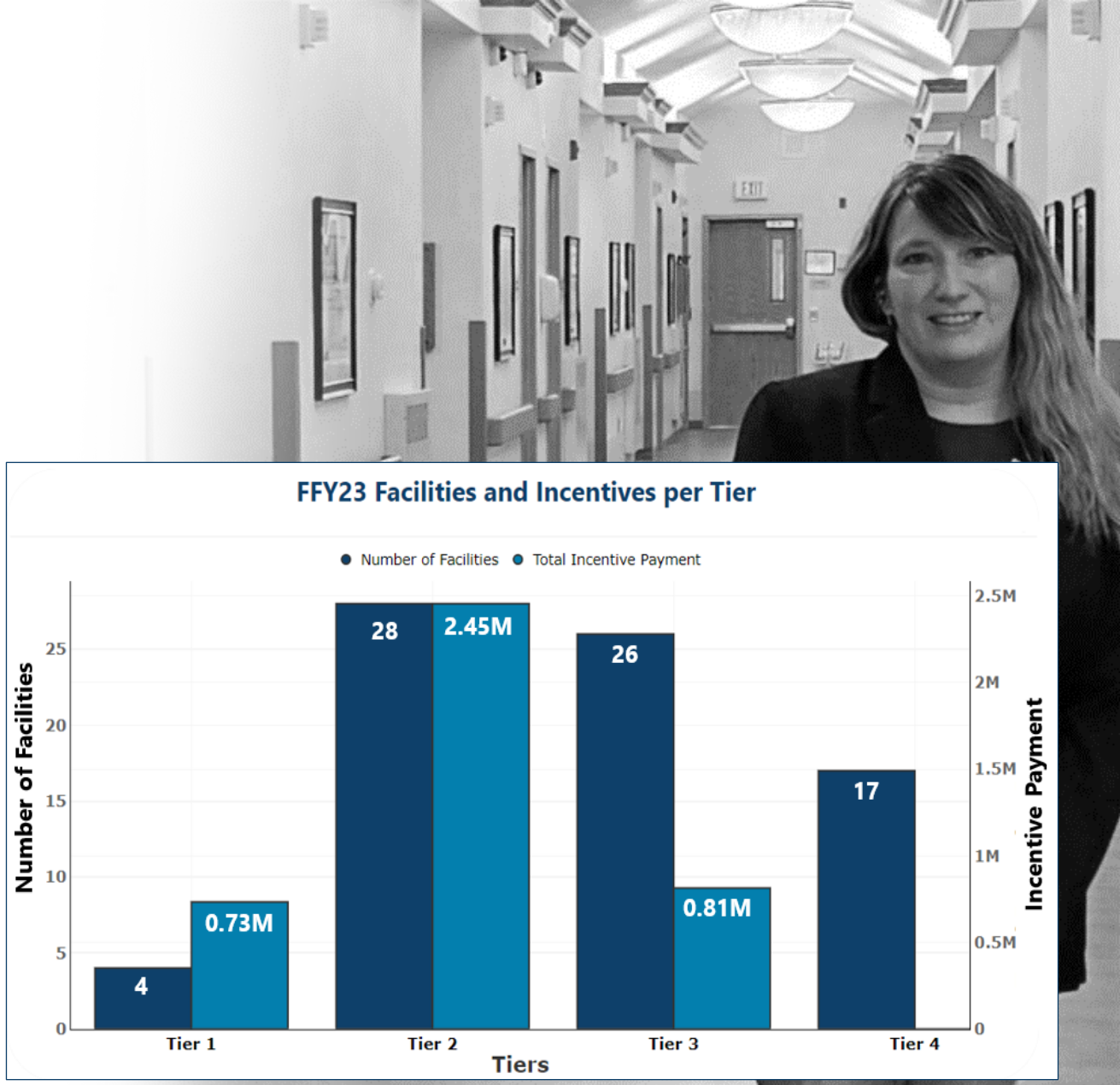
Improve resident outcomes through an incentive payment based on specific quality measures.

- 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)

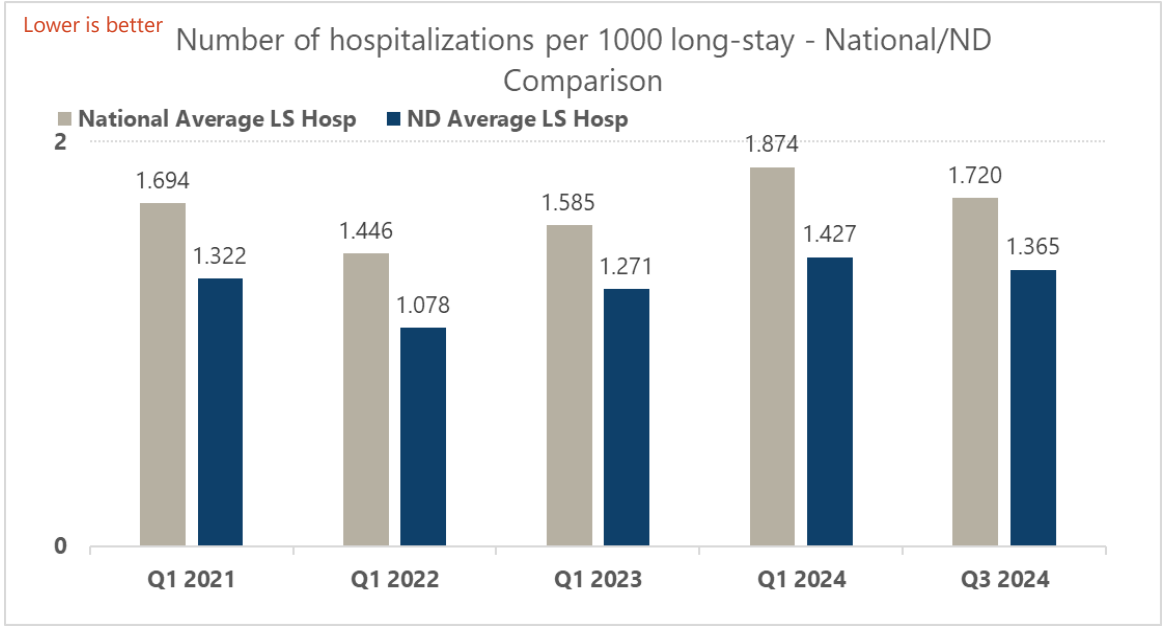
Initial Outcomes

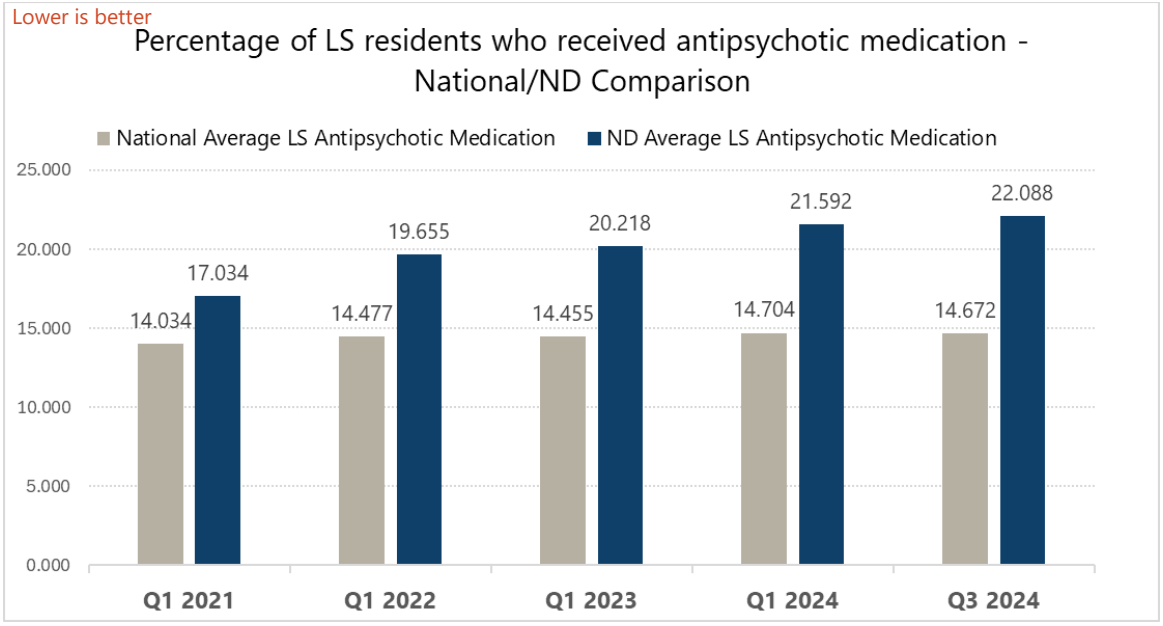
- $4 million dollars distributed in June 2024
- 58 out of 75 Nursing Facilities received incentives to improve quality of care for residents
- Examples of reported use of funds include
  - New mattresses for entire facility
  - Staff bonuses
  - Building renovation
  - Staff training

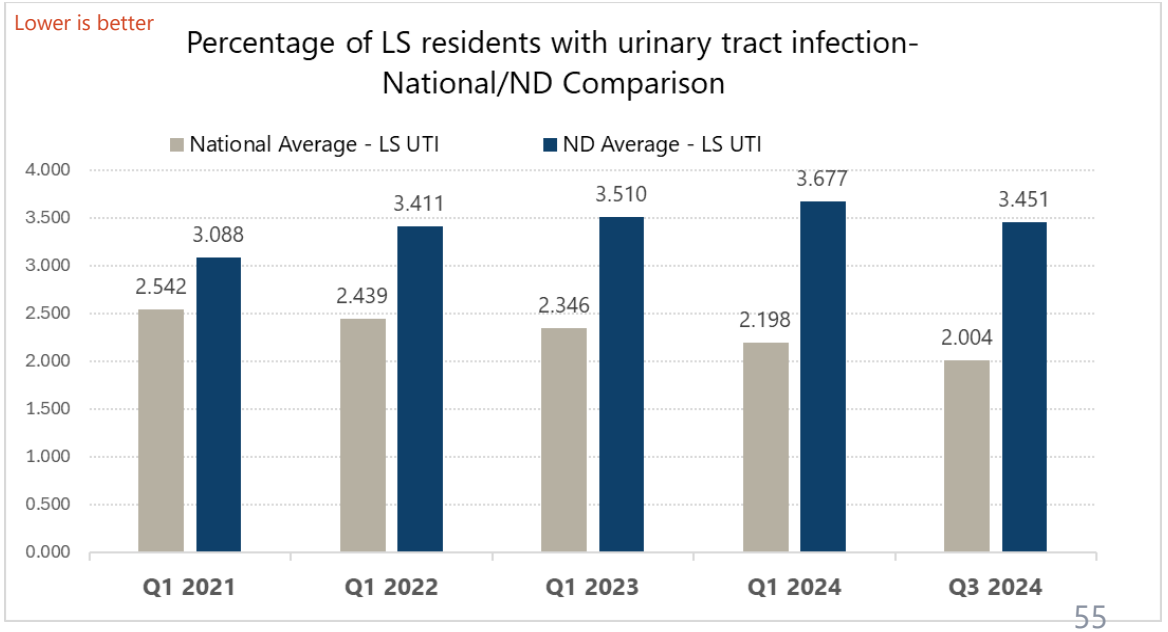


Carrie Zazeski, Administrator, Elm Crest Manor, New Salem

Nursing Facility Incentive Program Initial Outcomes







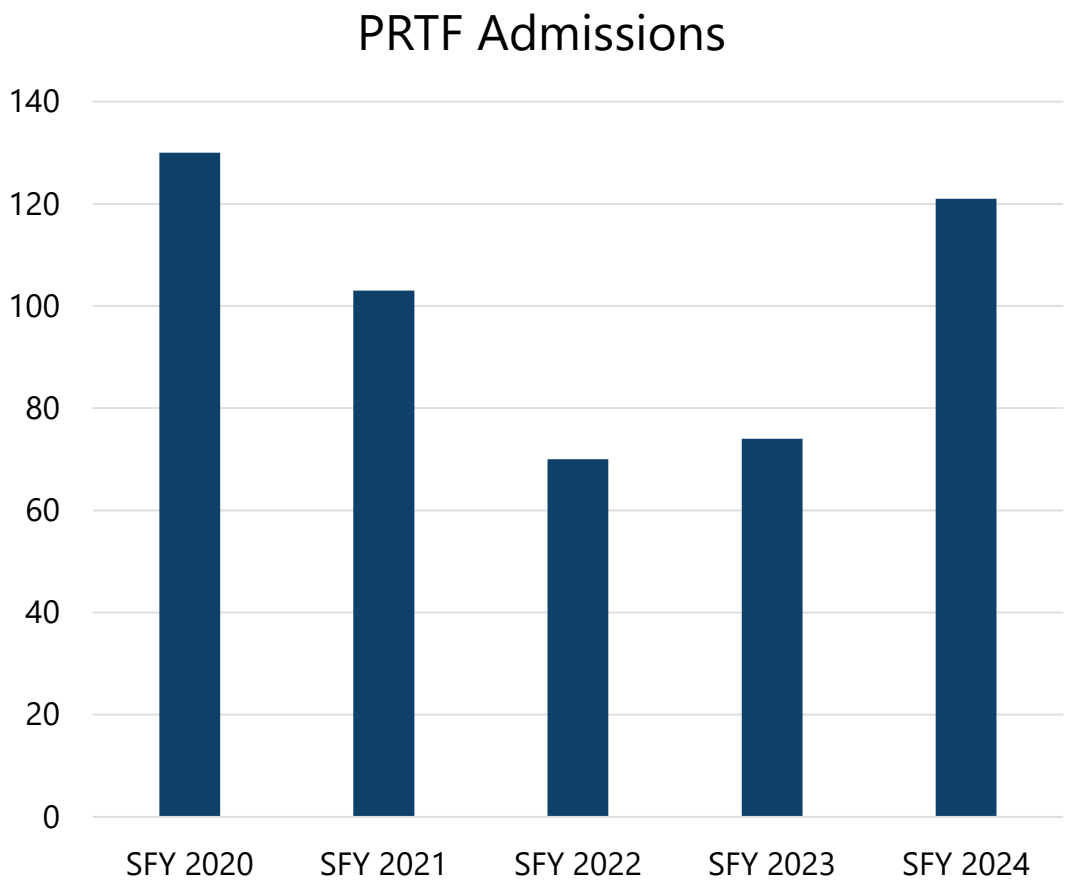
What's next in Value Based Care?

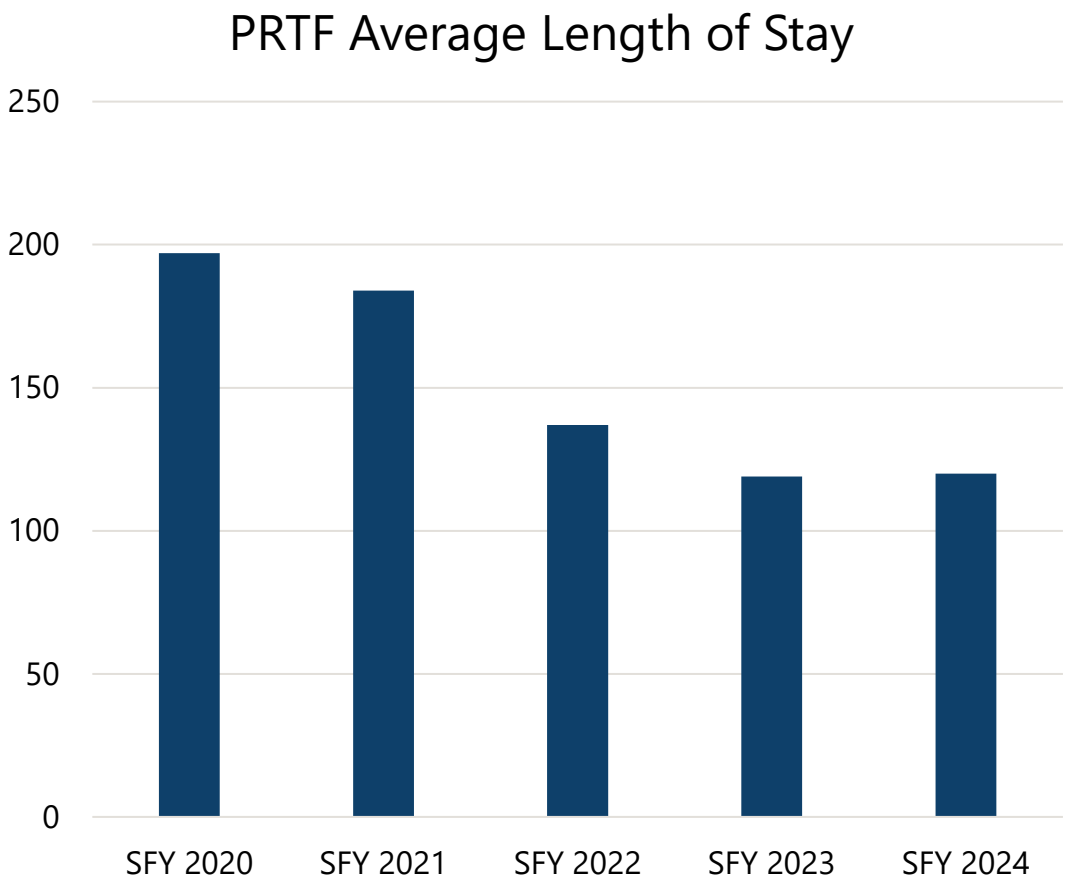
Refinement and Expansion of Current Programs

Exploration of New Provider Groups

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

Psychiatric Residential Treatment Facilities





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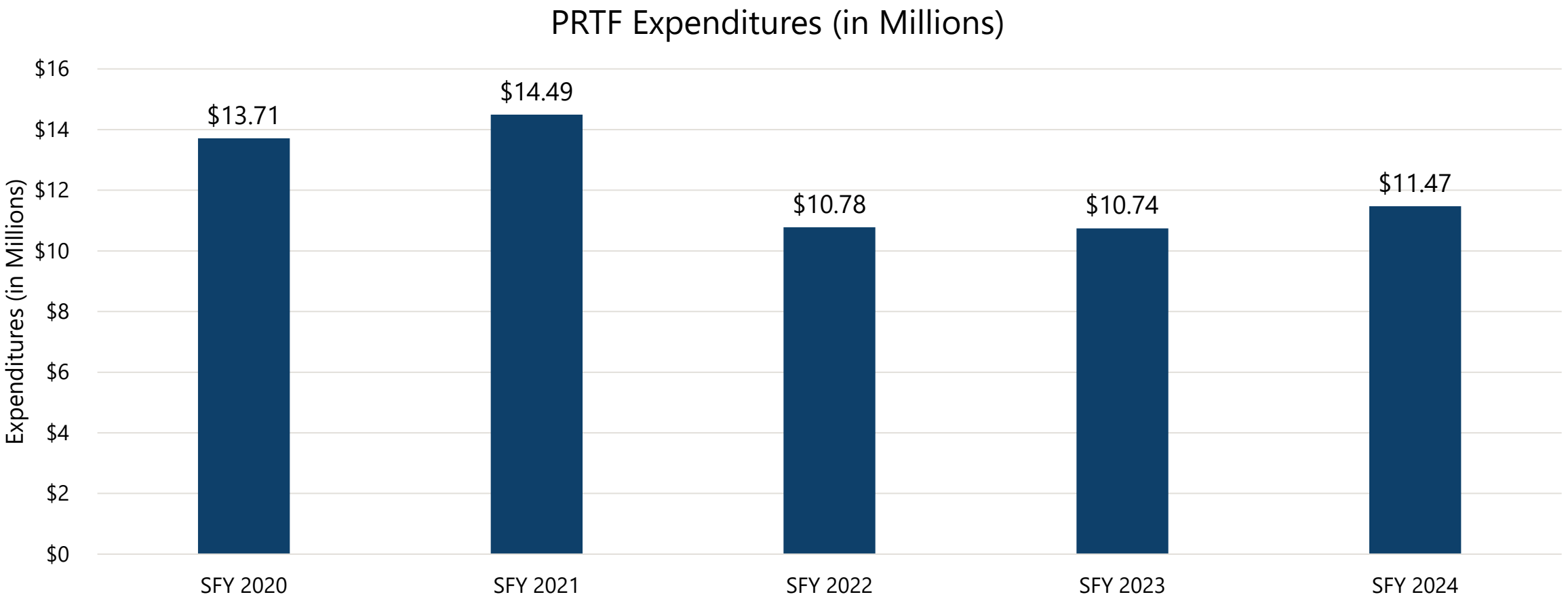
Psychiatric Residential Treatment Facility Expenditures



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Value Based Care
Ongoing

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

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

Refinement and Expansion of Current Programs

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

Exploration of New Provider Groups

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

Funding will support:

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

Rates & Reimbursement

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

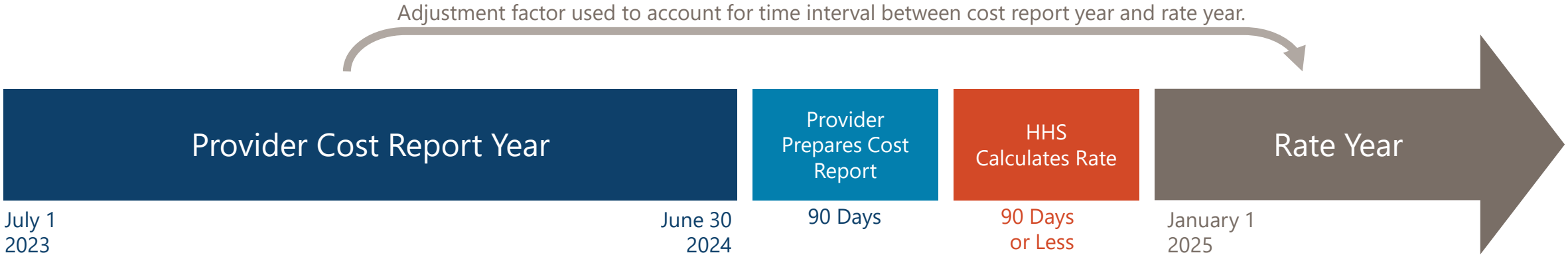
- **Cost Based Per Diem** – Uses cost reports as the basis for setting individual facility per diem payments. Per diem payments may be adjusted to account for patient acuity.
- **Classification System** – Defines an episode (ex. inpatient admission or outpatient visit) and assigns a classification based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

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.
- 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.

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

How does ND Medicaid reimbursement compare? Example Professional Services, SFY 2025 & CY 2025

Physician Services | 99214 – Established Patient Office Visit 30 - 39 Minutes				
North Dakota Medicaid	Medicare: North Dakota MAC	Minnesota Medicaid	Montana Medicaid	South Dakota Medicaid
$137.06	$122.84	$96.63	$169.11	$112.75

Obstetric Services | 59400 - Routine Obstetric Care Including Antepartum Care, Vaginal Delivery Postpartum Care				
North Dakota Medicaid	Medicare: North Dakota MAC	Minnesota Medicaid	Montana Medicaid	South Dakota Medicaid
$2,468.16	$2,198.30	$1,387.89	$3,199.23	$2,220.16

Behavioral Health | 90832 – Psychotherapy, 30 Minutes				
North Dakota Medicaid	Medicare: North Dakota MAC	Minnesota Medicaid	Montana Medicaid	South Dakota Medicaid
$84.48	$78.30	$64.71	$52.78 – $103.26	$69.48

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How does ND Medicaid reimbursement compare? Example Facility Services, SFY 2025 & CY 2025

Nursing Facility | Average Daily Rate

North Dakota Medicaid	Medicare[1]	Minnesota Medicaid[2]	Montana Medicaid	South Dakota Medicaid
$401.74	$513.18	$363.48	$282.78	$278.17

Psychiatric Residential Treatment Facility | Average Daily Rate

North Dakota Medicaid	Medicare	Minnesota Medicaid	Montana Medicaid	South Dakota Medicaid
$ 1,199.09	-	$952.76	$509.81	$408.43

Behavioral Health | Substance Use Disorder Services ASAM Level 3.5

North Dakota Medicaid	Medicare	Minnesota Medicaid	Montana Medicaid	South Dakota Medicaid
$612.46	-	$230.78	$256.95	$295.57

Hospital | Average PPS Hospital Base Rate[3]

North Dakota Medicaid	Medicare
$12,159	$7,493

Note:

1. Medicare Nursing Facility coverage is for short term, intensive rehab focused services. Medicare does not cover long term nursing facility stays. Medicare rate is sample rate in a rural facility.
2. Minnesota Medicaid rate is for double occupancy room; average rate provided by MN DHHS staff.
3. Medicaid and Medicare both use Diagnosis Related Groups (DRGs). North Dakota Medicaid uses All Patient Refined (APR) -DRG and Medicare uses Medicare Severity (MS)-DRG; each system has their own weights & final reimbursement.

Provider Inflation
Ongoing

Governor's Recommendation:

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

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

Engrossed by House:

Total	**$21,668,914**
General	$9,286,780
Federal	$12,382,134

- SFY 2026: 2%
- SFY 2027: 2%

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

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

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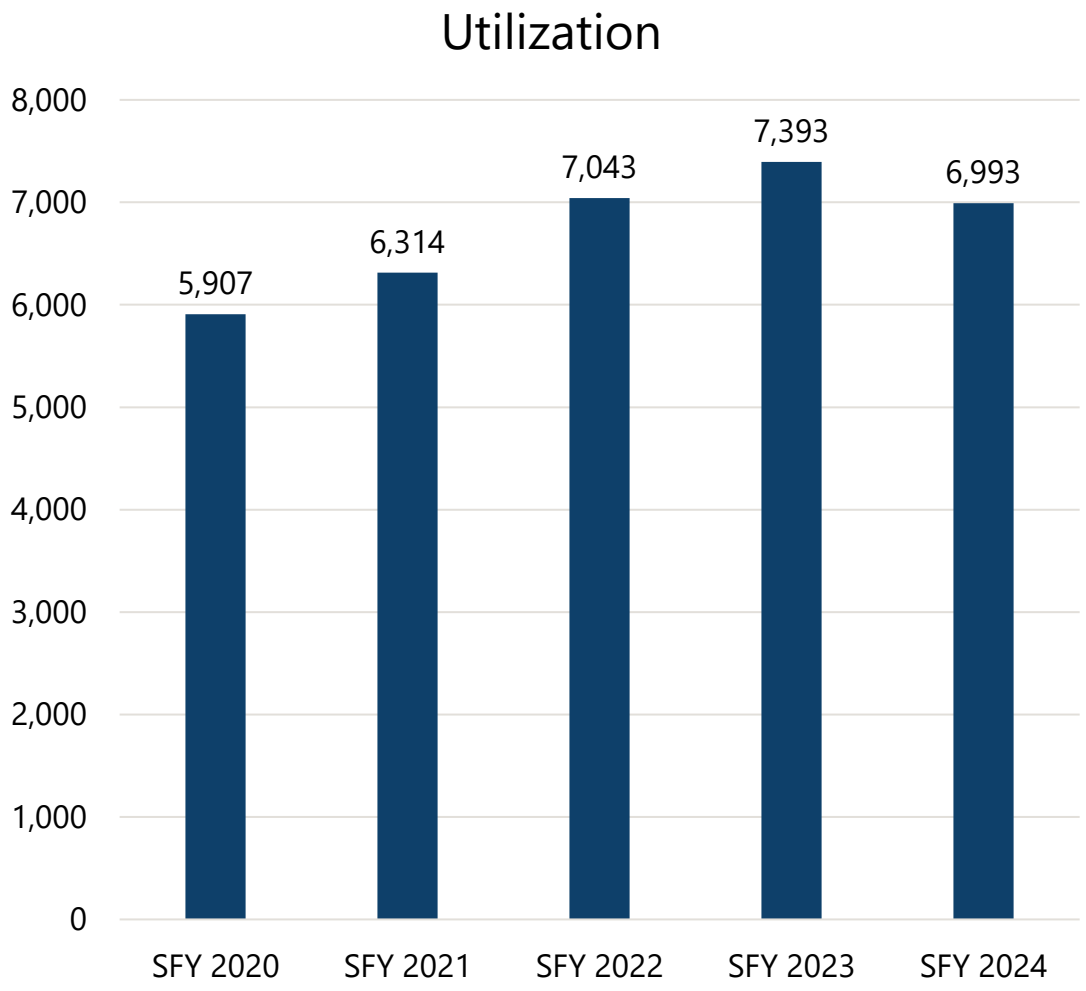
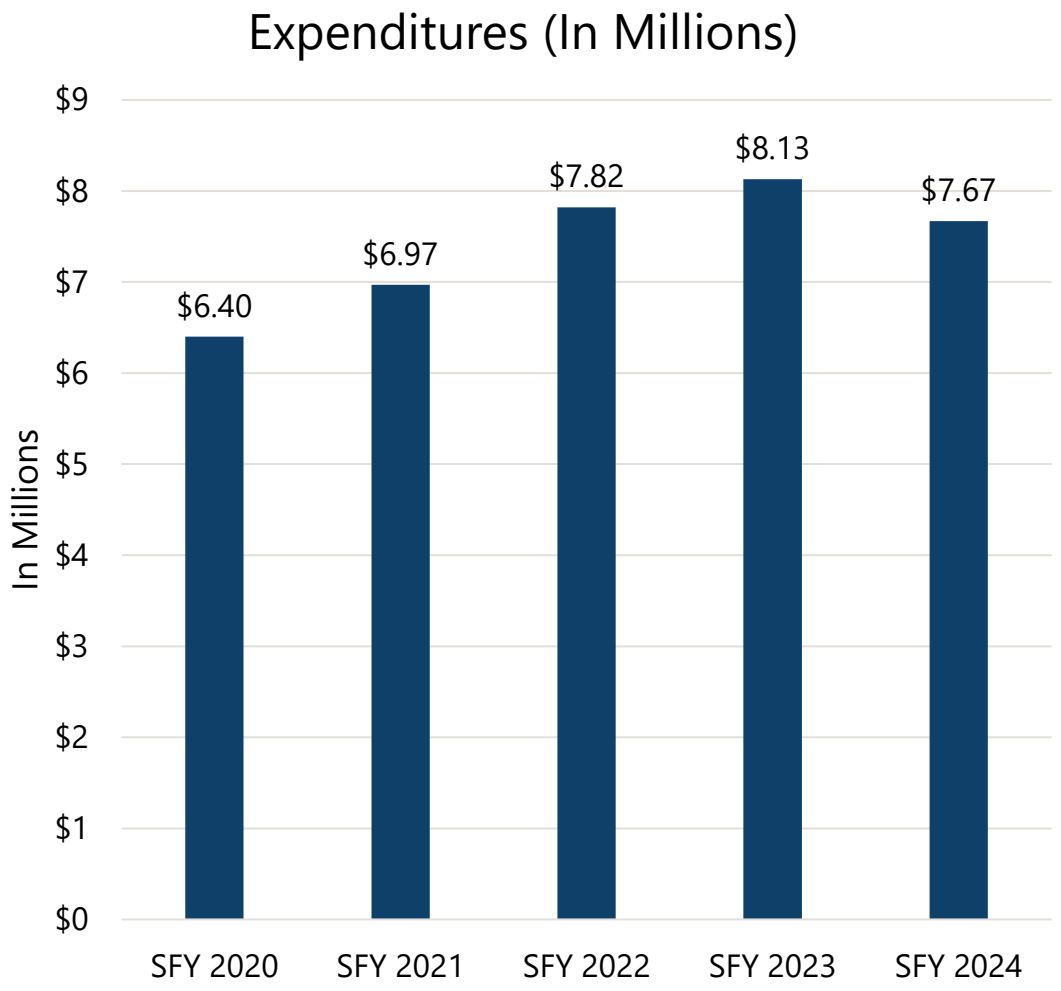
Inflation: Medical Services

Inflator		Total	General	Federal
1%		**$10,798,536**	$4,627,998	$6,170,538
1.5%	Governor's Recommended Budget	**$16,215,764**	$6,949,693	$9,266,071
2%	Recommended by House	**$21,668,914**	$9,286,780	$12,382,134

Ambulance Utilization & Expenditures





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Ambulance Targeted Rate Increase

Ongoing

Total	$4,379,540
General	$2,189,770
Federal	$2,189,770

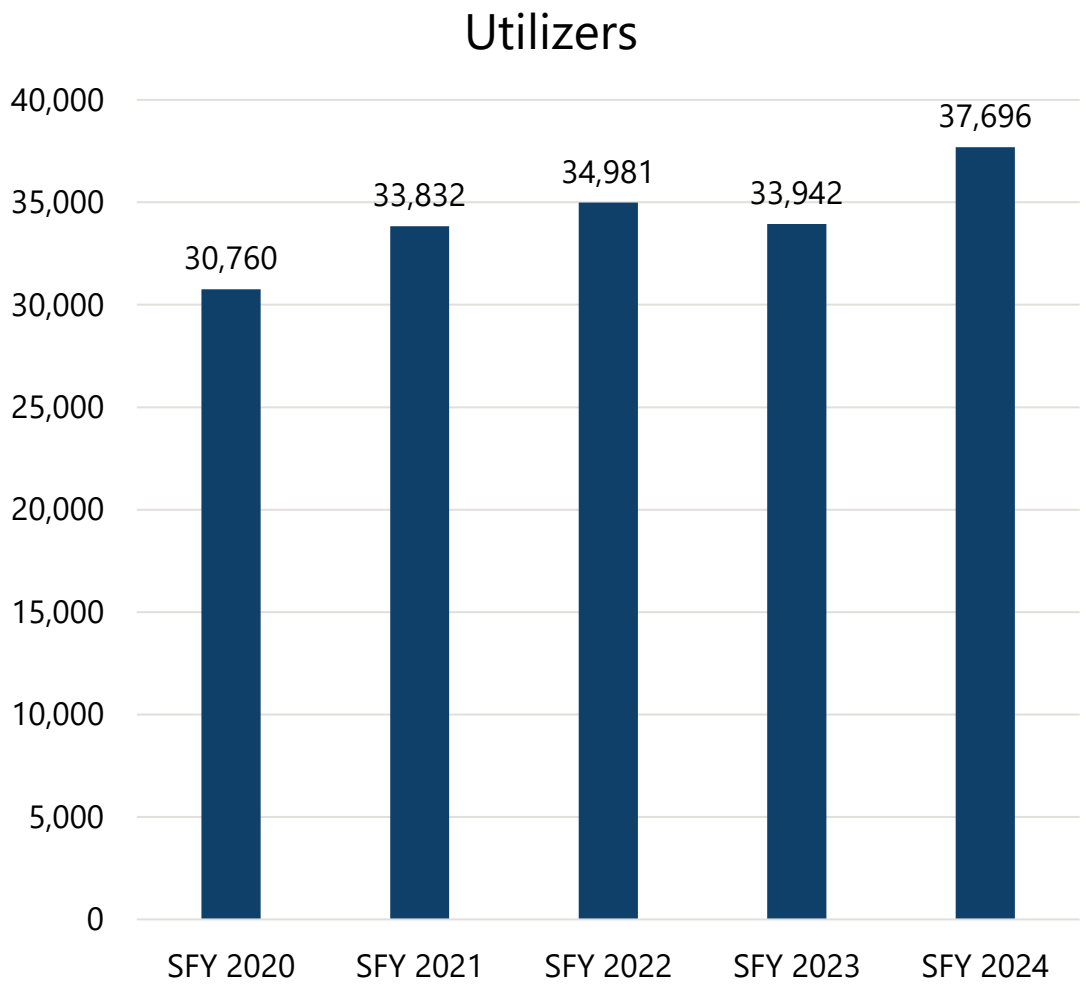
Increase rebases ambulance rates to the Lowest Quartile Medicare Rural Base Rate.

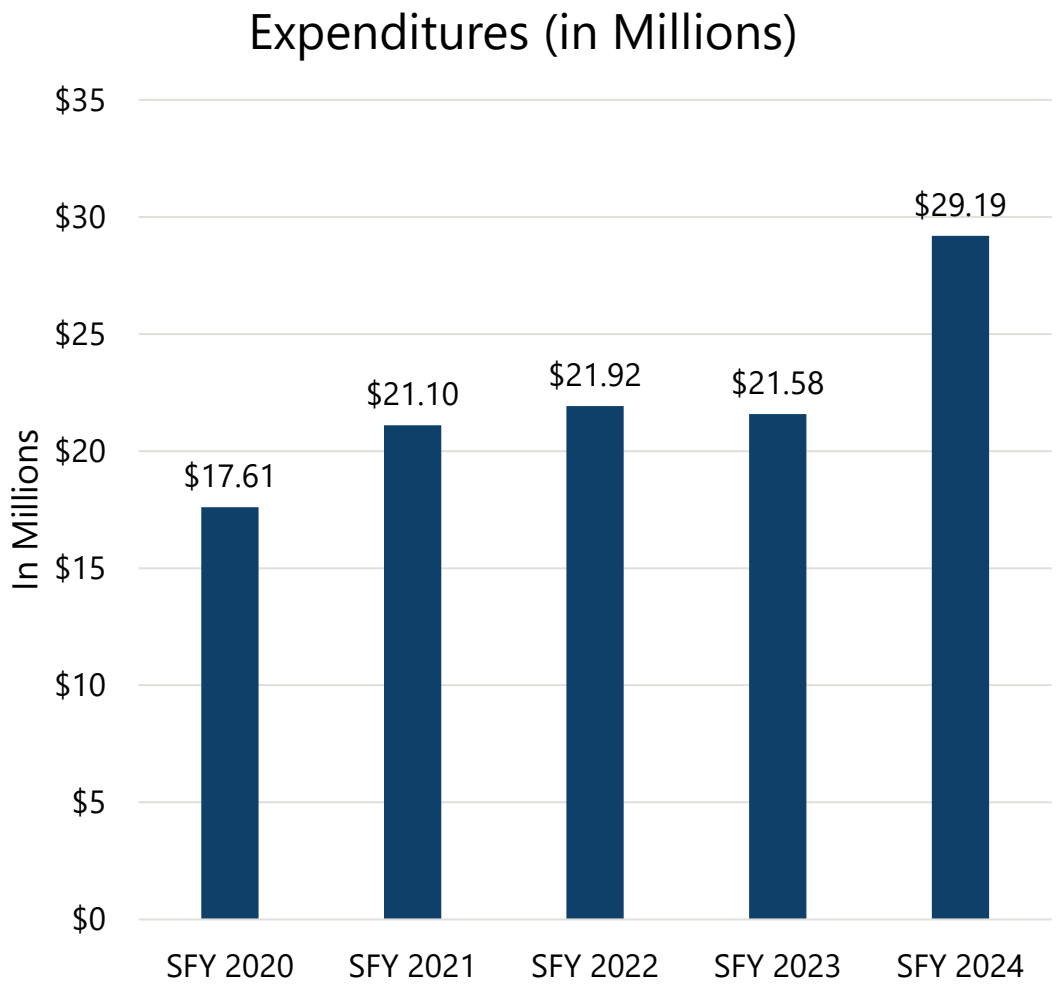
A0427: Ambulance Service, Advanced Life Support, Emergency Transport, Level 1 Base Rate					
North Dakota Medicaid	Medicare Rural – Lowest Quartile	Minnesota Medicaid	Montana Medicaid	South Dakota Medicaid	Wyoming Medicaid
$602.19	$669.35	$530.06	$280.94	$479.85	$291.24

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

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

Dental Utilization & Expenditures





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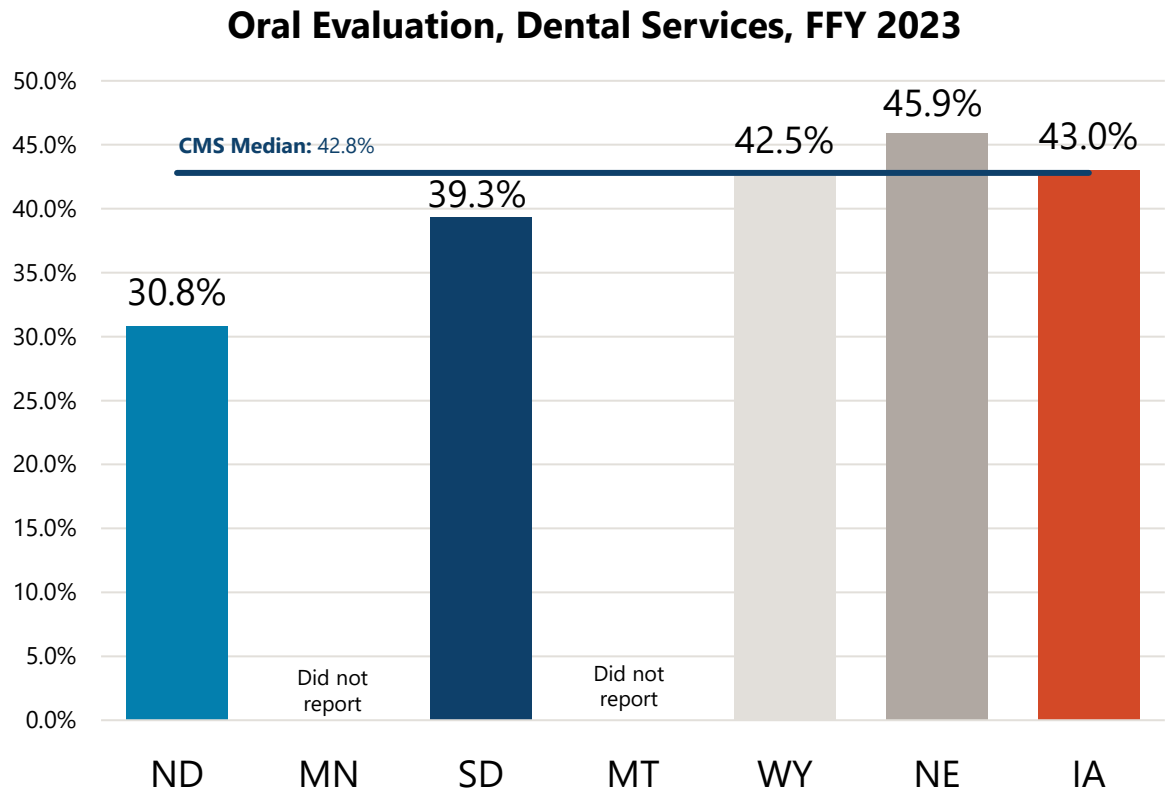
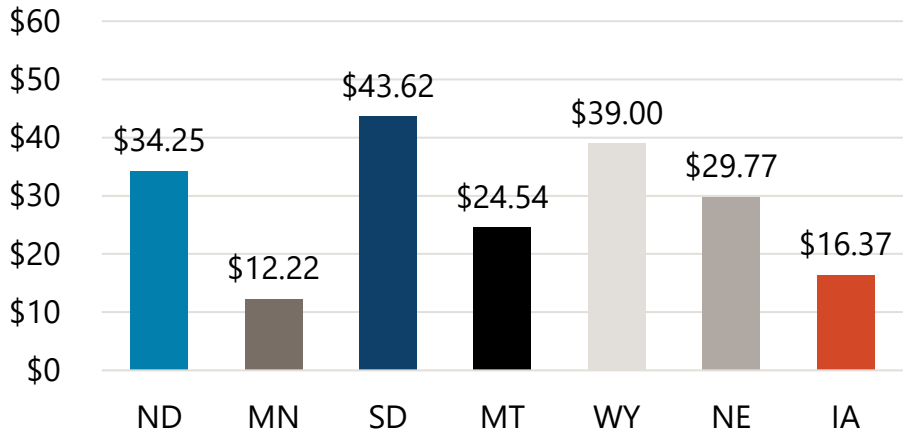
Dental Outcomes & Rates

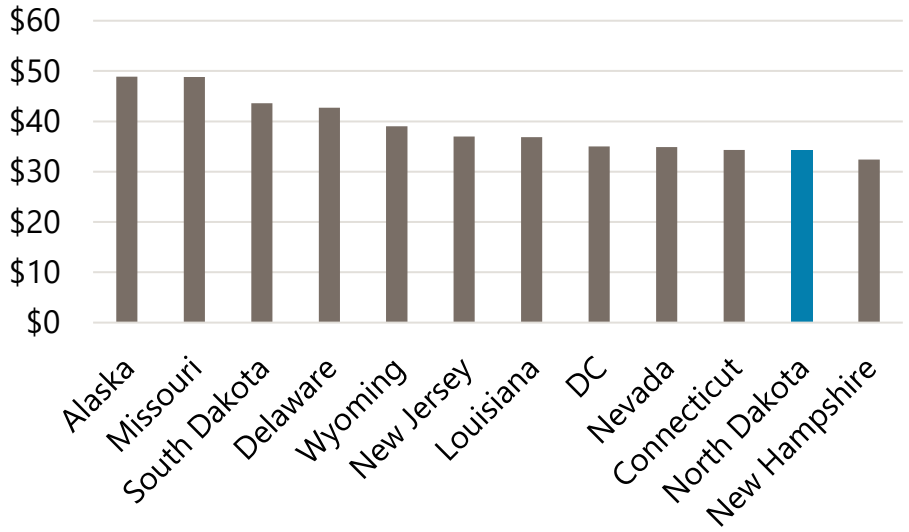
ND Medicaid Dental Rates were last rebased in 2009. Dental rates have increased approximately 42% since last rebase.



Related Bills:
House Bill 1567 | Relating to Dental and Oral Health Care Status among Medicaid Recipients and Workforce Support to Improve Access for Low-Income Children
Senate Bill 2231 | Relating to Covered Services for Medical Assistance



NORTH DAKOTA RANKS 3RD IN THE REGION



NORTH DAKOTA RANKS 11TH IN THE NATION

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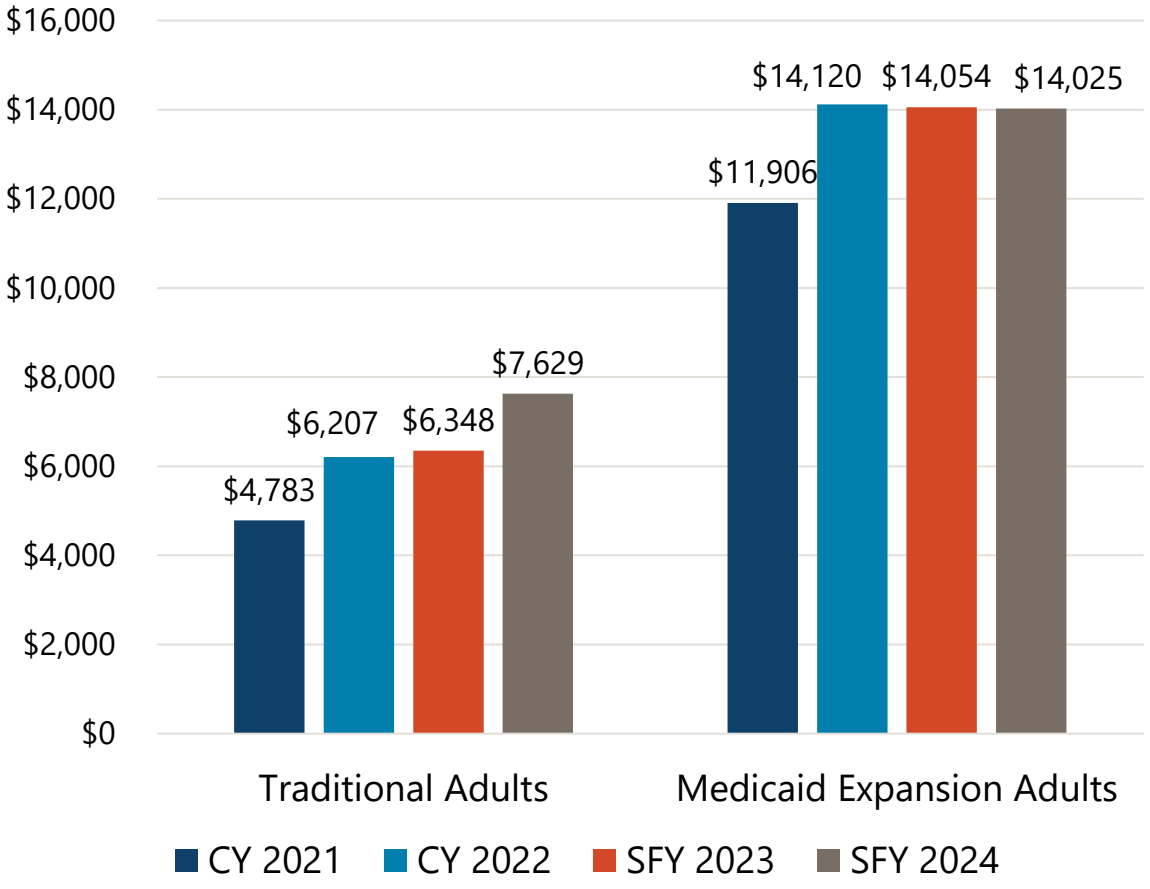
Managed Care & Medicaid Expansion

Per Capita Expenditures: Medicaid Expansion & Traditional Adults



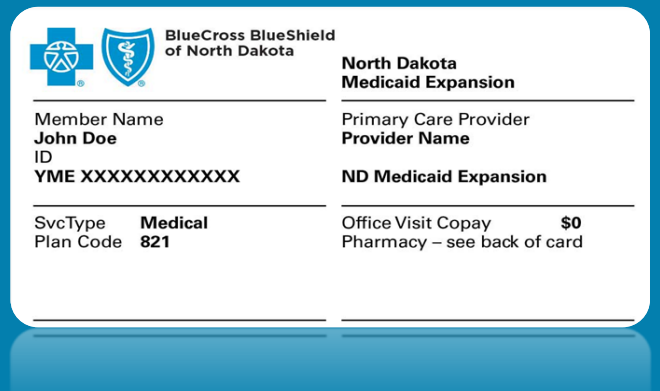
- ND Medicaid ranked **1st for Medicaid Expansion per capita** expenditures.
- ND Medicaid ranked 25th **for Traditional Adult** expenditures.

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

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

Related Bill:
Senate Bill 2231 | Relating to Covered Services for Medical Assistance

[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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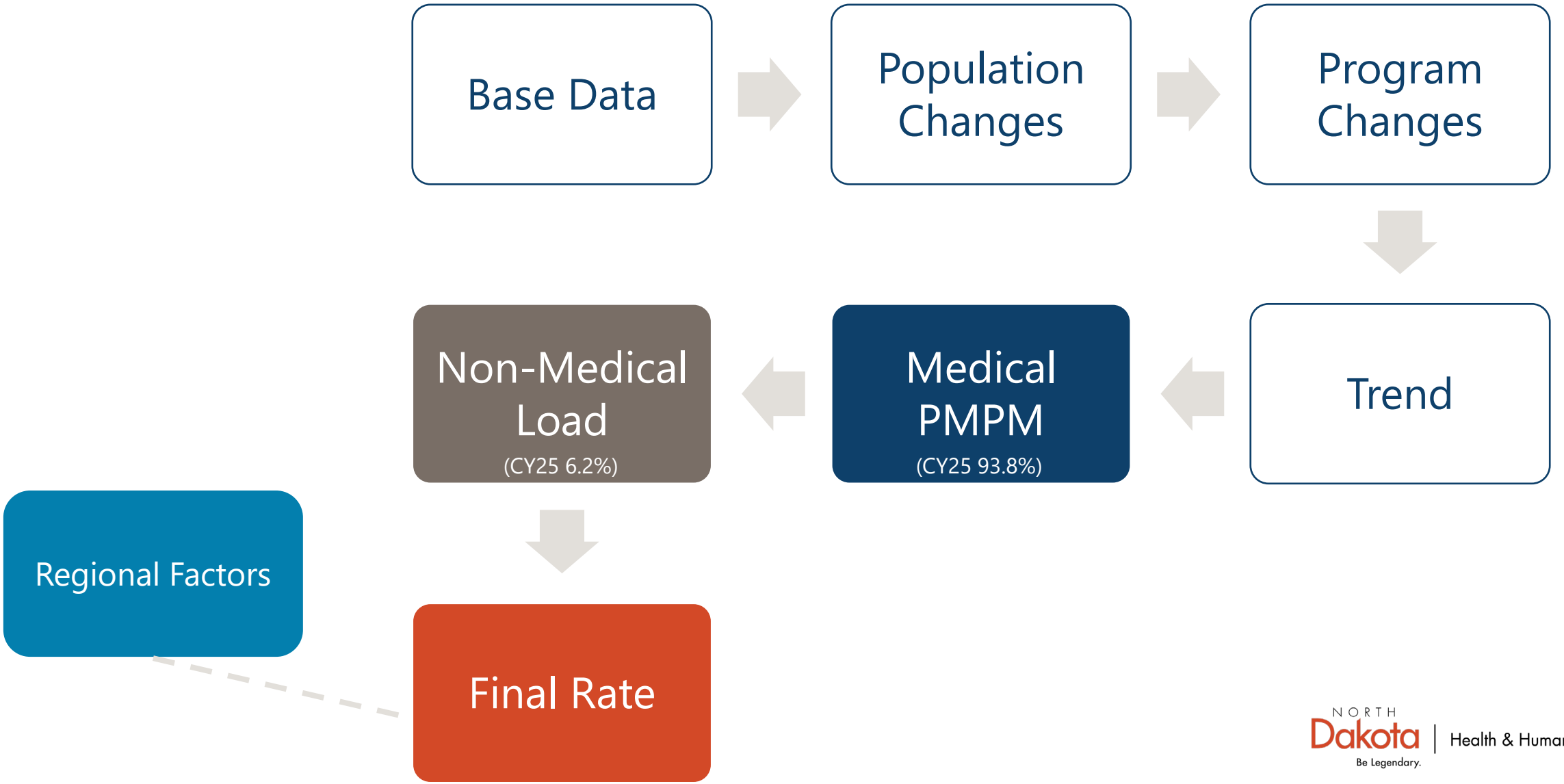
Managed Care

- **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?

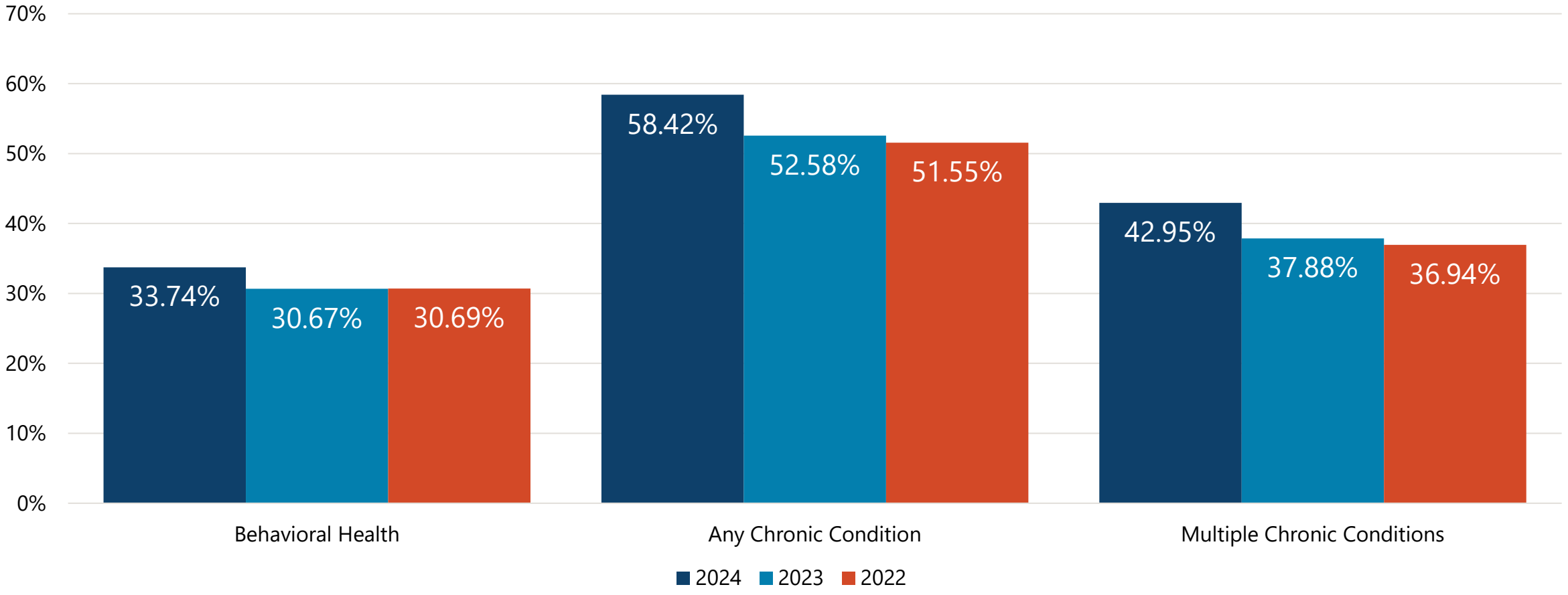
Traditional Medicaid: Fee For Service (FFS)	**Medicaid Expansion: Managed Care Organization (MCO)**
State pays providers directly for each covered service received by a Medicaid member.	State pays a monthly fee called a capitation payment to the managed care organization (MCO).
Only services received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

Capitation Rate Development Process



Medicaid Expansion: 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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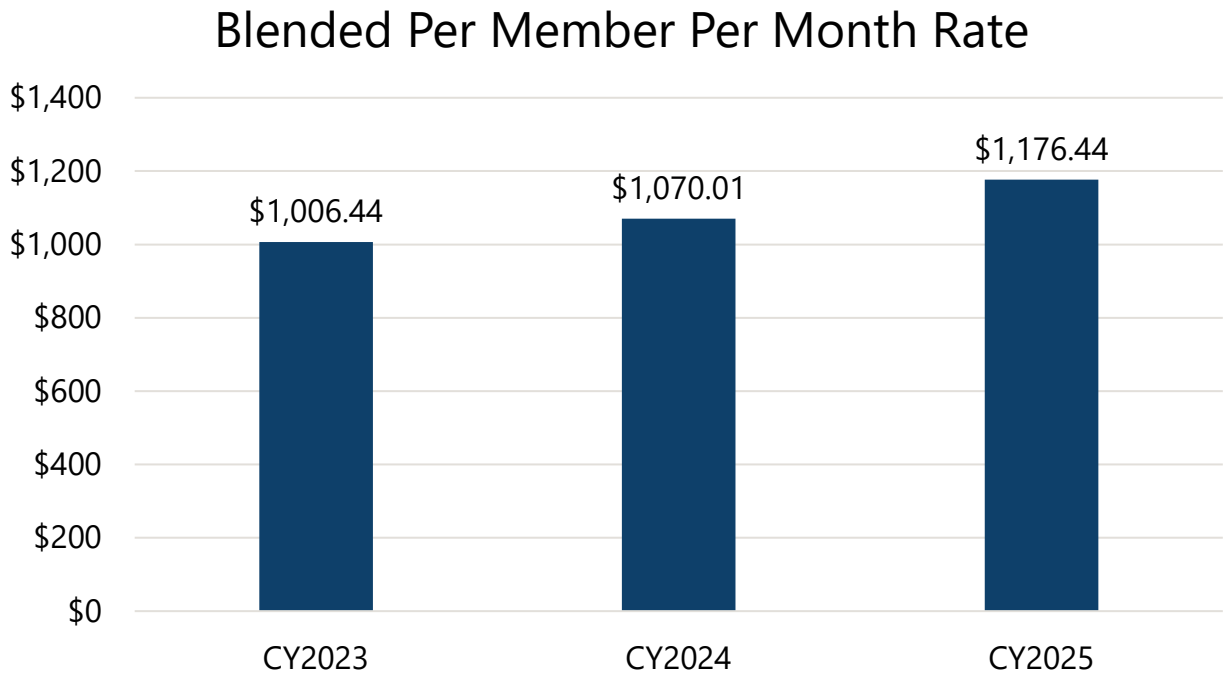
2025 Capitation Rates

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

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

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



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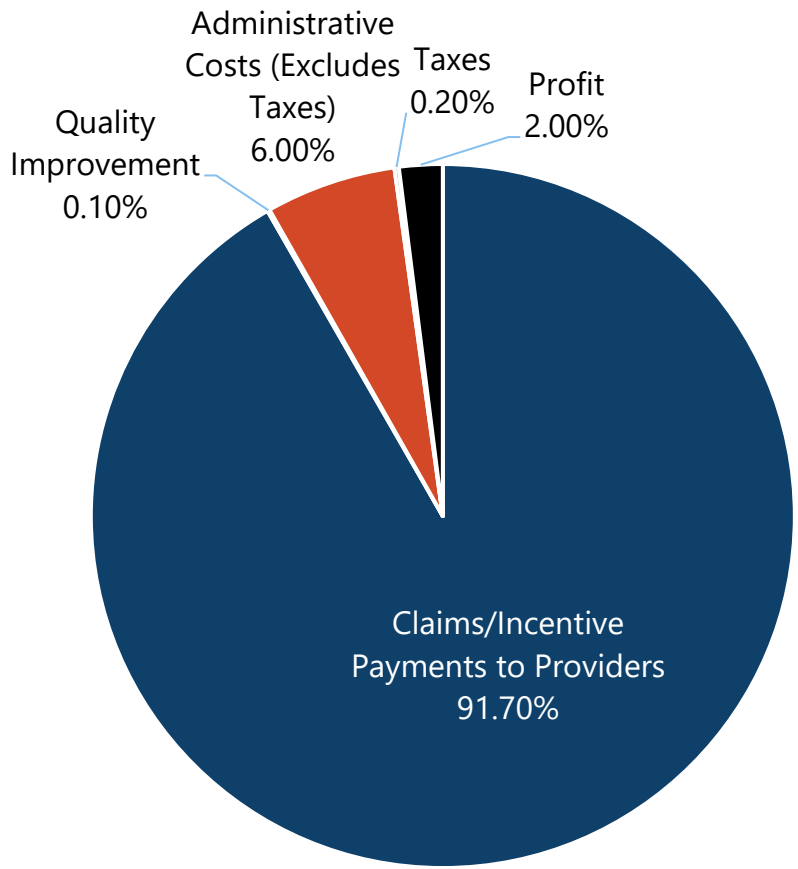
Medical Loss Ratio (MLR) & Profit Cap

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

Allocation of Retained MCO Revenue



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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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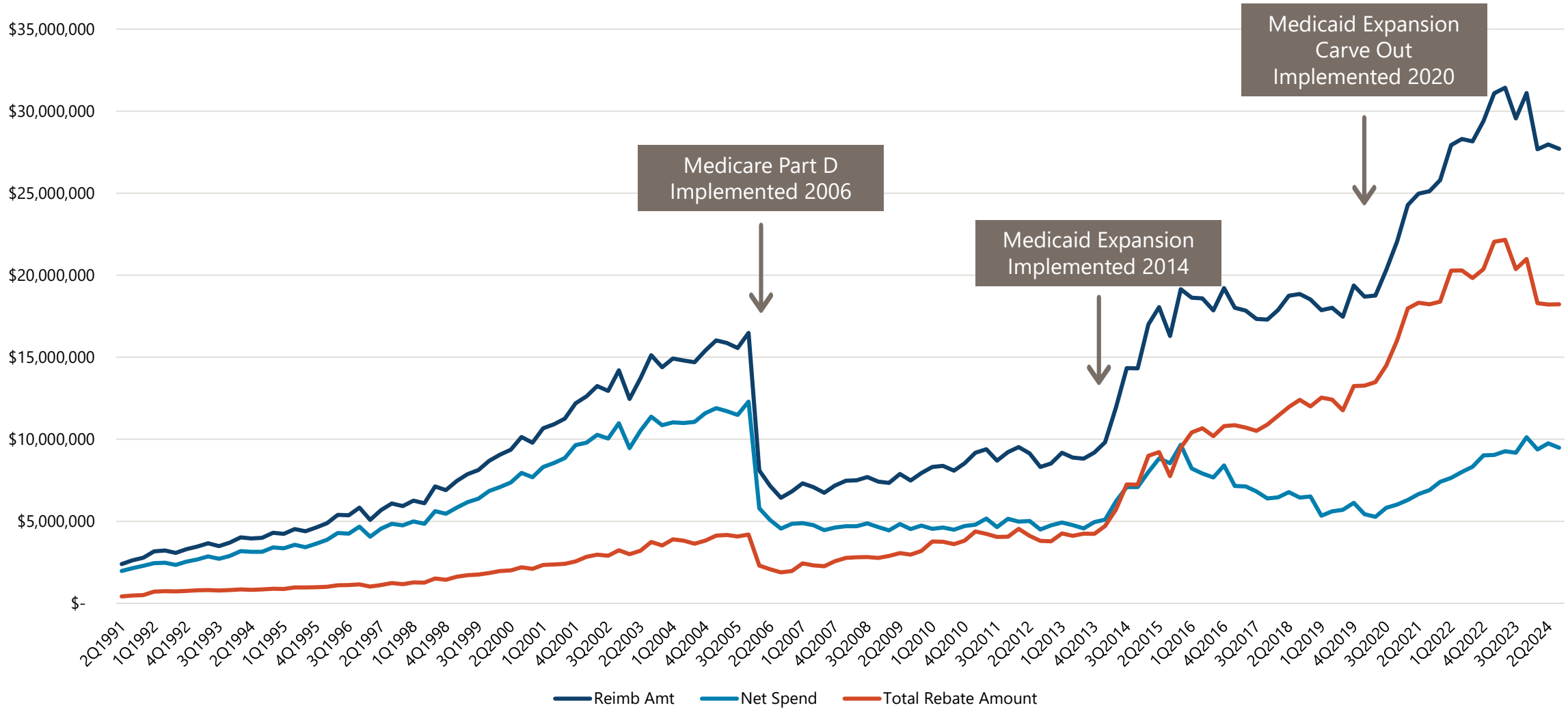
Drugs

Prescription Drug Spend History



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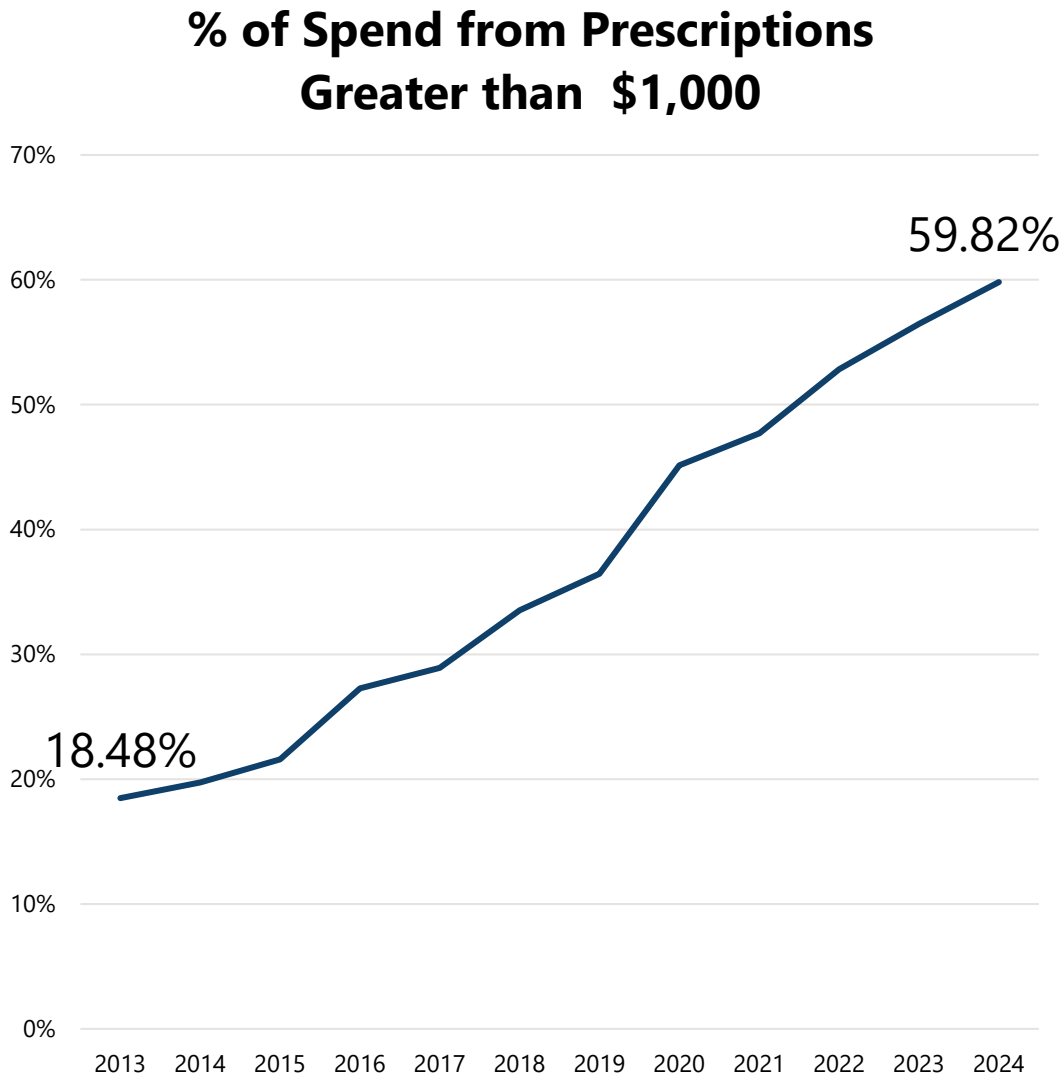
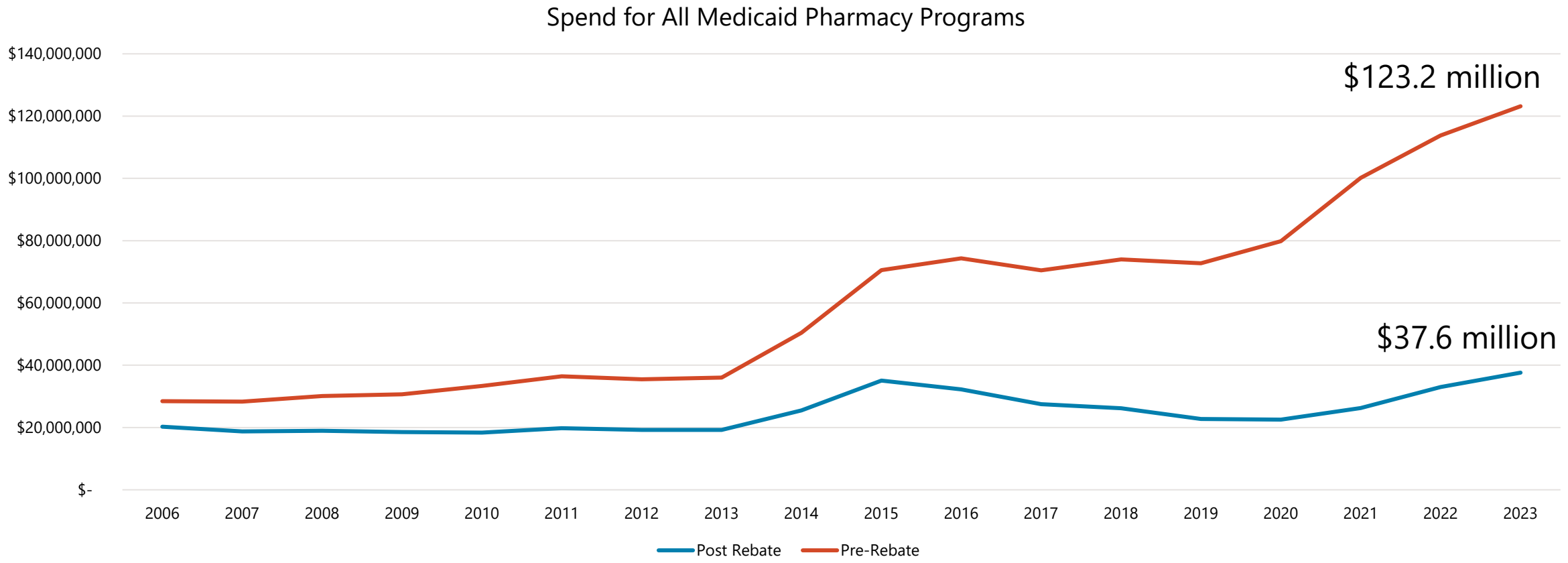
Cost Drivers

- **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%
- **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



Drug Rebates are Increasingly Important

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



Summary

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

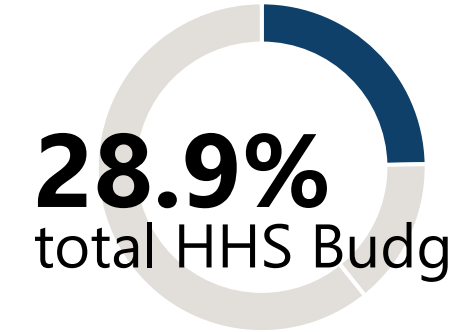
- Tools to minimize growth in spend:
  - Finding rebate opportunities
  - Utilization management
  - Eliminating fraud, waste, or abuse potential

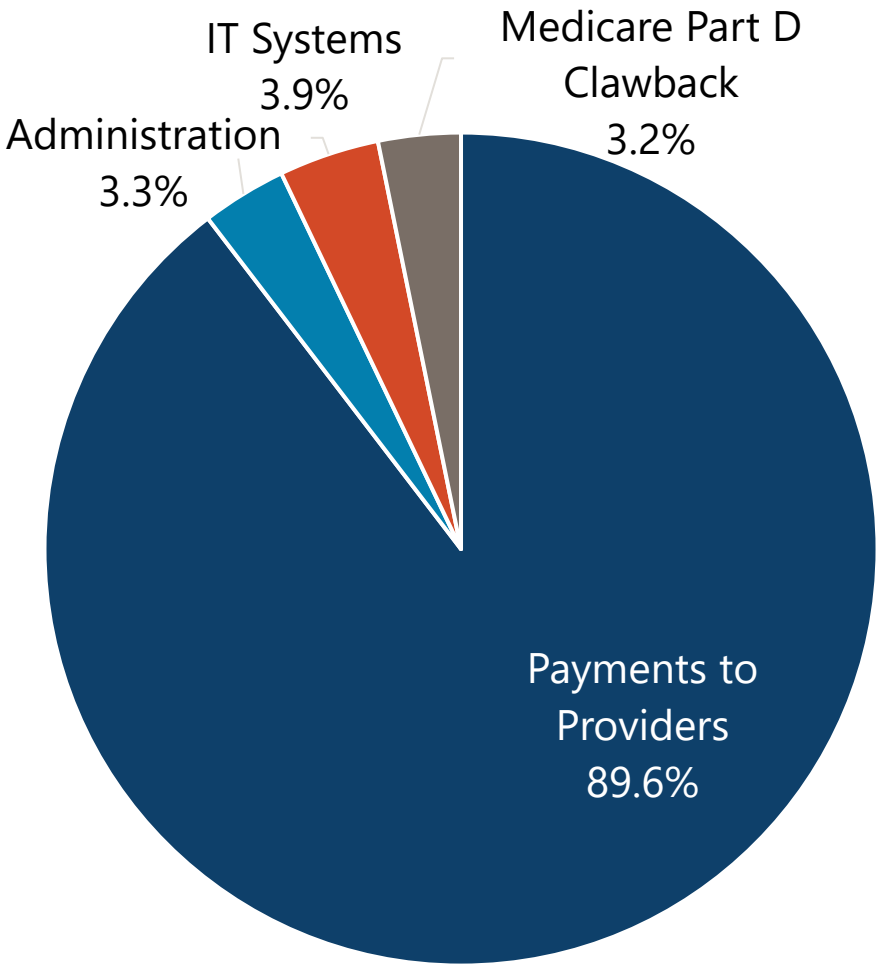
2025 – 2027 Budget & Other Resource Requirements

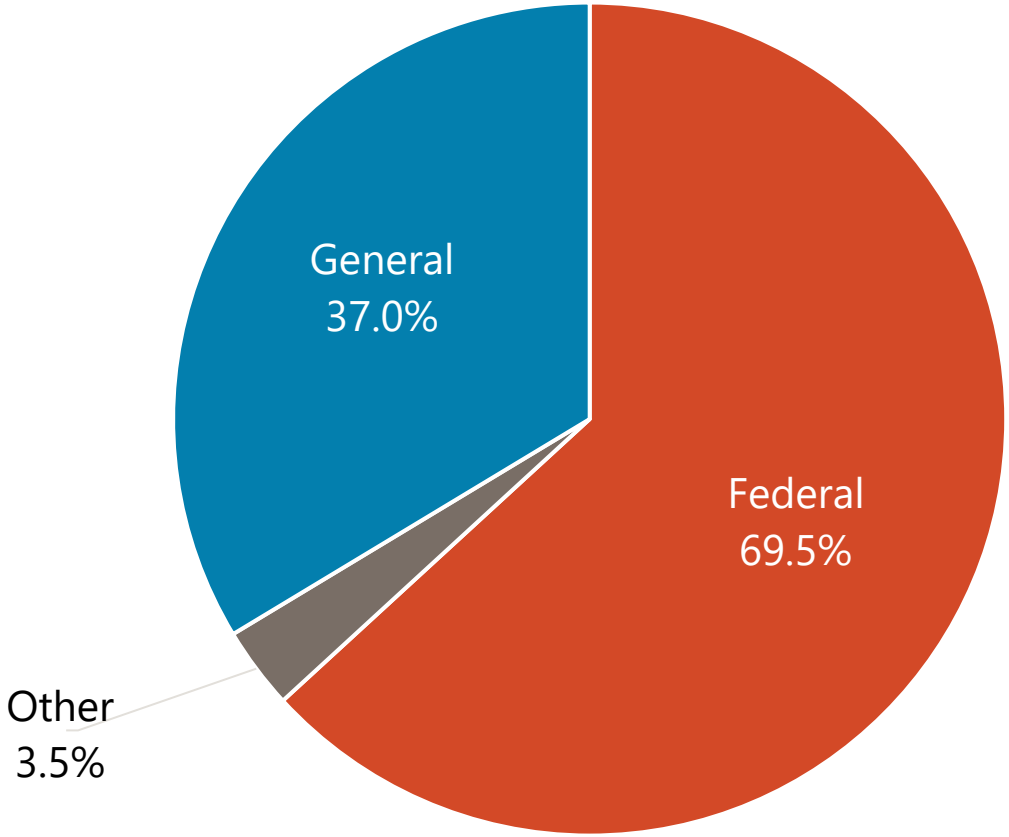
Medical Services

Budget Overview

Medical Services: $1.8 Billion Total Budget







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Comparison of budget expenditures and projections
By Program

PROGRAMS	2023-25 LEGISLATIVE BASE	ONE-TIME/ CARRYOVER	2023-25 EXPENSES THROUGH DECEMBER	2023-25 PROJECTED EXPENDITURES	2025-27 EXECUTIVE BUDGET RECOMMENDATION	INCREASE / (DECREASE)	ENGROSSED HB 1012	GENERAL	FEDERAL	OTHER
MEDICAL SERVICES ADMINISTRATION	$ 42,658,801	$ 6,500,000	$ 33,046,288	$ 52,561,958	$ 56,643,190	$ (1,535,850)	$ 55,107,340	$ 20,614,986	$ 34,492,354	$ -
MEDICAL SERVICES IT					70,088,697	-	70,088,697	11,994,518	57,594,179	500,000
DRUG CLAWBACK	49,291,723		31,171,799	43,494,730	56,426,848	-	56,426,848	54,266,848	-	2,160,000
COUNTY JAIL CLAIMS	1,000,000		678,943	928,943	1,000,000	-	1,000,000	-	-	1,000,000
CROSS DISABILITY WAIVER IMPLEMENTATION		-			4,948,452	-	4,948,452	2,474,226	2,474,226	
CRITICAL ACCESS HOSPITAL NETWORKING GRANT					-	2,000,000	2,000,000			2,000,000
MEDICAL SERVICES	**1,721,252,658**	**-**	**1,148,727,533**	**1,593,726,563**	**1,616,619,252**	**5,453,149**	**1,622,072,401**	**401,127,387**	**1,164,030,895**	**56,914,119**
Inpatient Hospital	227,650,273	-	157,894,416	218,399,757	235,436,722	1,581,875	237,018,597	117,944,763	119,073,834	-
Outpatient Hospital	125,343,902	-	87,526,972	122,743,731	127,121,698	553,643	127,675,341	46,228,667	64,972,555	16,474,119
Professional Services	137,991,523	-	106,260,015	149,800,633	151,553,918	1,126,354	152,680,272	74,482,154	78,198,118	-
Drugs	84,898,305	-	67,515,161	111,660,402	86,742,424	-	86,742,424	9,200,881	59,841,542	17,700,000
Indian Health Services	58,583,364	-	58,311,115	84,183,190	94,554,742	706,212	95,260,955	-	95,260,955	-
PRTF Services	24,340,239	-	15,354,505	21,383,435	21,445,266	159,382	21,604,648	10,534,399	11,070,249	-
Dental Services	36,094,013	-	26,257,349	36,718,477	36,993,255	274,935	37,268,190	18,111,629	19,156,561	-
Premiums	54,734,853	-	35,239,170	49,412,897	56,694,910	-	56,694,910	26,496,898	30,198,012	-
Other Services	153,836,340	-	105,776,050	152,799,846	136,815,944	997,527	137,813,470	28,324,324	86,749,147	22,740,000
1915(i) State Plan Services	15,163,012		1,208,913	1,555,798	7,161,033	53,221	7,214,254	3,593,739	3,620,515	-
Expansion Medicaid	802,616,834	-	487,383,867	645,068,397	662,099,340	-	662,099,340	66,209,934	595,889,406	-
TOTAL	**$ 1,814,203,182**	**$ 6,500,000**	**$1,213,624,563**	**$ 1,690,712,194**	**$ 1,805,726,439**	**$ 5,917,299**	**$ 1,811,643,738**	**$ 490,477,965**	**$ 1,258,591,654**	**$ 62,574,119**

Changes to Base Budget

By Ongoing, One-Time and Funding Source

BASE BUDGET CHANGES	DESCRIPTION	2025-27 EXECUTIVE BUDGET		ENGROSSED HB 1012	
		GENERAL	OTHER	GENERAL	OTHER
Services - Cost to Continue	Bed Assessment Tax	$ -	$7,209,580 - Provider Assessment Fund	$ -	$7,209,580 - Provider Assessment Fund
Compliance & Quality	Value-Based Purchasing	1,000,000	1,000,000 - Federal	1,000,000	1,000,000 - Federal
Services - DOJ	Home Health/Private Duty Nursing Targeted Rate Increase	1,235,768	1,235,768 - Federal	1,235,768	1,235,768 - Federal
Services - Home & Community Based Services	Cross Disability Waiver Implementation	2,474,226	2,474,226 - Federal	2,474,226	2,474,226 - Federal
Healthcare Workforce	Rebase Targeted Medicaid Rate Increase for Ambulance Services	2,189,770	2.189,770 - Federal	2,189,770	2,189,770 - Federal
IT - Existing	Retire Medicaid legacy system on mainframe (One-time Funding)		2,000,000 - Federal 1,500,000 SIIF 500,000		2,000,000 - Federal 1,500,000 SIIF 500,000
Additional Executive Decision Packages	Provider Inflation (1.5%/1.5%) vs (2%/2%)	6,949,693	9,266,071 - Federal	9,175,044	12,493,870 - Federal
Additional Executive Decision Packages	FMAP Reduction	15,065,248	(18,978,279) - Federal	15,065,248	(18,978,279) - Federal
House Amendment	Provides Funding for a Critical Access Hospital Networking Grant (One-Time Funding)				2,000,000 - CHTF
House Amendment	FTE Block Grant Salary Reduction	-	-	(659,167)	(73,683) - Federal
House Amendment	Operating Reduction	-	-	(803,000)	-

Note:
1. Private Duty Nursing & Home Health Targeted Rate Increase discussed in Long Term Care Budget slides.

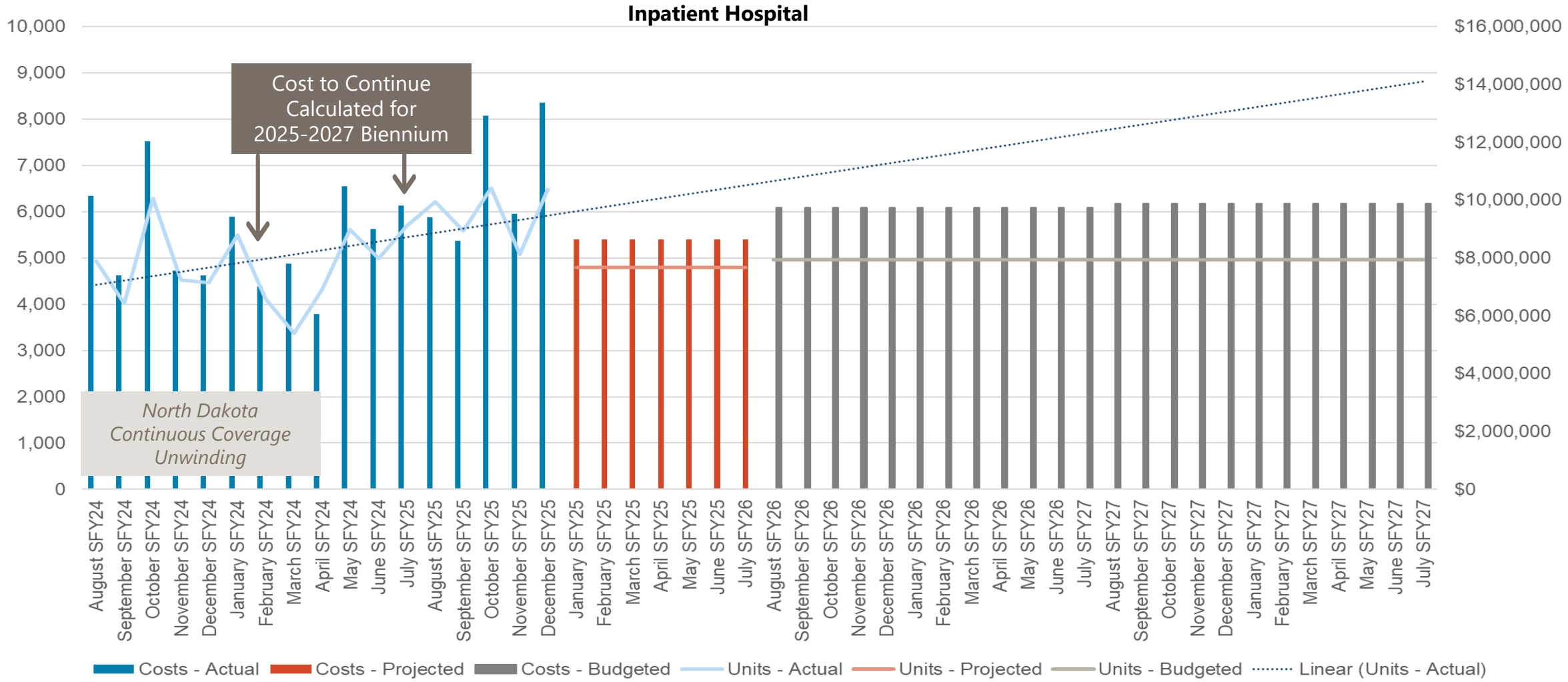
Comparison of budgets and funding

By Major Expense

DESCRIPTION	2023-25 LEGISLATIVE BASE	INCREASE / (DECREASE)	2025-27 EXECUTIVE BUDGET RECOMMENDATION	INCREASE / (DECREASE)	ENGROSSED HB 1012
Salaries & Benefits	$ 21,008,344	$ 3,792,100	$ 24,800,444	$ (732,850)	$ 24,067,594
Operating	70,807,976	22,275,866	93,083,842	(803,000)	92,280,842
IT Services	-	70,088,697	70,088,697	-	70,088,697
Capital Asset Expense	-	-	-	-	-
Capital Assets	-	-	-	-	-
Grants	1,722,386,862	(104,633,406)	1,617,753,456	7,453,149	1,625,206,605
Total	**$ 1,814,203,182**	**$ (8,476,743)**	**$ 1,805,726,439**	**$ 5,917,299**	**$ 1,811,643,738**
General Fund	**$ 471,540,015**	**$ 18,174,765**	**$ 489,714,780**	**$ 763,184**	**$ 490,477,964**
Federal Funds	**1,283,426,535**	**(27,988,995)**	**1,255,437,540**	**3,154,115**	**1,258,591,655**
Other Funds	**59,236,632**	**1,337,487**	**60,574,119**	**2,000,000**	**62,574,119**
Total Funds	**$ 1,814,203,182**	**$ (8,476,743)**	**$ 1,805,726,439**	**$ 5,917,299**	**$ 1,811,643,738**

How We Budget

Medical Services & Long-Term Care



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How We Budget

Top Services: Medical Services

North Dakota Department of Health and Human Services
Medical Services
Unit and Cost Comparison
12 Month Average to Executive Budget Request (EBR) 2025 - 2027 Biennium

Program	12 Month Average in Units (April 2023 - March 2024)	Monthly average units for EBR 2025 - 2027	Change from EBR to 12 mo Avg units	12 Month Average in Cost per Unit (April 2023 - March 2024)	Monthly average cost per unit for EBR 2025 - 2027	Change from EBR to 12 mo Avg cost per unit	Monthly average units for first 14 months of 23-25	Monthly average unit cost for first 14 months of 23-25
INPATIENT HOSPITAL	4,775	4,962	187	$1,813.98	$1,977.00	$163.02	4,976	$1,752.06
OUTPATIENT HOSPITAL	231,057	239,415	8,358	$21.29	$22.12	$0.83	263,361	$18.81
PROFESSIONAL SERVICES	326,120	298,372	(27,748)	$17.47	$21.16	$3.69	309,126	$19.52
DRUGS	95,349	86,375	(8,974)	$67.73	$41.84	($25.89)	90,364	$30.36
INDIAN HEALTH SERVICES	23,383	25,582	2,199	$135.17	$154.01	$18.84	23,708	$144.36
1915i STATE PLAN SERVICES	2,748	13,023	10,275	$16.18	$22.91	$6.73	3,331	$16.34
PRTF SERVICES	1,230	1,270	40	$686.58	$703.58	$17.00	1,232	$713.69
DENTAL SERVICES	18,716	18,408	(308)	$80.43	$83.73	$3.30	18,269	$80.93
PREMIUMS	11,266	11,413	147	$171.61	$206.98	$35.37	11,059	$174.15
EXPANSION MEDICAID	30,675	23,500	(7,175)	$986.69	$1,173.94	$187.25	26,882	$991.27

Savings Plan
Medical Services

DESCRIPTION OF SAVINGS	GENERAL FUND	FEDERAL FUND	OTHER FUND
Pay Co-Pays on $0 Drugs to Allow Rebate	(450,000)	(1,050,000)	-
Bed Tax Assessment	-	-	(7,209,580)
Operational Reduction	(3,866,980)		
Information Technology Reduction	(9,561,053)		
TPL/Claims Recoveries	(1,830,000)	(1,830,000)	

Grants on a Walkthrough

Recommendation to the Governor

DESCRIPTION	2025-27 BASE BUDGET	COST TO CONTINUE	FMAP	SAVINGS PLAN	REDUCTION	TOTAL CHANGES	TO GOVERNOR
TRADITIONAL MEDICAID	$ 918,635,886	$ 45,160,756	$ (3,913,031)	$ (8,709,580)	$ (28,930,539)	$ 3,607,606	$ 922,243,492
INPATIENT HOSPITAL	227,650,273	3,082,453	-	-	-	3,082,453	230,732,726
OUTPATIENT HOSPITAL	125,343,902	131,436	-	-	-	131,436	125,475,338
PROFESSIONAL SERVICES	137,991,523	10,212,973	-	-	-	10,212,973	148,204,496
DRUGS	84,898,305	3,344,118	-	(1,500,000)	-	1,844,118	86,742,423
INDIAN HEALTH SERVICES	58,583,364	33,871,506	-	-	-	33,871,506	92,454,870
PRTF SERVICES	24,340,239	(3,368,924)	-	-	-	(3,368,924)	20,971,315
DENTAL SERVICES	36,094,013	81,672	-	-	-	81,672	36,175,685
PREMIUMS	54,734,853	1,960,057	-	-	-	1,960,057	56,694,910
OTHER SERVICES	168,999,414	(4,154,535)	(3,913,031)	(7,209,580)	(28,930,539)	(44,207,685)	124,791,729
EXPANSION MEDICAID	802,616,834	(140,517,494)	-	-	-	(140,517,494)	662,099,340
TOTAL FUNDS	**$ 1,721,252,720**	**$ (95,356,738)**	**$ (3,913,031)**	**$ (8,709,580)**	**$ (28,930,539)**	**$ (136,909,888)**	**$ 1,584,342,832**
GENERAL FUND	**$ 408,309,812**	**$ (6,464,515)**	**$ 15,065,248**	**$ (450,000)**	**$ (28,930,539)**	**$ (20,779,806)**	**$ 387,530,006**

Governor's Recommendation to the House

DESCRIPTION	TO GOVERNOR	INFLATION	SERVICES - COST TO CONTINUE	COMPLIANCE & QUALITY	SERVICES- DOJ	HEALTHCARE WORKFORCE	TOTAL CHANGES	TO HOUSE
TRADITIONAL MEDICAID	$ 922,243,492	$ 16,215,764	$ 7,209,580	$ 2,000,000	$ 2,471,536	$ 4,379,540	$ 32,276,420	$ 954,519,912
INPATIENT HOSPITAL	230,732,726	4,703,996	-	-	-	-	4,703,996	235,436,722
OUTPATIENT HOSPITAL	125,475,338	1,646,360	-	-	-	-	1,646,360	127,121,698
PROFESSIONAL SERVICES	148,204,496	3,349,422	-	-	-	-	3,349,422	151,553,918
DRUGS	86,742,423	-	-	-	-	-	-	86,742,423
INDIAN HEALTH SERVICES	92,454,870	2,099,873	-	-	-	-	2,099,873	94,554,743
PRTF SERVICES	20,971,315	473,952	-	-	-	-	473,952	21,445,267
DENTAL SERVICES	36,175,685	817,570	-	-	-	-	817,570	36,993,255
PREMIUMS	56,694,910	-	-	-	-	-	-	56,694,910
OTHER SERVICES	124,791,729	3,124,592	7,209,580	2,000,000	2,471,536	4,379,540	19,185,248	143,976,977
EXPANSION MEDICAID	662,099,340	-	-	-	-	-	-	662,099,340
TOTAL FUNDS	**$ 1,584,342,832**	**$ 16,215,764**	**$ 7,209,580**	**$ 2,000,000**	**$ 2,471,536**	**$ 4,379,540**	**$ 32,276,420**	**$ 1,616,619,252**
GENERAL FUND	**$ 387,530,006**	**$ 6,949,693**	**$ -**	**$ 1,000,000**	**$ 1,235,768**	**$ 2,189,770**	**$ 11,375,231**	**$ 398,905,237**

Grants on a Walkthrough

Governor's Recommendation to the House

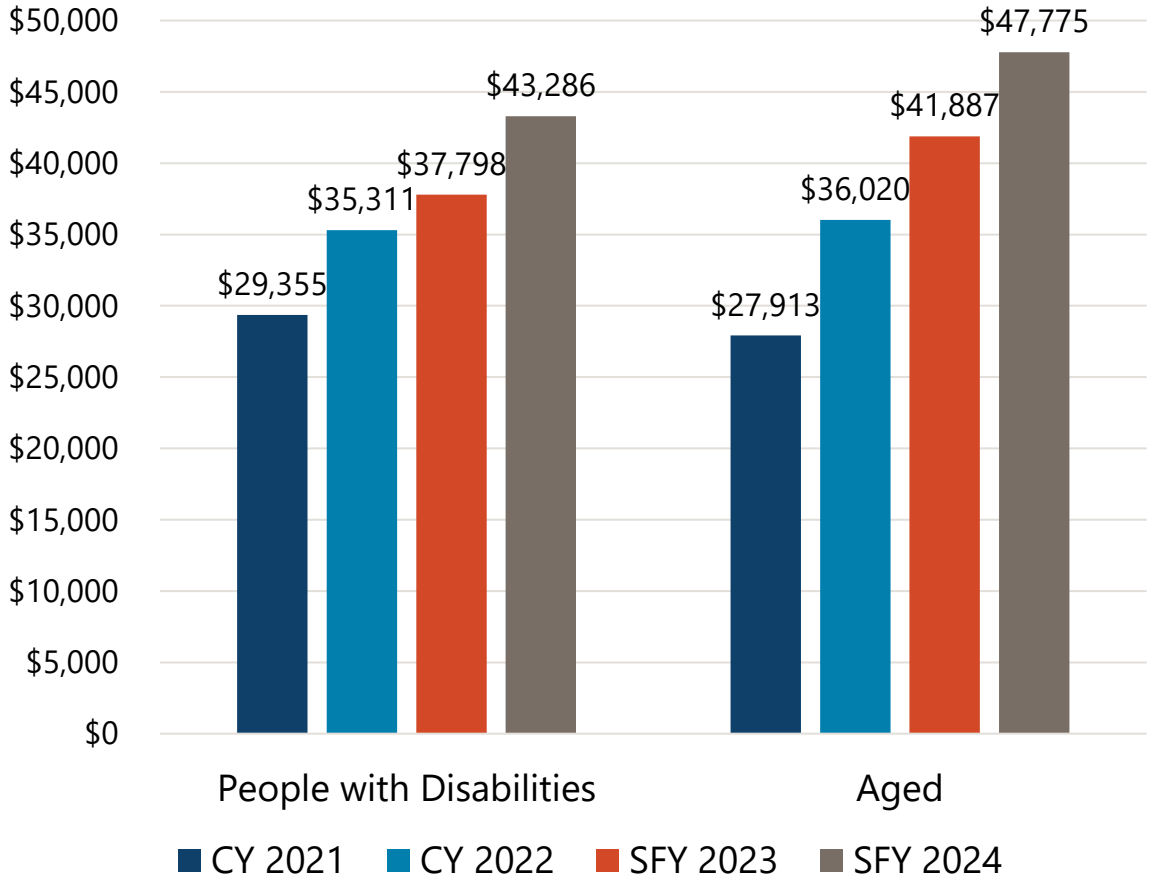
DESCRIPTION	TO GOVERNOR	INFLATION	SERVICES - COST TO CONTINUE	COMPLIANCE & QUALITY	SERVICES- DOJ	HEALTHCARE WORKFORCE	TOTAL CHANGES	TO HOUSE
TRADITIONAL MEDICAID	$ 922,243,492	$ 16,215,764	$ 7,209,580	$ 2,000,000	$ 2,471,536	$ 4,379,540	$ 32,276,420	$ 954,519,912
INPATIENT HOSPITAL	230,732,726	4,703,996	-	-	-	-	4,703,996	235,436,722
OUTPATIENT HOSPITAL	125,475,338	1,646,360	-	-	-	-	1,646,360	127,121,698
PROFESSIONAL SERVICES	148,204,496	3,349,422	-	-	-	-	3,349,422	151,553,918
DRUGS	86,742,423	-	-	-	-	-	-	86,742,423
INDIAN HEALTH SERVICES	92,454,870	2,099,873	-	-	-	-	2,099,873	94,554,743
PRTF SERVICES	20,971,315	473,952	-	-	-	-	473,952	21,445,267
DENTAL SERVICES	36,175,685	817,570	-	-	-	-	817,570	36,993,255
PREMIUMS	56,694,910	-	-	-	-	-	-	56,694,910
OTHER SERVICES	124,791,729	3,124,592	7,209,580	2,000,000	2,471,536	4,379,540	19,185,248	143,976,977
EXPANSION MEDICAID	662,099,340	-	-	-	-	-	-	662,099,340
TOTAL FUNDS	**$ 1,584,342,832**	**$ 16,215,764**	**$ 7,209,580**	**$ 2,000,000**	**$ 2,471,536**	**$ 4,379,540**	**$ 32,276,420**	**$ 1,616,619,252**
GENERAL FUND	**$ 387,530,006**	**$ 6,949,693**	**$ -**	**$ 1,000,000**	**$ 1,235,768**	**$ 2,189,770**	**$ 11,375,231**	**$ 398,905,237**

House Recommendation to the Senate

DESCRIPTION	INFLATION 2% / 2%	TOTAL CHANGES	TO SENATE
TRADITIONAL MEDICAID	$ 5,453,149	$ 5,453,149	$ 959,973,061
INPATIENT HOSPITAL	1,581,875	1,581,875	237,018,597
OUTPATIENT HOSPITAL	553,643	553,643	127,675,341
PROFESSIONAL SERVICES	1,126,354	1,126,354	152,680,272
DRUGS	-	-	86,742,423
INDIAN HEALTH SERVICES	706,212	706,212	95,260,955
PRTF SERVICES	159,382	159,382	21,604,649
DENTAL SERVICES	274,935	274,935	37,268,190
PREMIUMS	-	-	56,694,910
OTHER SERVICES	1,050,748	1,050,748	145,027,725
EXPANSION MEDICAID	-	-	662,092,940
TOTAL FUNDS	**$ 5,453,149**	**$ 5,453,149**	**$ 1,622,072,401**
GENERAL FUND	**$ 2,225,351**	**$ 2,225,351**	**$ 401,127,388**

Long Term Care

Per Capita Expenditures: Aged & People with Disabilities

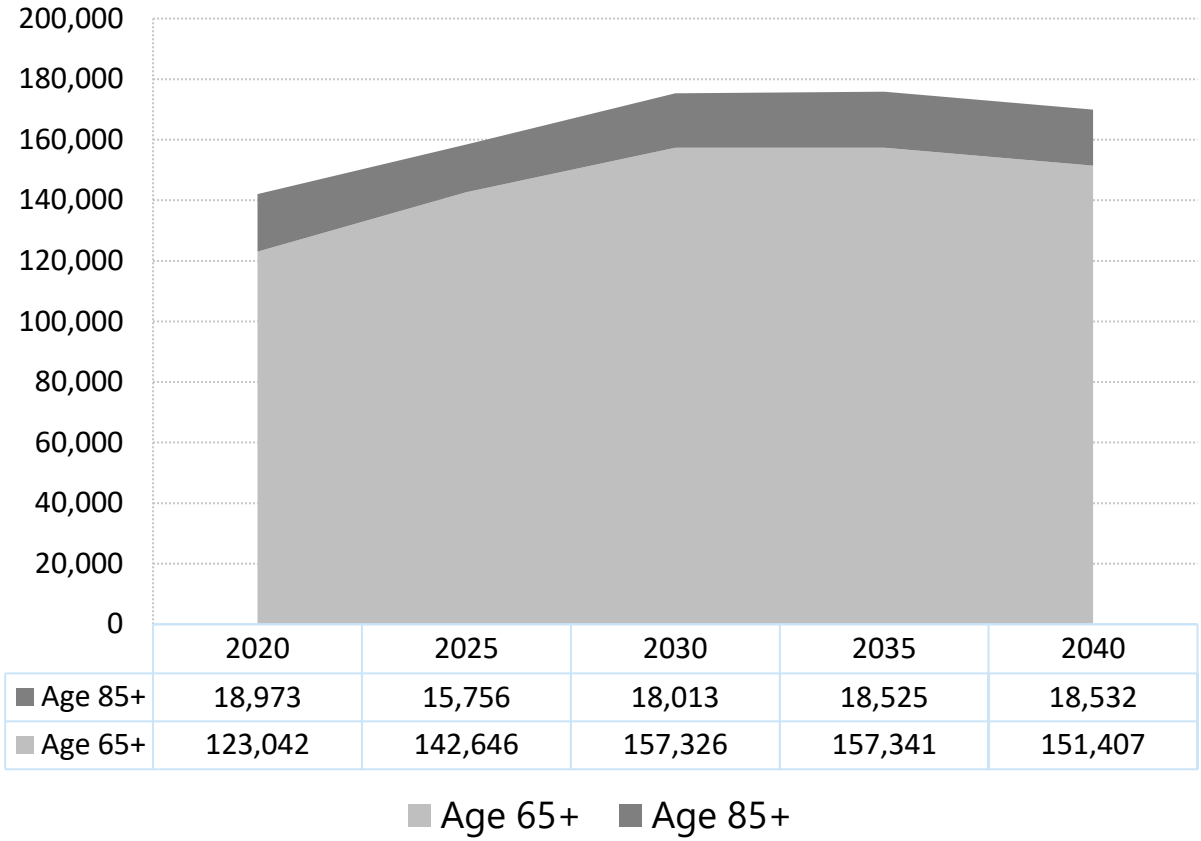


- ND Medicaid ranked **1st for Aged per capita** expenditures.
- ND Medicaid ranked **7th for People with Disabilities per capita** expenditures.

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

Who We Serve

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



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

Source: 2024 ND State Data Center Population Projections

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

7 in 10

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

Long Term Care Eligibility

Functional Need

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

+

Financial Need

Income Limit

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

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

Asset Limit

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

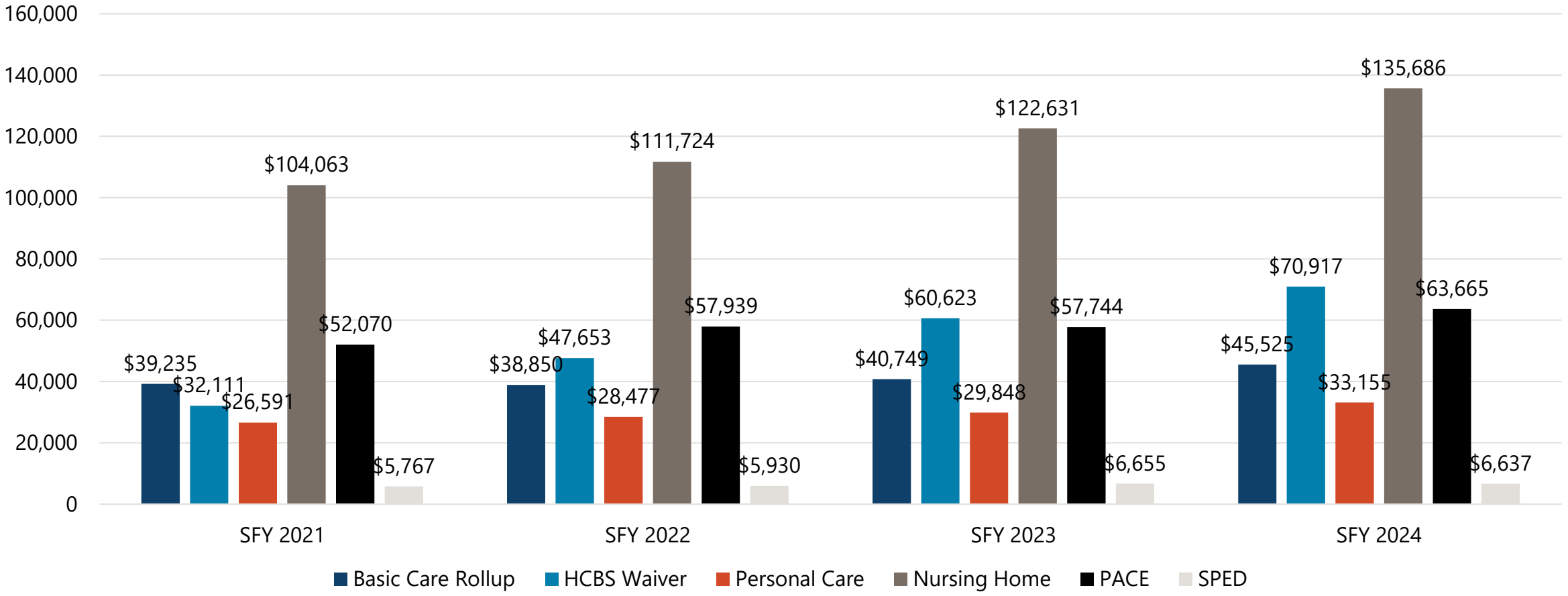
Note: Special Spousal Impoverishment rules apply when the individual's spouse is not applying or not in a medical facility.

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

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

Where the Long-Term Care Budget Goes

Average Cost per Person



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

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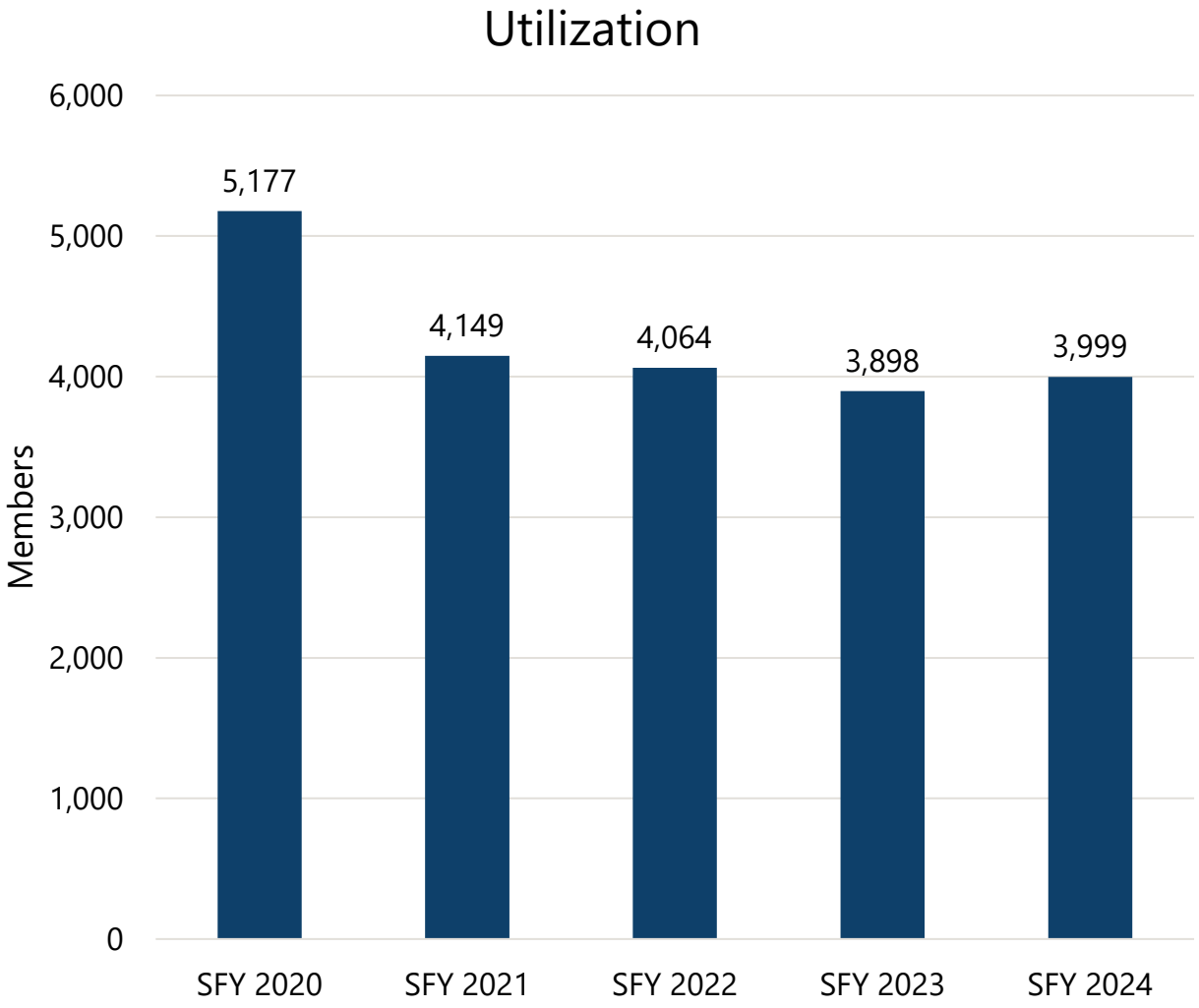
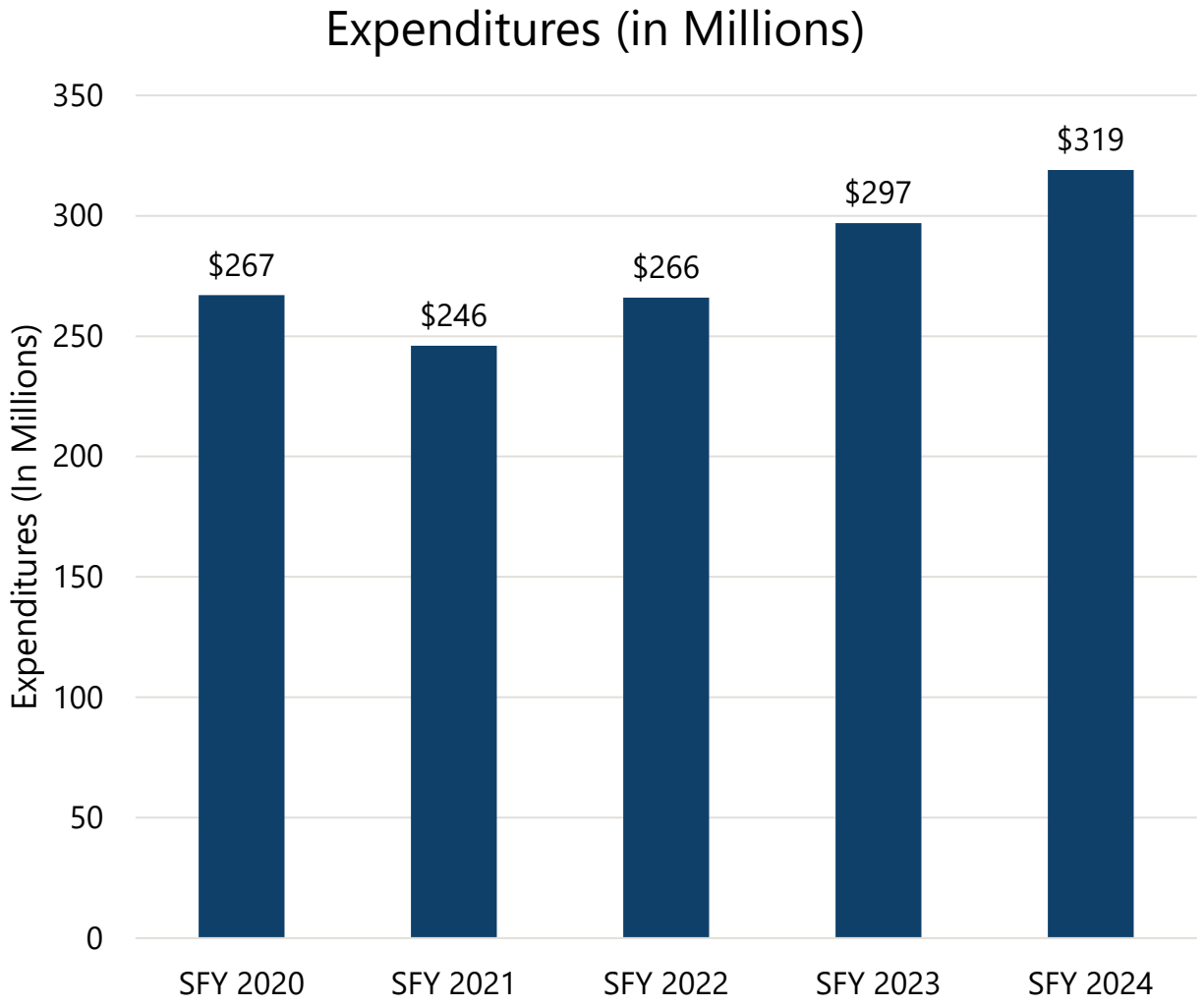
Nursing Facility Utilization & Expenditures





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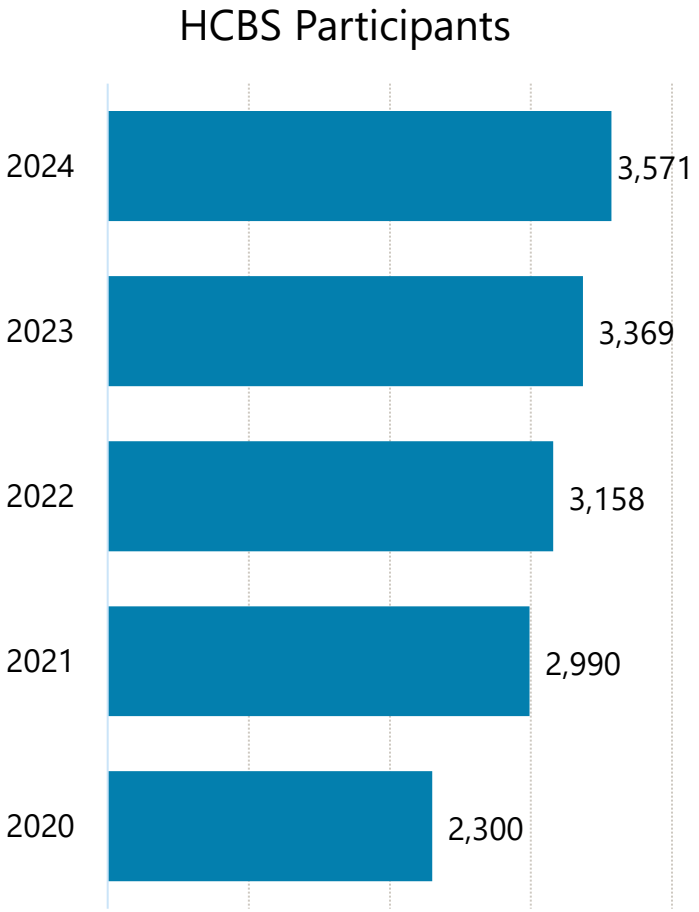
More North Dakotans are choosing home-based community care options every year

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



54% increase since 2020

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

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

Implementing the Settlement Agreement between U.S. DOJ & State of North Dakota

PURPOSE is to ensure that ND will **meet Americans with Disabilities Act (ADA) requirements** by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

Effective Dec. 14, 2020

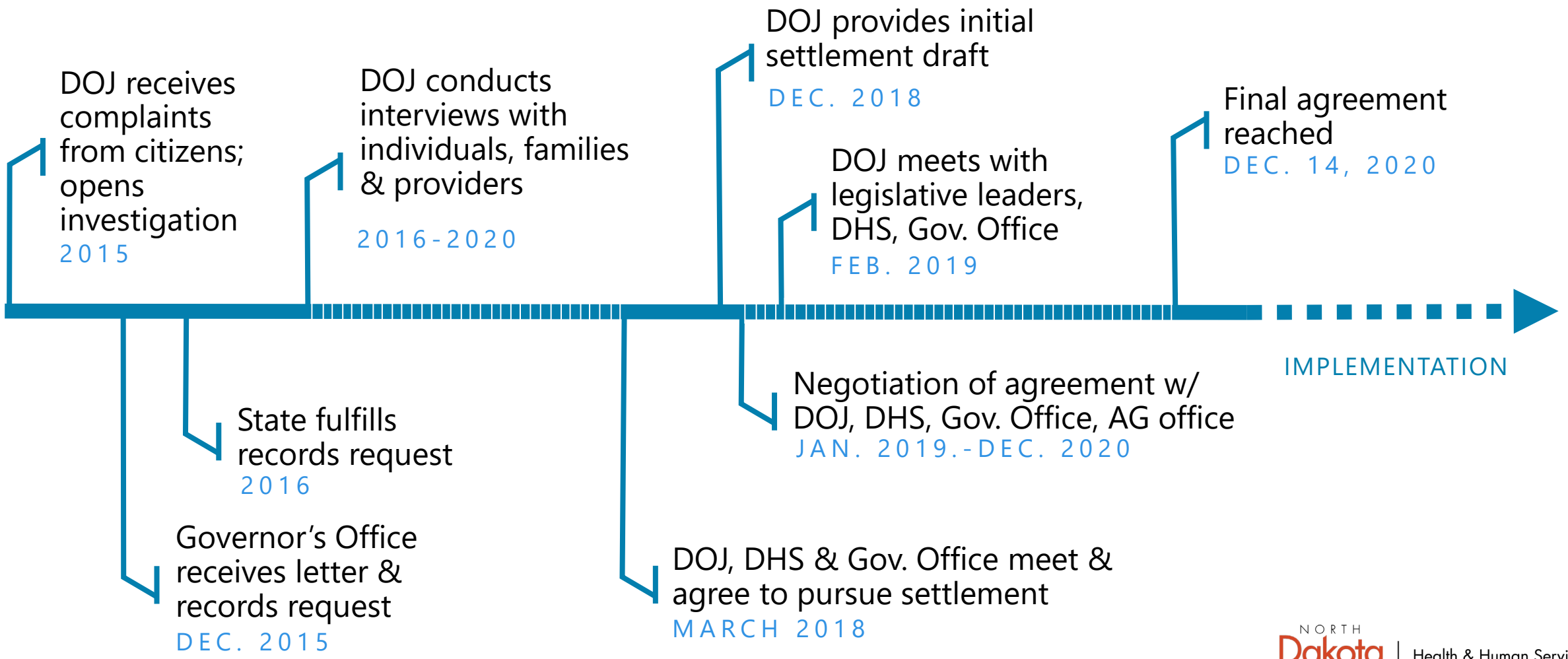
Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.

Watch Diversion and Transition Testimonials- Adults and Aging Health and Human Services North Dakota

US DOJ Settlement Agreement Americans with Disabilities Act

- The Americans with Disabilities Act (ADA) requires public agencies to **eliminate unnecessary segregation** of persons with disabilities and provide services in the **most integrated setting appropriate** to the needs of the individual.
- In **1999** the Federal Supreme Court **Olmstead** decision **affirmed** the **ADA** requirements.
- Most **integrated setting** is an individual or family home

DOJ Settlement Agreement Timeline



Who are we trying to reach?

Target population members (TPMs)

Basic Eligibility

- Individual with physical disability
- Over age 21
- Eligible or likely to become eligible to receive Medicaid long-term services and supports (LTSS)
- Is likely to require LTSS for at least 90 days.

IF in skilled nursing setting

- Receive Medicaid-funded nursing facility services AND
  - Likely to require long term services and supports
- Receive nursing facility services AND
  - Likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay

IF in hospital or home setting

- Referred for a nursing facility level of care determination AND
  - Likely to need services long term
- Need services to continue living in the community AND
  - Currently have a HCBS Case Manager or have contacted the ADRL

49
PER 1000

PEOPLE OVER 65 IN CERTIFIED NURSING FACILITIES

HIGHEST RATE IN THE U.S. **IN 2015**

Sources: Henry J Kaiser Foundation, US Census Bureau (2016)

DOJ Settlement Agreement

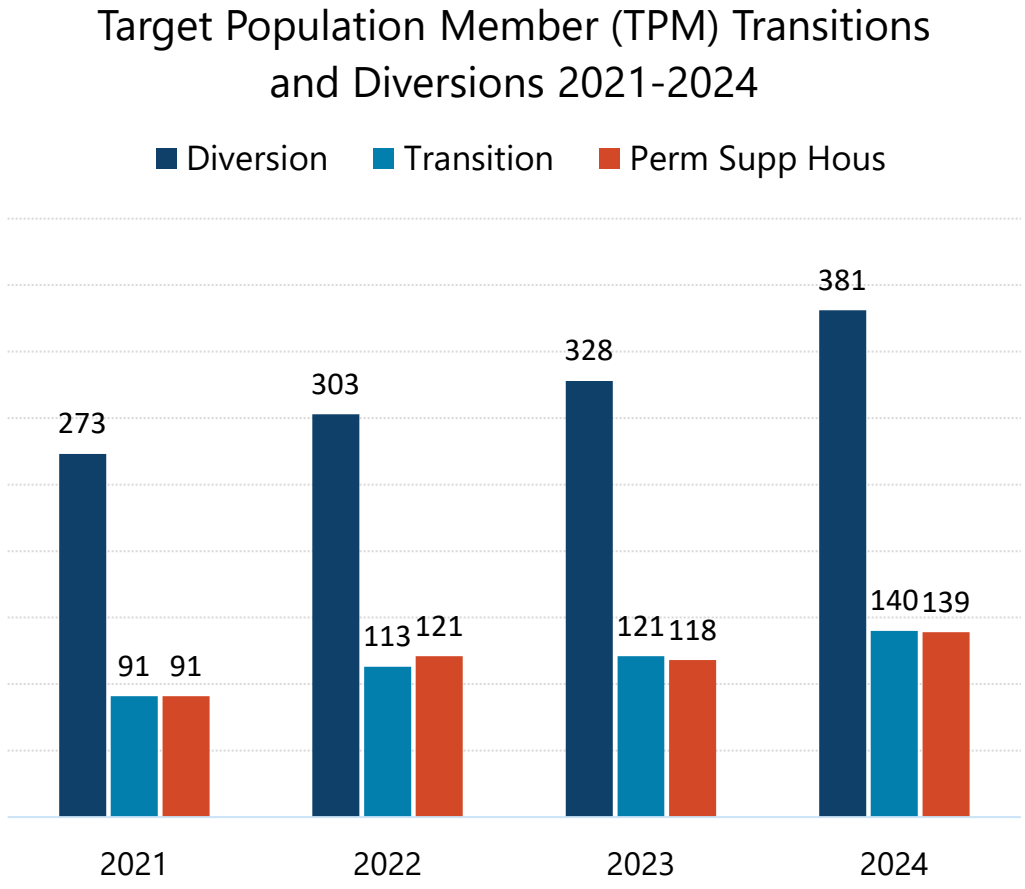
HCBS is supporting increase in Transition and Diversion from institutional settings

"**Diversion**" happens when a Medicaid eligible individual who screens at a nursing facility level of care receives a set of services (HCBS, housing etc.) that allows them to remain in an integrated setting and avoid institutionalization.

"Transition" happens when a Medicaid eligible individual who resides at a nursing facility receives transition supports and a set of services (HCBS, housing etc.) that allows them to move to an integrated setting in the community.

"**Permanent Supported Housing**" is providing affordable housing, rental assistance, meeting with landlords, application assistance etc., in addition to other traditional HCBS that allows an individual to live in a private residence alone or with family, their significant other or roommates of their choosing.

Housing is the #1 barrier to transition



DOJ Settlement Agreement Benchmarks

2020-2024

- **Transition at least 100 TPMs** by the end of **year 2 (2022)**, and by the end of **year 4 (2024) transition at least 60%** of those requesting to transition out of the SNF (within 120 days of request).
- **Divert** at least **100** TPMs within **2 years (2022)** and an **additional 150** by the end of **year 4 (2024)** who are choosing to receive care in the community.
- Provide permanent supported housing (rental assistance) to **20 TPMs in year 1 (2021)**, **30 in year 2 (2022), 60 in year 3 (2023).**

2025-2028

- **Transition 70% of TPMs by year 6 (2026) and 85% by year 7 (2027)** who are requesting transition out of the SNF (within 120 days of request).
- **Divert** an **additional 150 TPMs** to community-based services by **year 6** (2026) and **continue to divert** all who are **choosing to receive care in the community.**
- **Provide** permanent supported housing **(rental assistance)** to additional TPMs based on the aggregate need. *Note: Almost all transitions require some type of state or federally funded rental assistance.*

The Agreement will terminate **eight years (Dec 13, 2028)** after the effective date if the Parties agree that the State has attained substantial compliance with all provisions and maintained that compliance for a period of one year.

Cost to Continue: Home and Community Based Services Growth

Ongoing

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

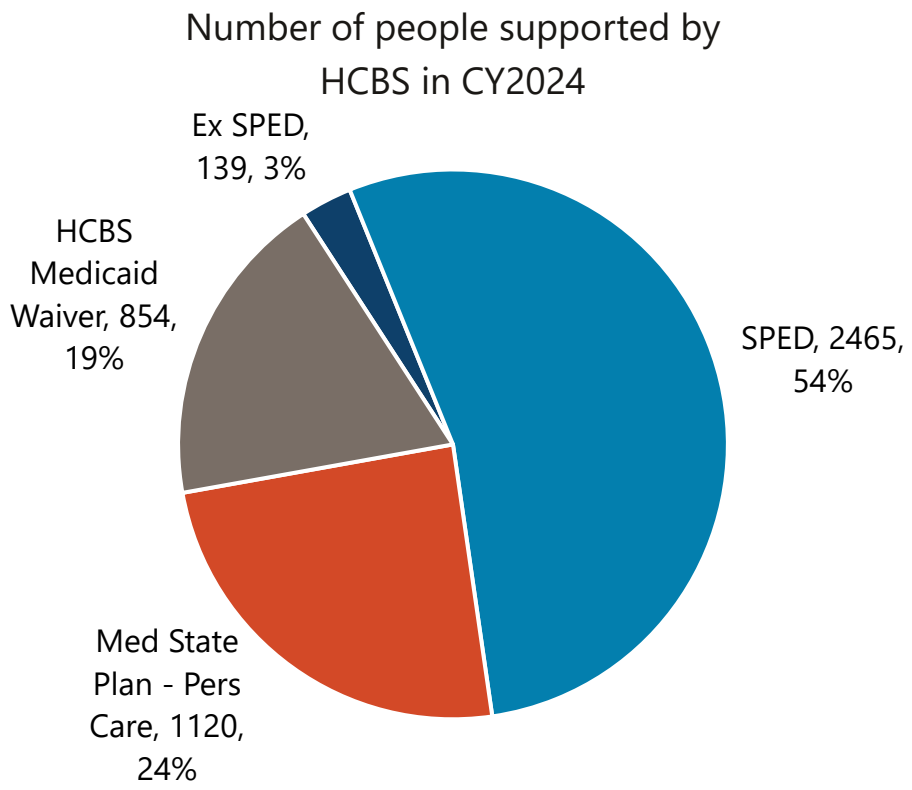
The original submission of cost-to-continue related costs for HHS neglected to include HCBS Growth that is typically part of the calculation; the omission was an error and not reflective of change in policy or operation.

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

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

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

3,571



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

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

Adult & Aging Services

HCBS Case Management

HCBS Case Managers

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

What do they do?

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

73 and **4**

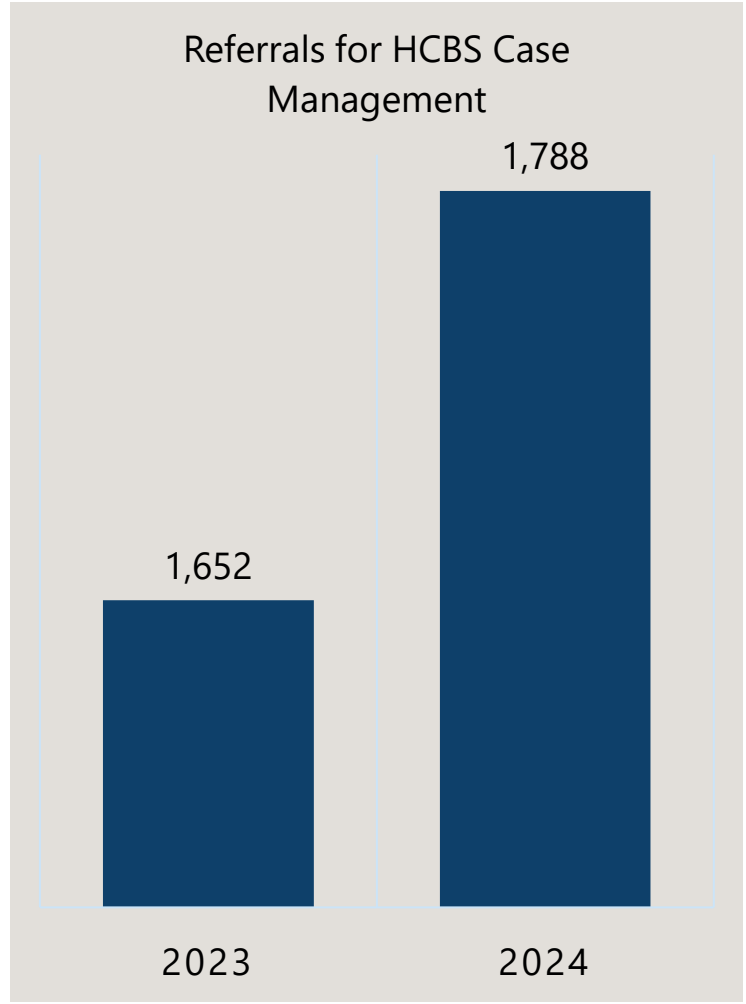
73 HCBS case managers and 4 Basic Care case managers are supervised by Adult & Aging Services

150 and **80**

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

4,329

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



Adult & Aging Services

Supporting QSPs who deliver care is a top priority

Qualified Service Providers (QSPs)

Agency and individual independent contractors who enroll to provide various HCBS

1,359
Qualified Services Providers (QSPs) provide services

206
Agency QSPs

1,153
Individual QSPs

Agency QSPs ranked the rate of compensation as the most important factor to retain employees.
UND Independent QSP Survey Oct 2024

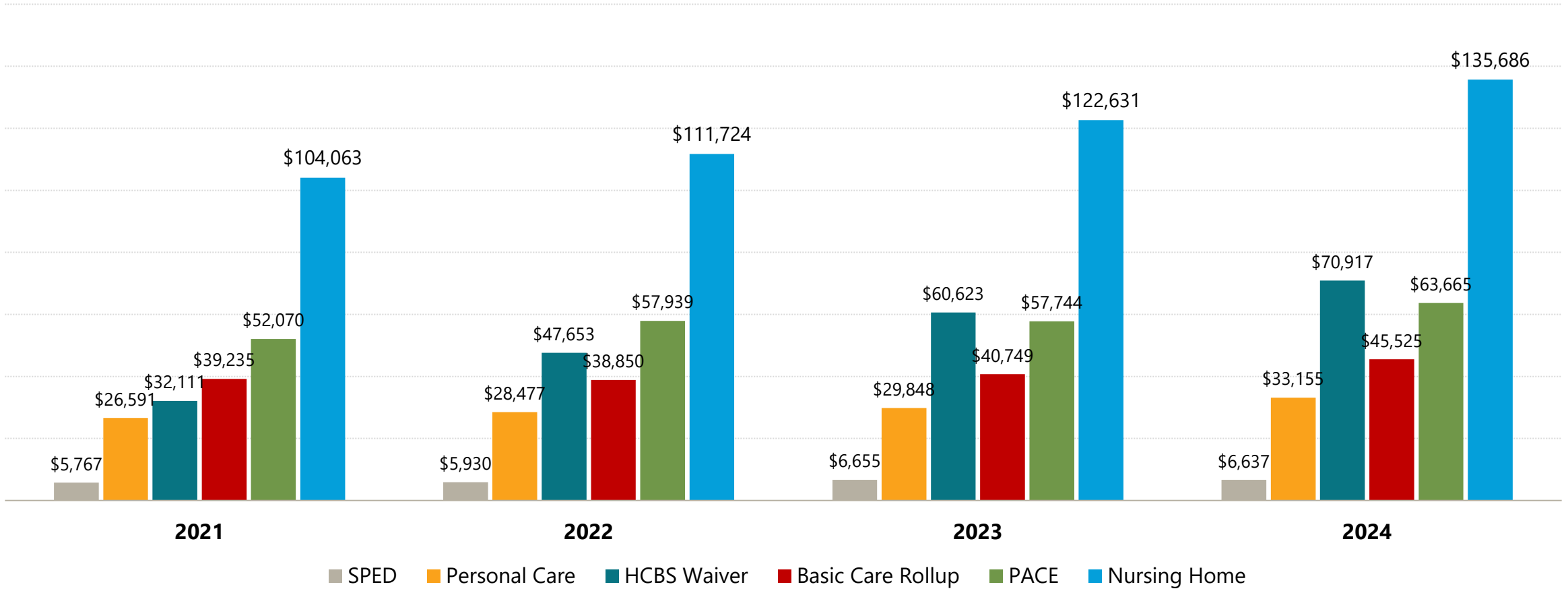
334 new individual QSPs

and **45** new agency QSPs enrolled to provide care in 2024

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

Average spending per person per year

Long-Term Care services and supports

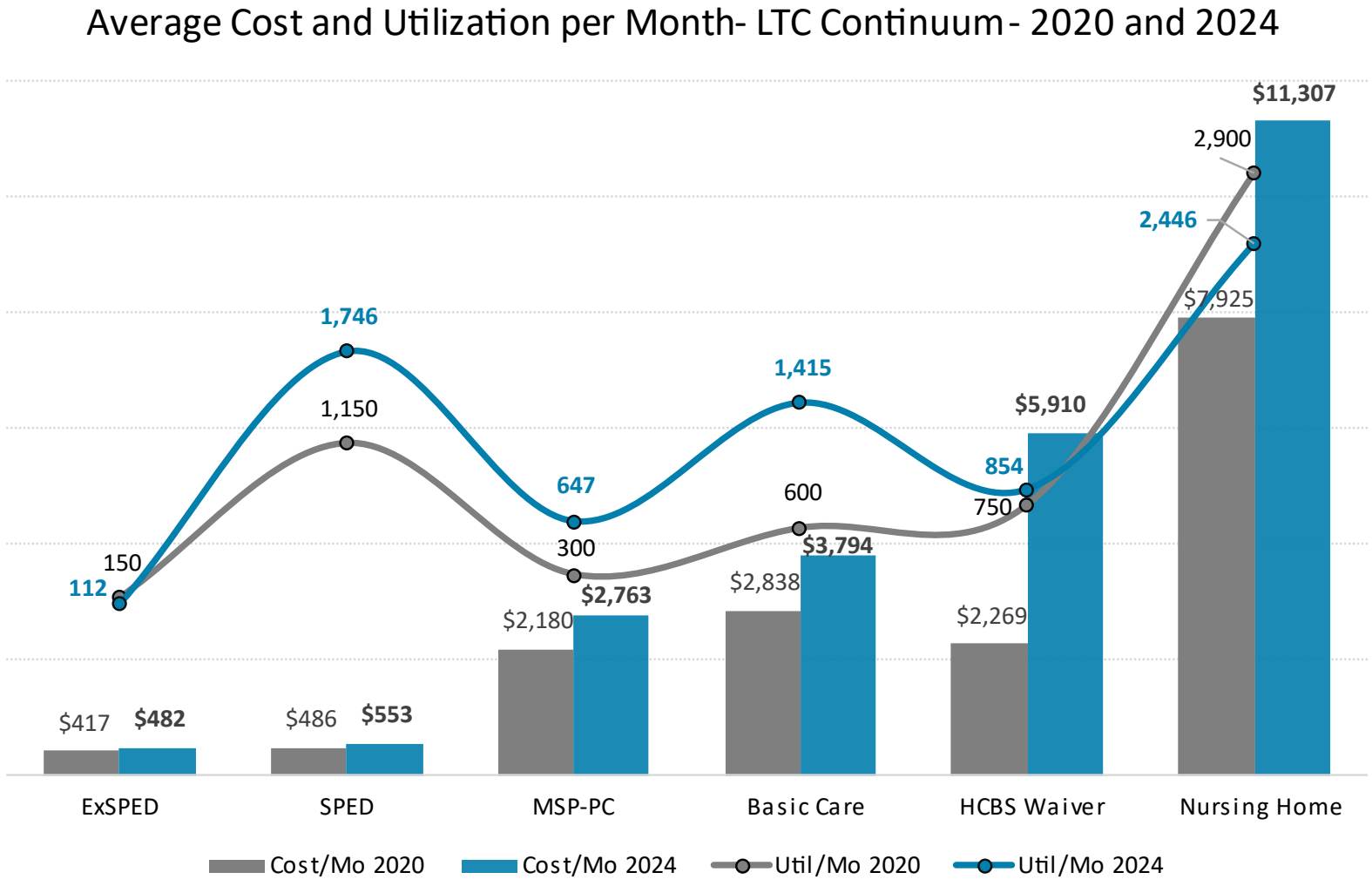


Note: Basic Care Rollup includes both Basic Care Personal Care and Room and Board

Connecting the Housing-Service Continuum to Budget

Long Term Care Services and Supports

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



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

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

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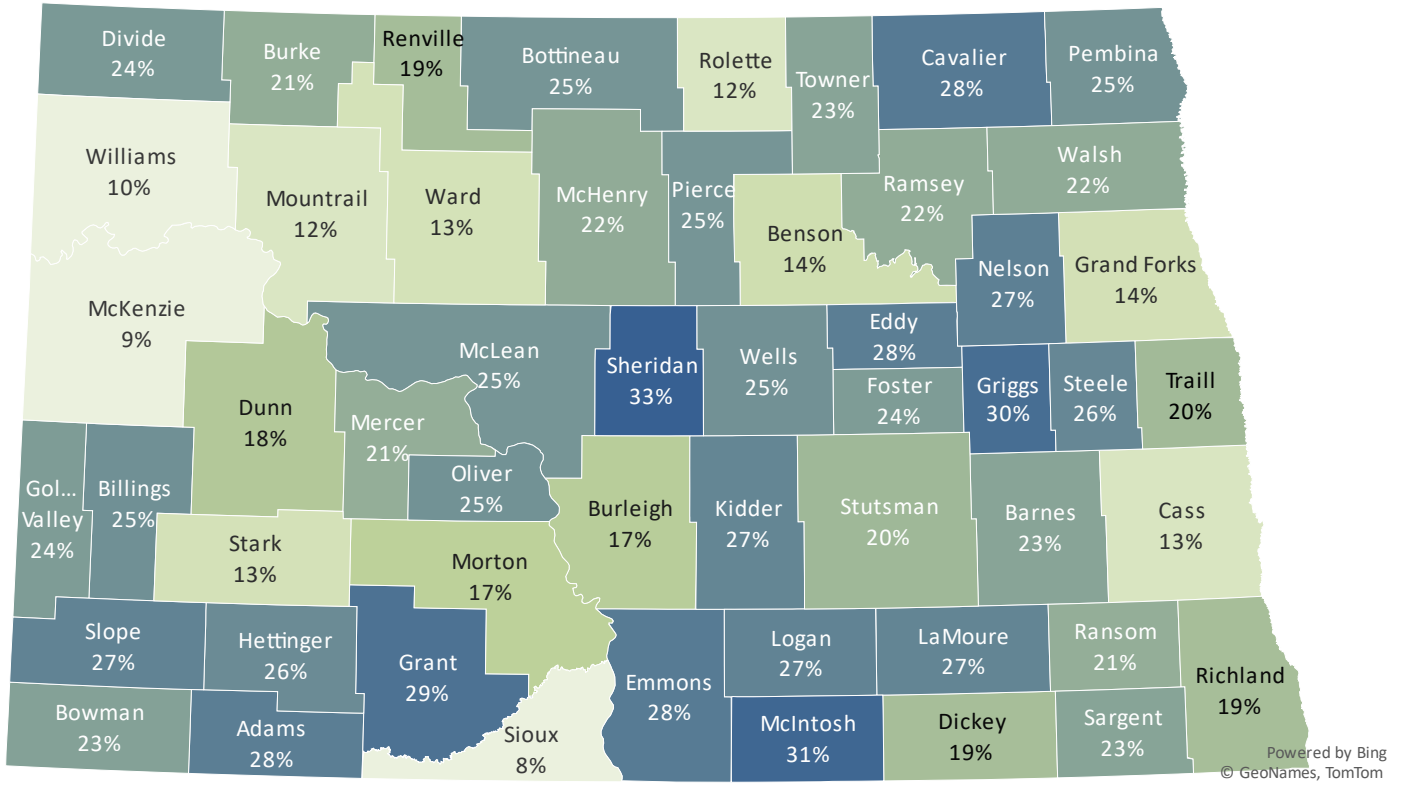
There are several factors driving the need for the full array of Adult/Aging services and for HCBS generally

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

15.9% of ND population was age 65+ in 2022

% of population age 65+ by county



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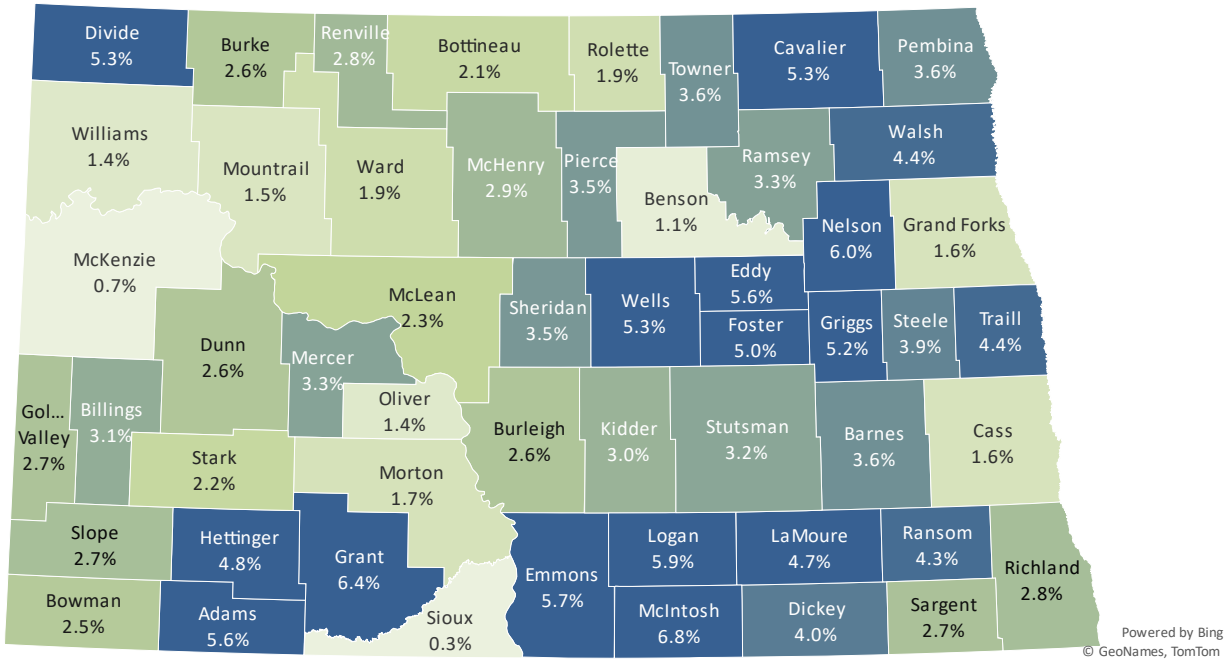
The next 10 years will represent the most significant shift in demographics for ND and most US states

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

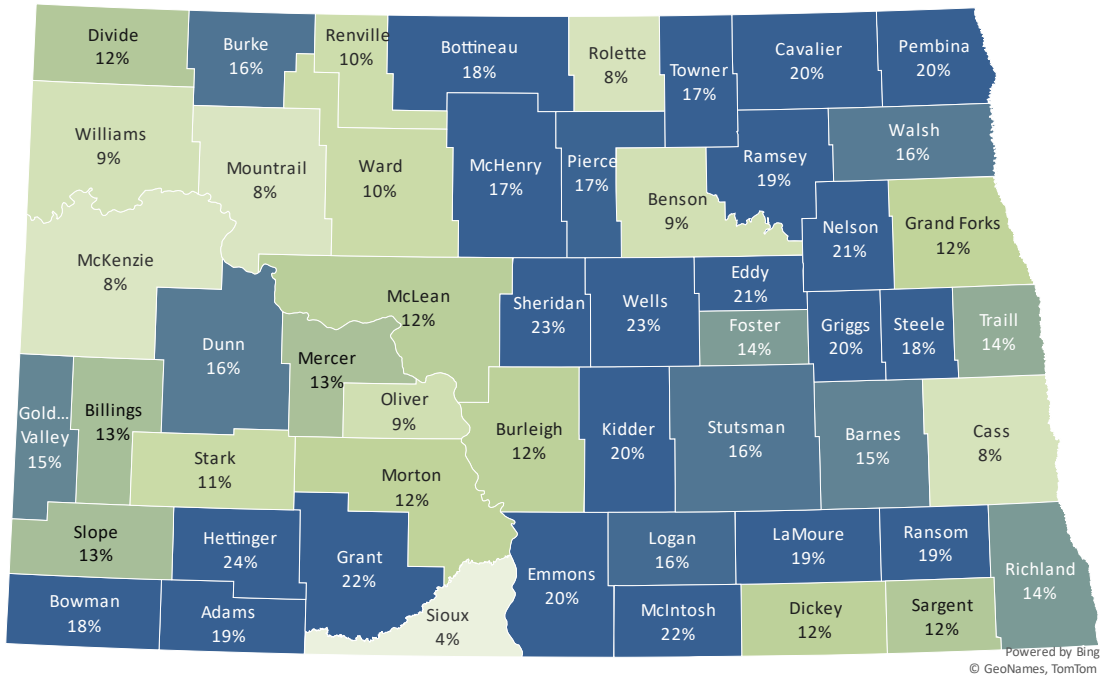
2.3% of ND population was age 85+ in 2022

% of population age 85+ by county



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

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



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

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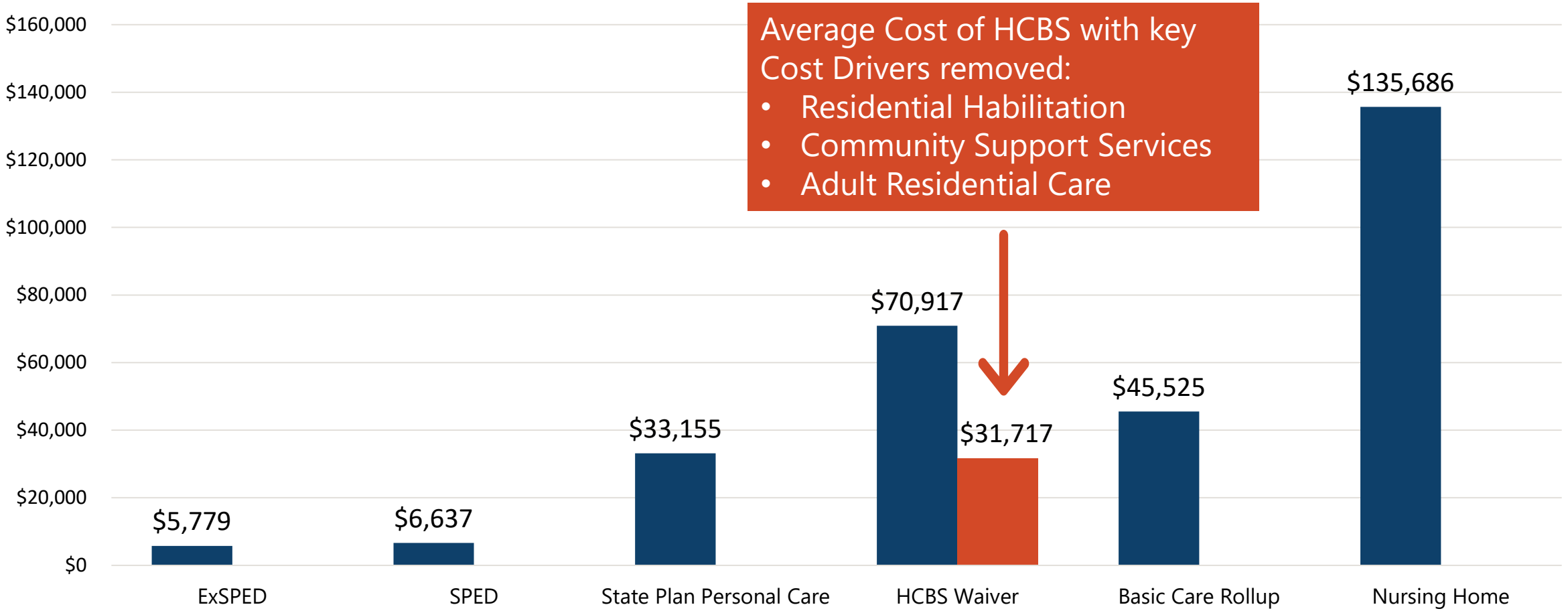
SFY 2024 Long Term Care Continuum

Average Cost Per Person Per Year



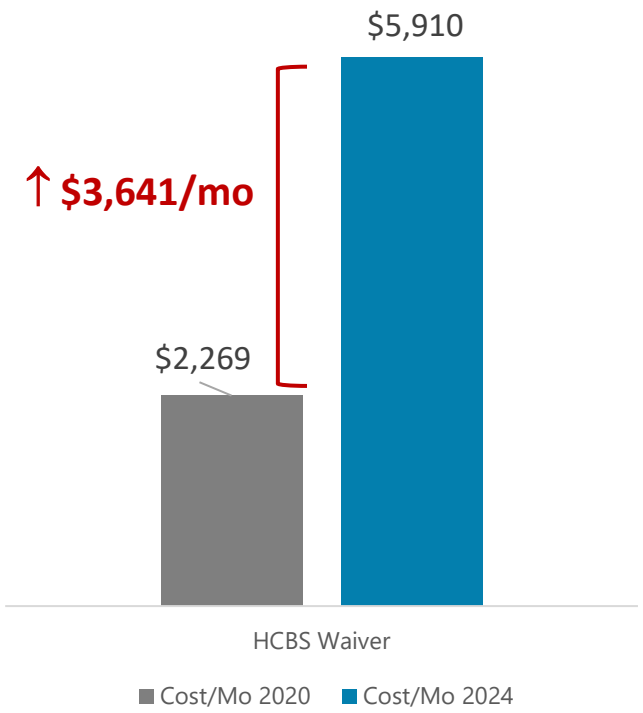
Note: Basic Care Rollup includes both Basic Care Personal Care and Room and Board

What's driving HCBS Waiver cost growth?

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

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

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



Top HCBS Cost Drivers

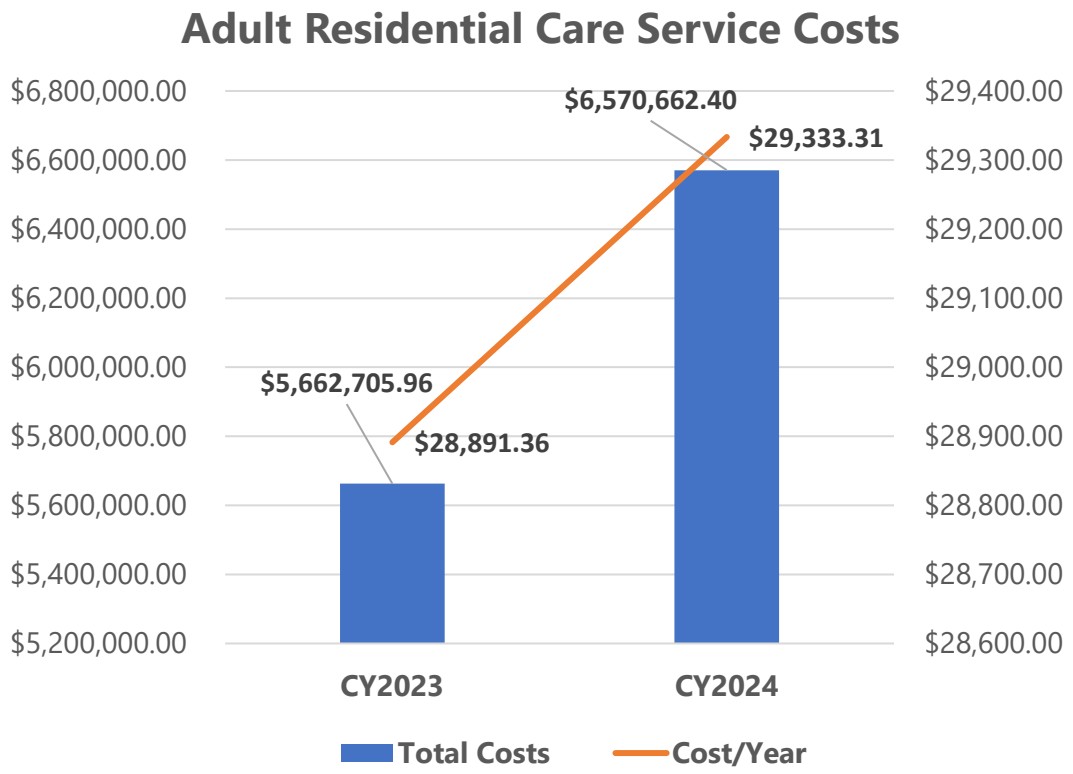
1. **24-hour** delivery of complex cares
2. Prevalence of **serious mental illness** and **substance use disorder** in HCBS recipients
3. Increasing number of HCBS recipients with **complex medical** needs

Cost driver #1

24-hour delivery of complex cares

Adult Residential Care

- 24-hour residential services for individual with **memory impairment** or **traumatic brain injury.**
- Individuals have a daily need for a **safe supervised structured environment**, personal care, and medication supports. Not impaired in eating, bathing, toileting.
- In SFY 24 **29%** (224) **of waiver participants** were enrolled in this service.
- Average service cost per person per year = **$29,333**
- Individual also pays up to $1,005 for room and board = **$12,060** year



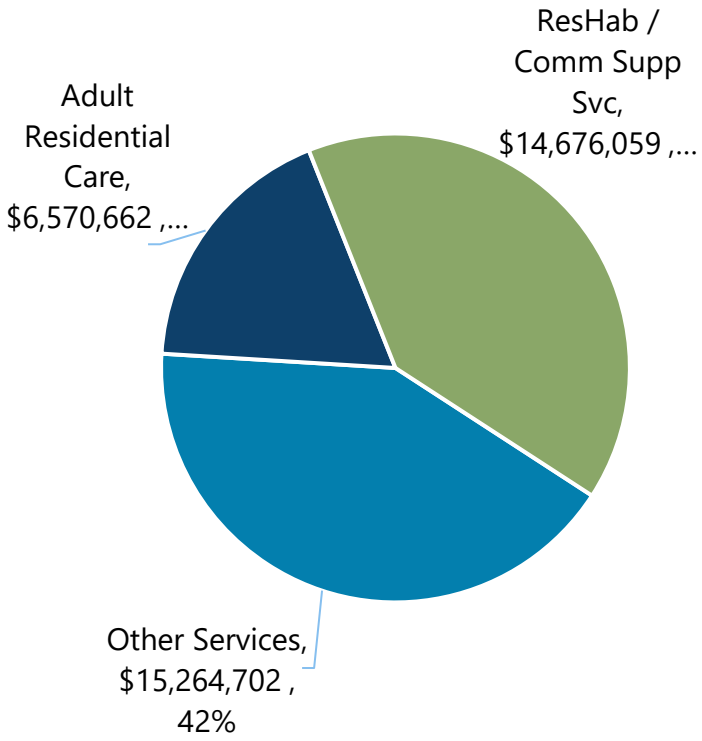
13,700 individuals 65+ are living with Alzheimer's in ND. *Source: Alzheimer's Association (2024)*

Cost driver #1

24-hour delivery of complex cares

Residential Habilitation and **Community Support Svcs**

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



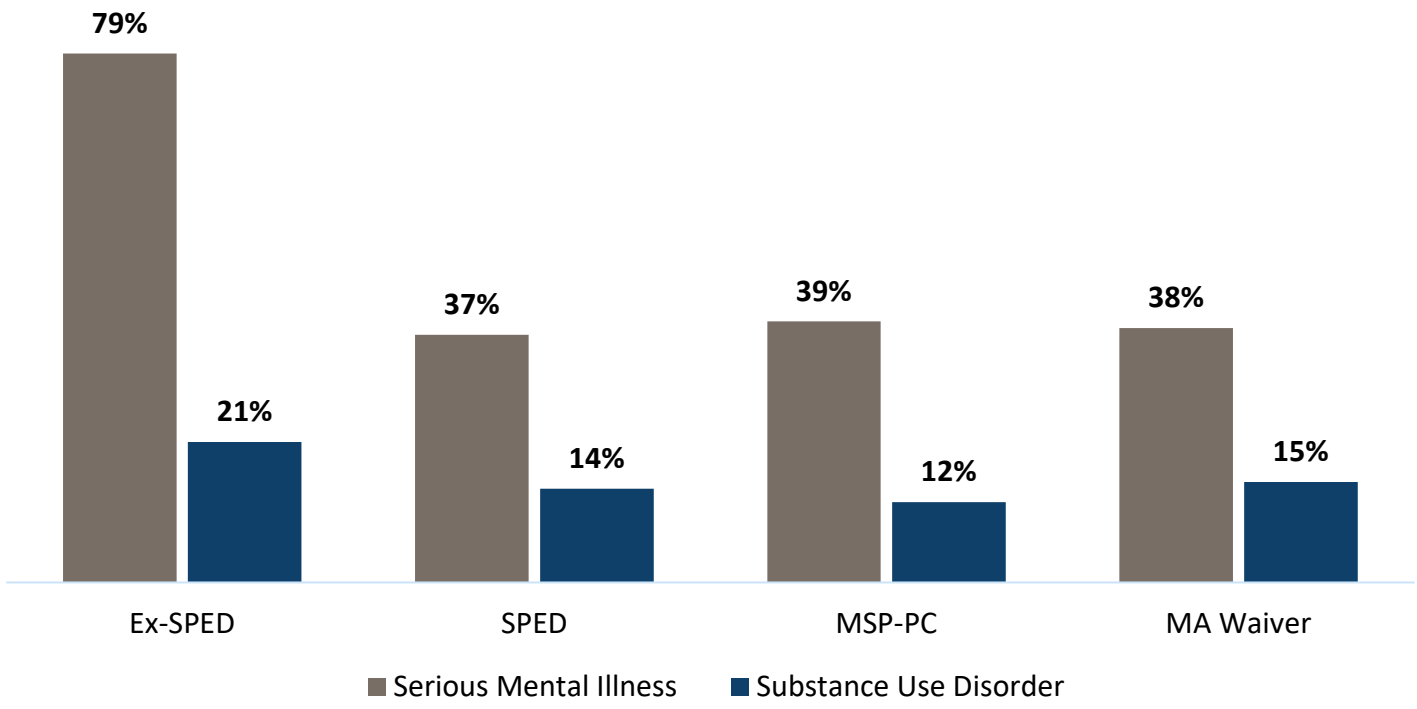
16% of waiver **participants** account for **40%** of the **cost** of care

Cost driver #2

Prevalence of Behavioral Health Needs

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

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



Source: NDHHS HCBS Case Management data system, 2024

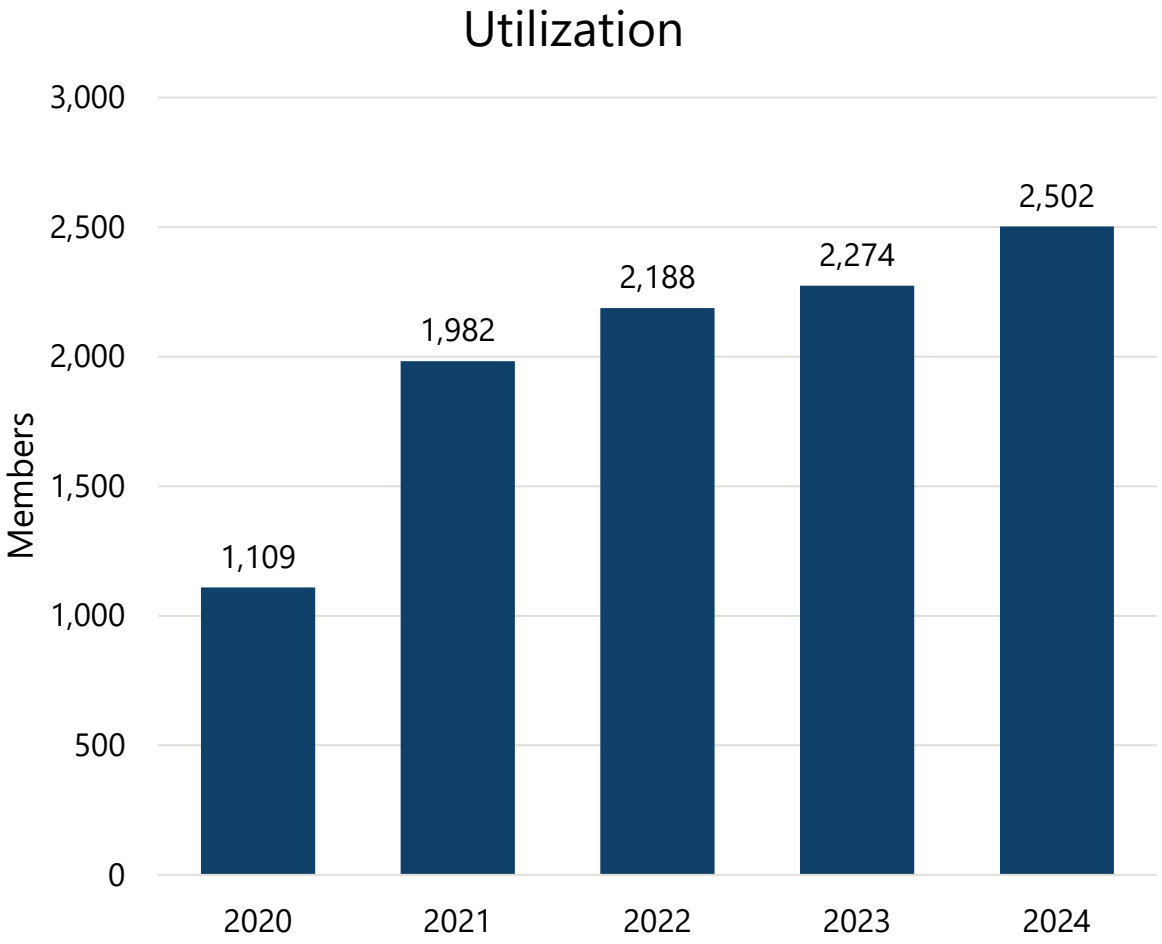
Cost driver #3

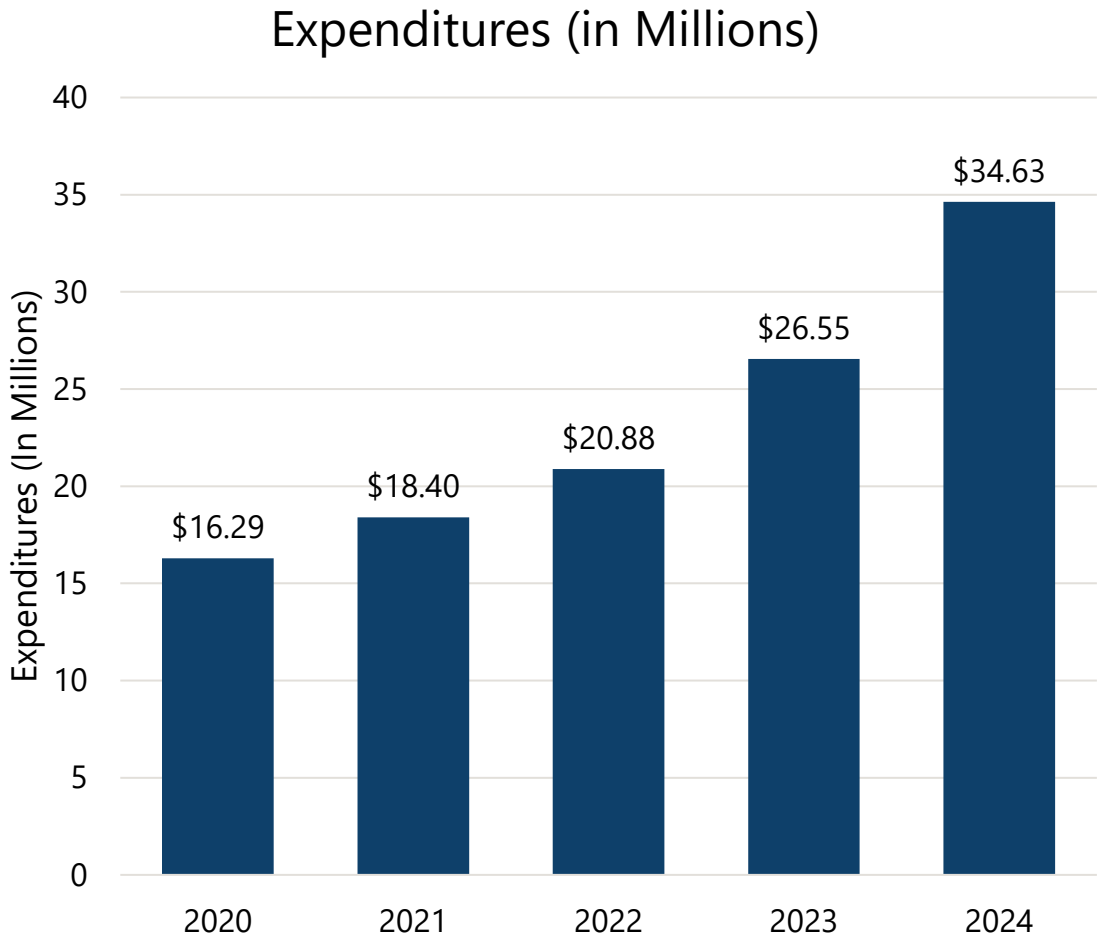
Prevalence of Complex Medical Needs

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

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

Qualified Service Provider Utilization & Expenditures





Types of SUPPORT SERVICES available via HCBS

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

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

Qualified Service Providers Targeted Rate Increase

Ongoing

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

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

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

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

QSP rate increases target areas of highest need

QSP Nursing Services

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

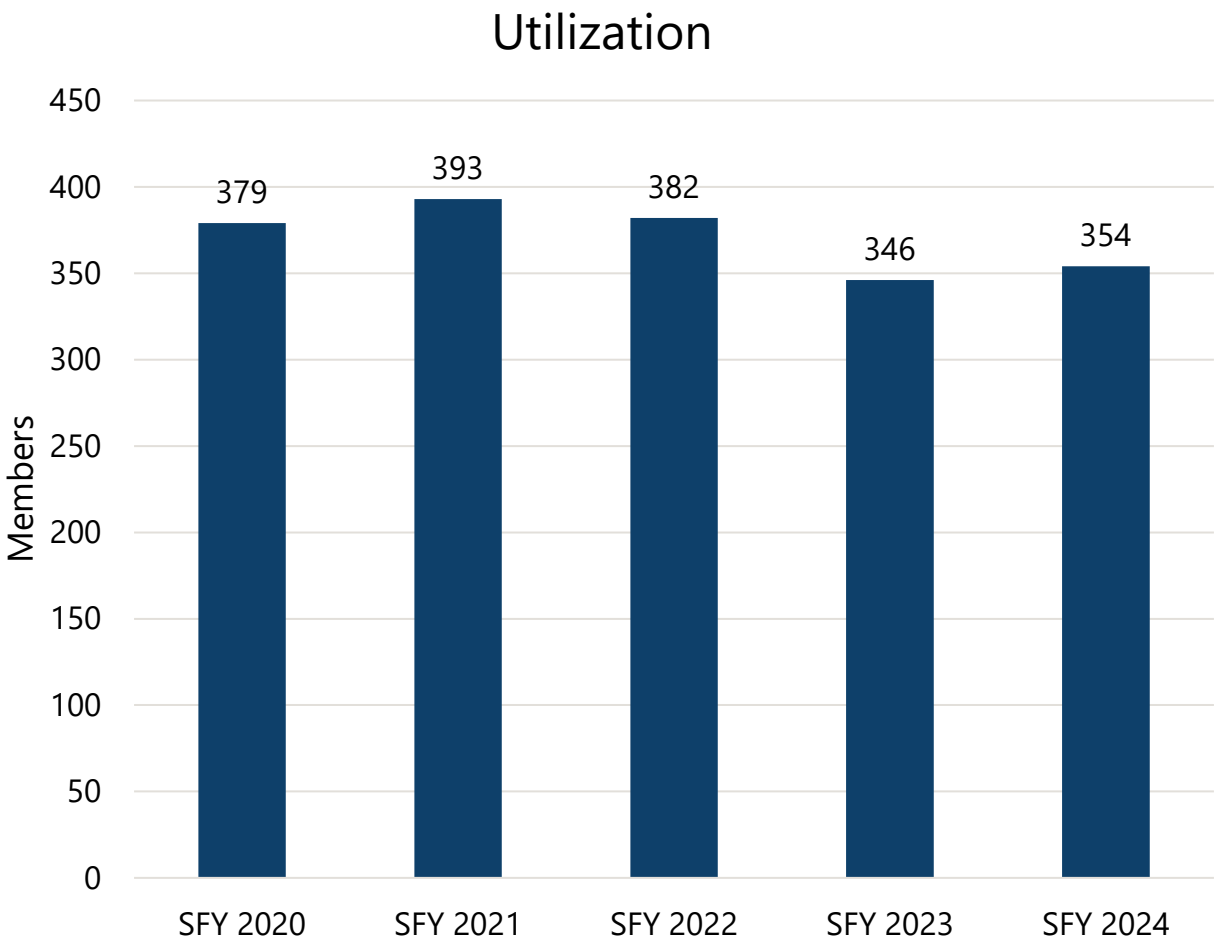
QSP Aide Services

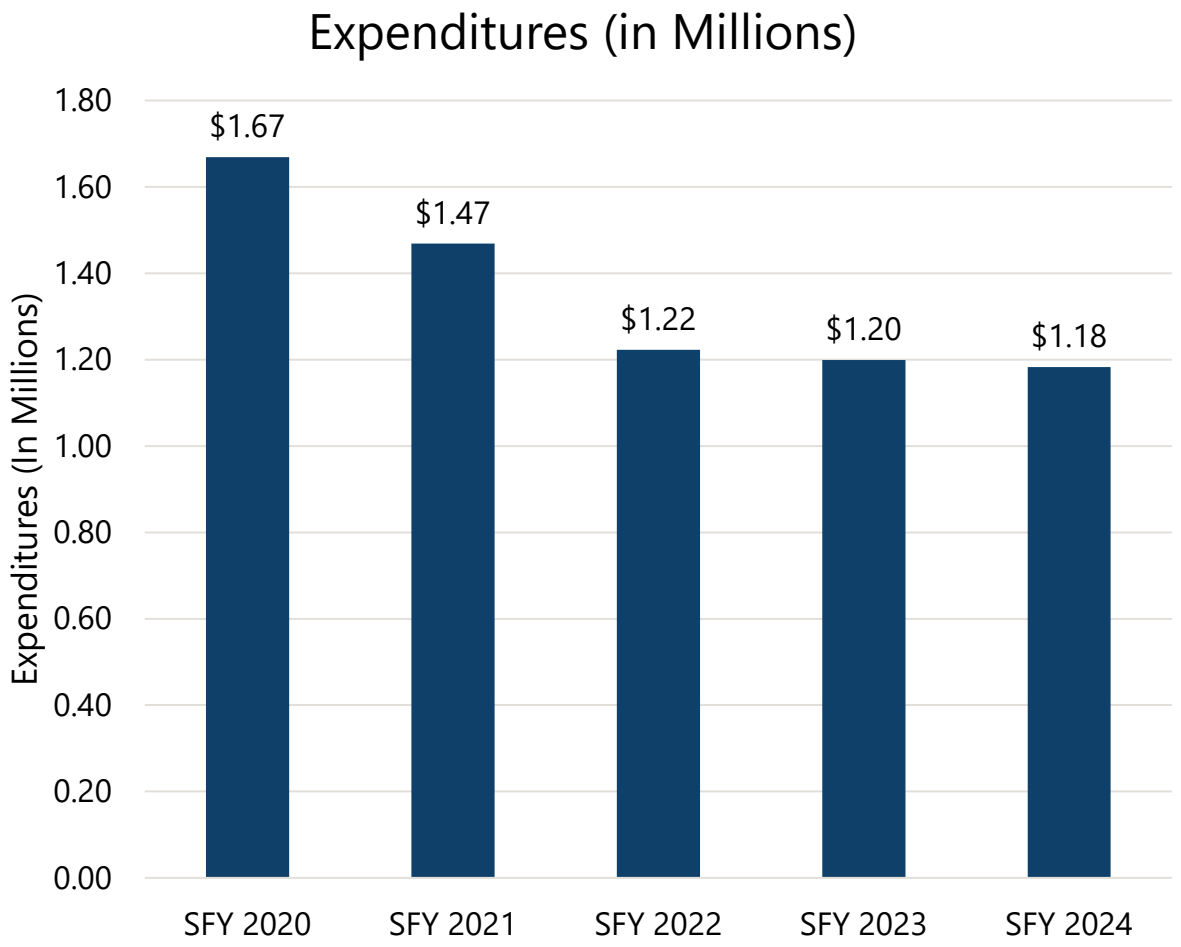
- **Homemaker** – housework, meal prep, laundry, shopping assistance
- **Chore** – Heavy cleaning, snow removal, lawn care
- **Personal Care** (unit rate) – help with personal hygiene, mobility etc.
- **Respite** – short break for caregivers
- **Supported Employment** – on the job support to remain employed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

QSP Companion Services

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

Home Health Utilization & Expenditures





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Private Duty Nursing & Home Health Targeted Rate Increase

Ongoing

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

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

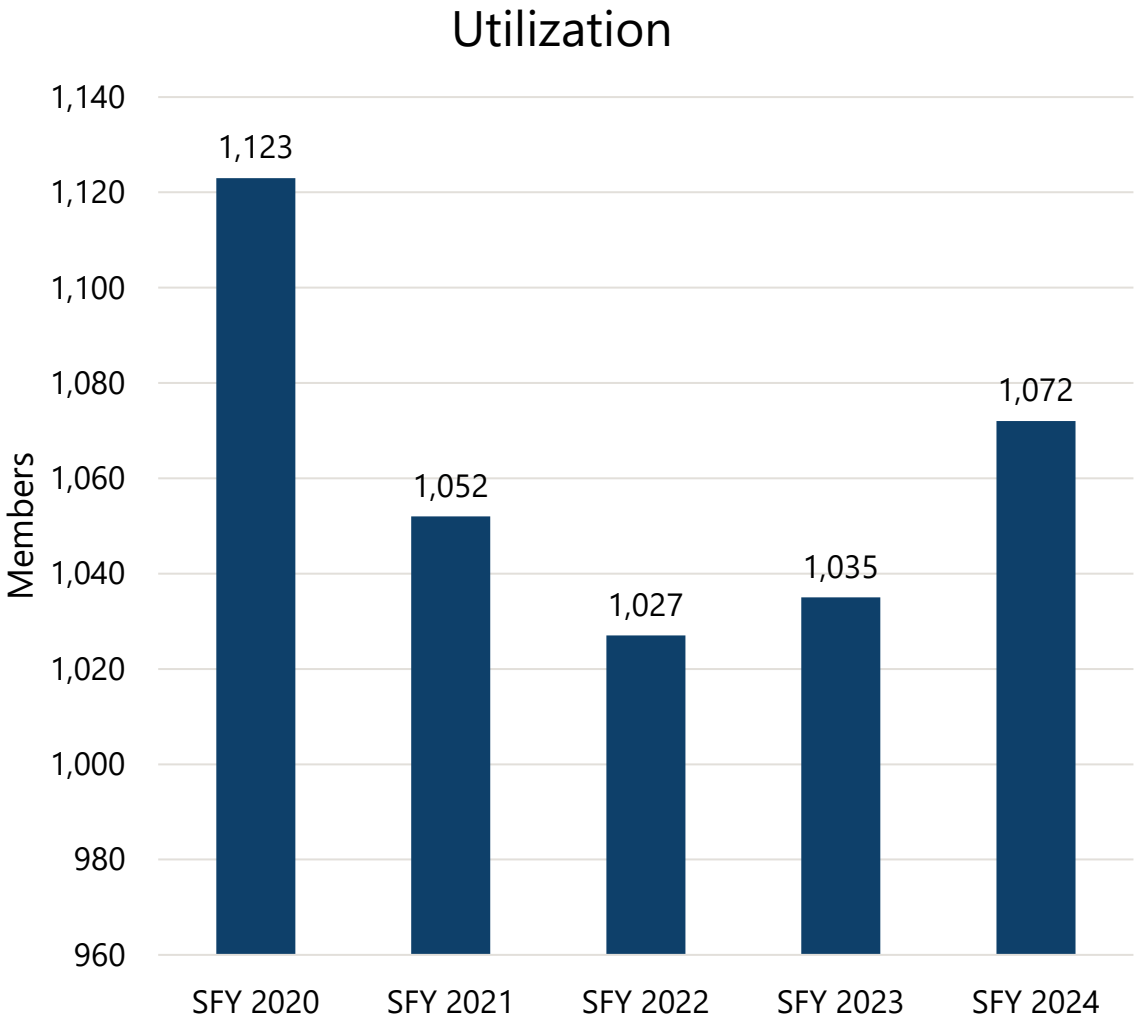
Included in Medical Services Budget

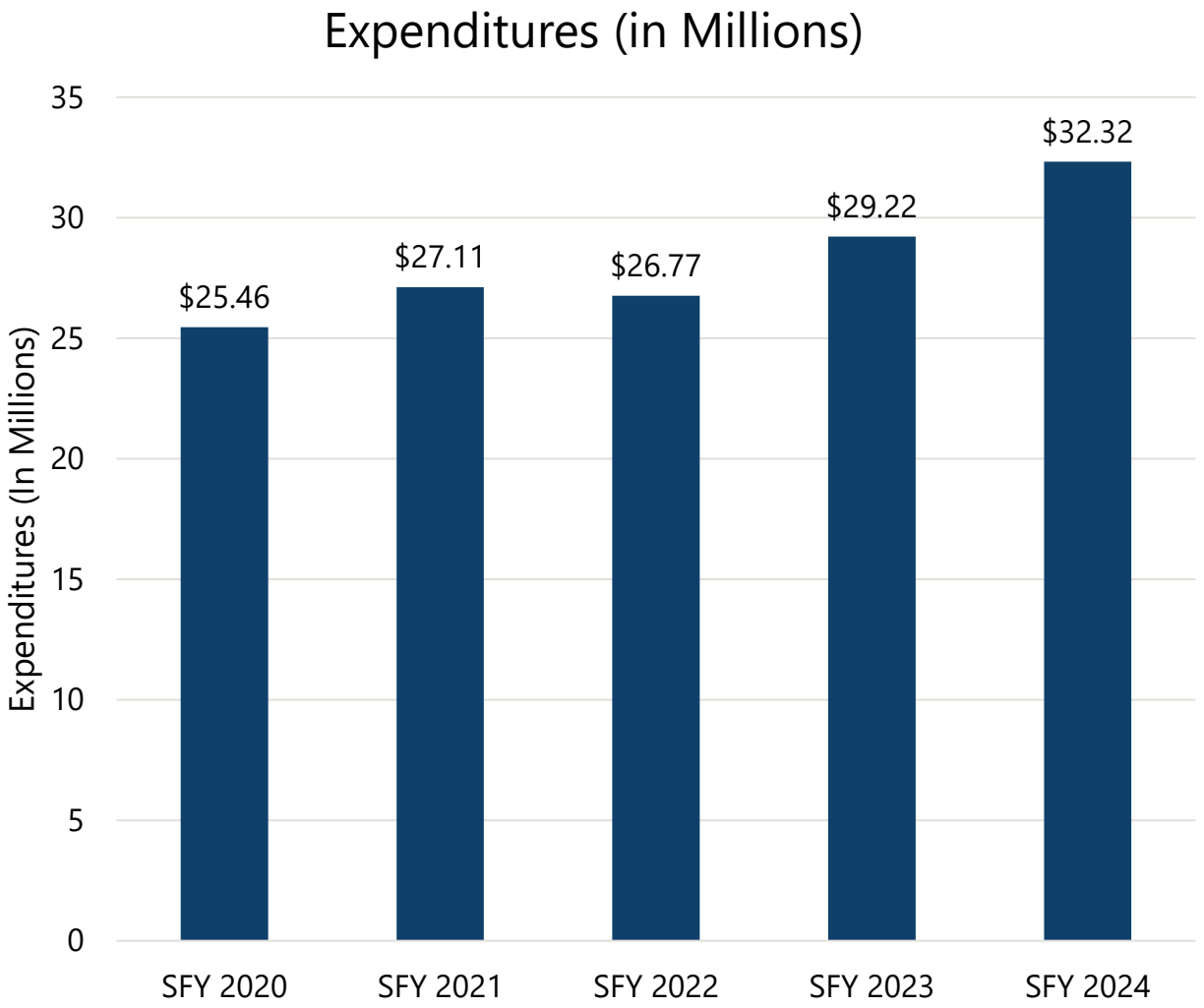
- Private Duty Nursing rates lag Home Health which may disincentivize agencies from serving patients with long term care needs.

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

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

Basic Care Utilization & Expenditures





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

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Basic Care, Assisted Living & Adult Residential Concerns

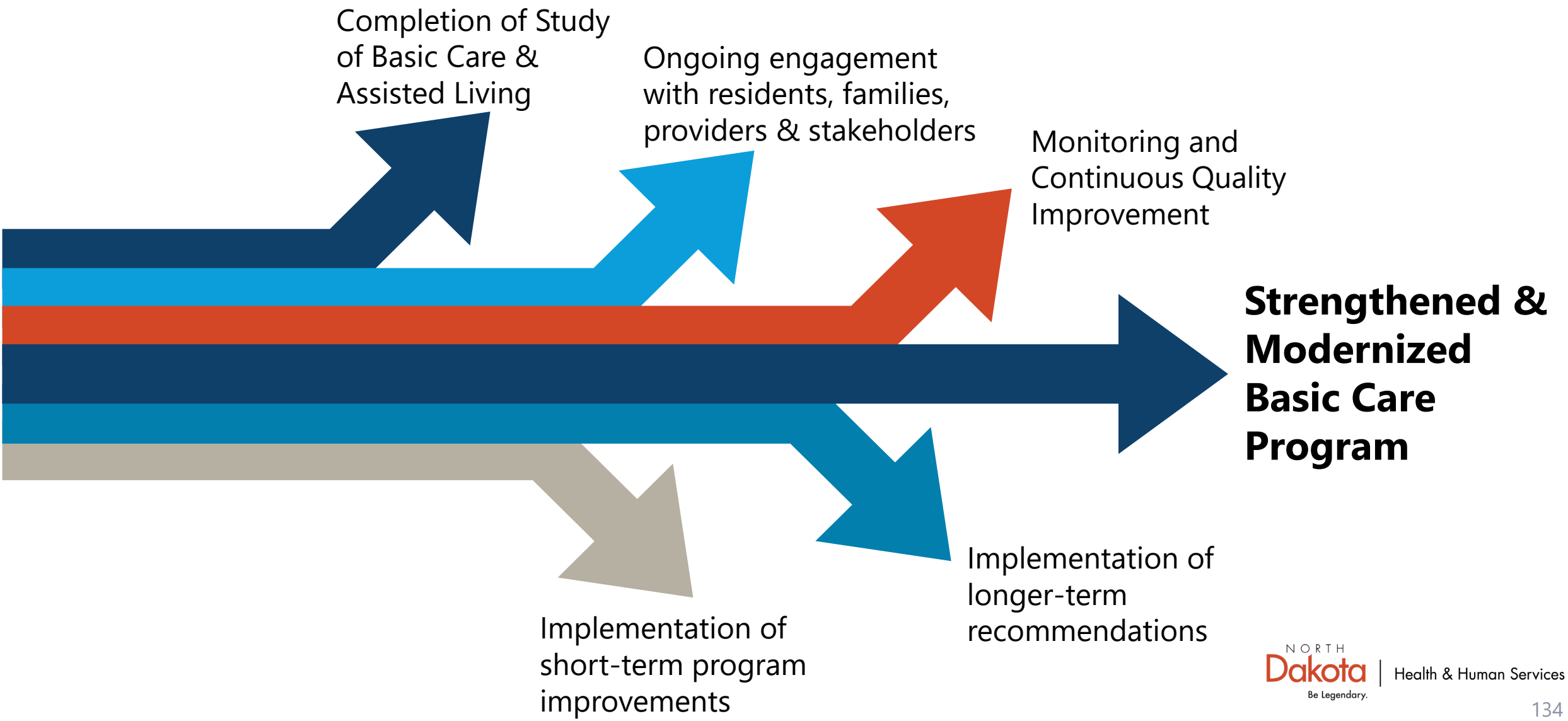
Top Health Response Section Concerns

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

Top Medical Services Division Concerns

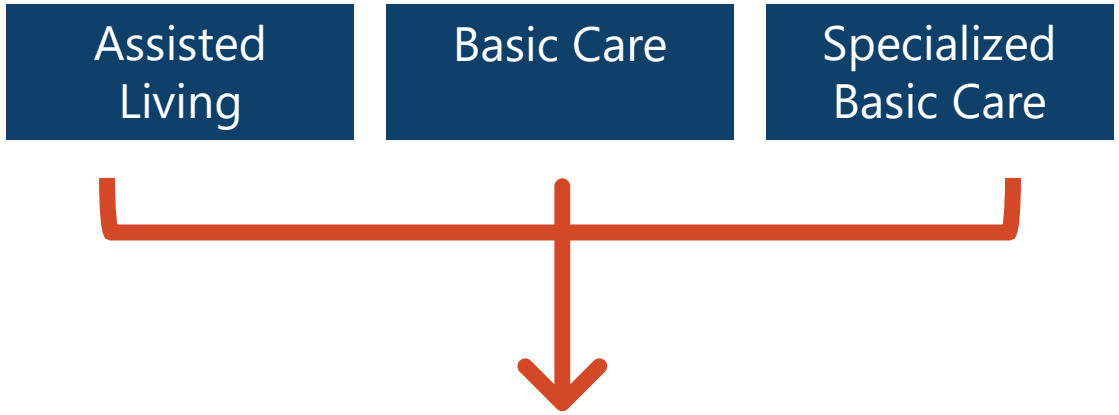
- Family Confusion
- Licensure Based on Payer Source
- Federal Funding Risk
- HCBS Settings Rule Compliance
- Department of Justice Risk

Basic Care Strategy



Basic Care Study Recommendations

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



New Streamlined Licensure

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

Basic Care Study Recommendations

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

New Streamlined Licensure

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

Person-Centered Sustainable
Funding Model
Incentivizing Continued Improvement & Innovation

Related Bill:
House Bill 1619 | Relating to a long-term care facility infrastructure loan fund

Provider Inflation
Ongoing

Governor's Recommendation:

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

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

Engrossed by House:

Total	**$7,211,726**
General	$4,402,892
Federal	$2,808,834

- SFY 2026: 2%
- SFY 2027: 2%

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

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

Inflation: Long Term Care

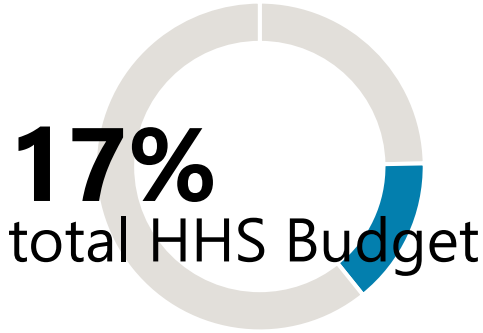
Inflator		Total	General	Federal
1%		**$3,593,922**	$2,194,151	$1,399,771
1.5%	Governor's Recommended Budget	**$5,396,854**	$3,294,874	$2,101,980
2%	Recommended by House	**$7,211,726**	$4,402,892	$2,808,834

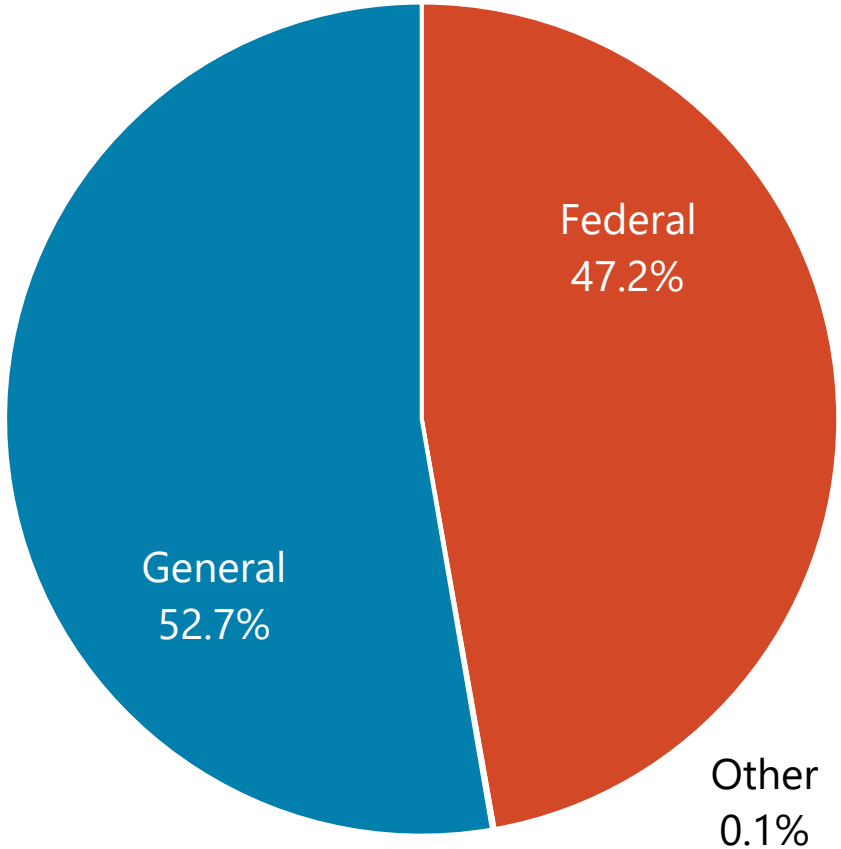
2025 – 2027 Budget & Other Resource Requirements

Long Term Care

Budget Overview

Long-Term Care: $1.07 Billion Total Budget





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Comparison of budget expenditures and projections
By Program

PROGRAMS	2023-25 LEGISLATIVE BASE	ONE-TIME/ CARRYOVER	2023-25 EXPENSES THROUGH DECEMBER	2023-25 PROJECTED EXPENDITURES	2025-27 EXECUTIVE BUDGET RECOMMENDATION	INCREASE / (DECREASE)	ENGROSSED HB 1012	GENERAL	FEDERAL	OTHER
NURSING FACILITIES	$ 734,744,666	$ -	$ 464,338,300	$ 681,054,722	$ 748,874,436	$ -	$ 748,874,436	$ 371,493,486	$ 377,380,950	$ -
AGED & DISABLED WAIVER	54,112,132	-	64,185,967	93,205,221	132,086,653	546,405	132,633,058	68,262,976	64,370,082	-
BASIC CARE	72,887,129	-	45,958,465	65,346,018	67,973,866	505,184	68,479,050	48,522,912	19,056,137	900,000
SPED	22,402,748	-	17,492,181	25,061,812	30,129,473	165,482	30,294,955	30,294,955	-	-
EXPANDED SPED	1,313,728	-	946,589	1,324,401	1,324,973	9,960	1,334,932	1,334,932	-	-
PERSONAL CARE SERVICES	33,664,038	-	29,309,396	43,331,650	56,779,642	311,152	57,090,795	28,335,617	28,755,177	-
TARGETED CASE MANAGEMENT	940,828	-	887,039	1,230,059	1,329,776	9,883	1,339,659	662,113	677,546	-
CHILDREN'S MED FRAGILE WAIVER	814,760	-	326,114	541,107	768,988	2,890	771,877	383,994	387,883	-
PACE PROGRAM	29,356,221	-	17,356,351	24,201,173	24,271,866	180,389	24,452,256	12,085,324	12,366,932	-
COMMUNITY OF CARE	330,000	-	85,115	85,115	330,000	-	330,000	330,000	-	-
PERSONAL NEEDS ALLOWANCE	193,200	-	279,192	279,192	376,800	-	376,800	376,800	-	-
CHILDREN'S HOSPICE WAIVER	76,950	-	-	19,507	79,644	544	80,188	39,725	40,462	-
AUTISM VOUCHER	300,000	-	77,292	77,292	-	-	-	-	-	-
AUTISM WAIVER	10,906,545	-	670,742	869,069	1,388,898	82,984	1,471,882	680,156	791,726	-
TOTAL	**$ 962,042,944**	**$ -**	**$ 641,912,745**	**$ 936,626,339**	**$ 1,065,715,015**	**$ 1,814,873**	**$ 1,067,529,887**	**$ 562,802,991**	**$ 503,826,896**	**$ 900,000**

Changes to Base Budget

By Ongoing, One-Time and Funding Source

BASE BUDGET CHANGES	DESCRIPTION	2025-27 EXECUTIVE BUDGET		ENGROSSED HB 1012	
		GENERAL	OTHER	GENERAL	OTHER
Services - Cost to Continue	Home & Community Based Services Growth	$ 36,977,113	$27,837,811 - Federal	$ 36,977,113	$27,837,811 - Federal
Services - DOJ	QSP/HCBS Targeted Rate Increase	$ 3,595,104	1,797,552 - Federal	$ 3,595,104	1,797,552 - Federal
Additional Executive Decision Packages	FMAP Reduction	$ 15,974,519	(18,516,068) - Federal	$ 15,974,519	(18,516,068) - Federal
Additional Executive Decision Packages	Provider Inflation (1.5%/1.5%) vs (2%/2%)	$ 3,294,874	2,101,980 - Federal	$ 4,369,070	2,842,652 - Federal

Comparison of Budgets and Funding

By Major Expense

DESCRIPTION	2023-25 LEGISLATIVE BASE	INCREASE / (DECREASE)	2025-27 EXECUTIVE BUDGET RECOMMENDATION	INCREASE / (DECREASE)	ENGROSSED HB 1012
Salaries & Benefits	$ -	$ -	$ -	$ -	$ -
Operating	-	-	-	-	-
IT Services	-	-	-	-	-
Capital Asset Expense	-	-	-	-	-
Capital Assets	-	-	-	-	-
Grants	962,042,944	103,672,071	1,065,715,015	1,814,872	1,067,529,887
Total	**$ 962,042,944**	**$ 103,672,071**	**$ 1,065,715,015**	**$ 1,814,872**	**$ 1,067,529,887**
General Fund	**$ 486,676,583**	**$ 75,052,209**	**$ 561,728,792**	**$ 1,074,199**	**$ 562,802,991**
Federal Funds	**474,554,361**	**28,531,862**	**503,086,223**	**740,673**	**503,826,896**
Other Funds	**812,000**	**88,000**	**900,000**	**-**	**900,000**
Total Funds	**$ 962,042,944**	**$ 103,672,071**	**$ 1,065,715,015**	**$ 1,814,872**	**$ 1,067,529,887**

How We Budget

Top Services: Long Term Care

North Dakota Department of Health and Human Services
Long Term Care
Unit and Cost Comparison
12 Month Average to Executive Budget Request (EBR) 2025 - 2027 Biennium

Program	12 Month Average in Units (April 2023 - March 2024)	Monthly average units for EBR 2025 - 2027	Change from EBR to 12 mo Avg units	12 Month Average in Cost per Unit (April 2023 - March 2024)	Monthly average cost per unit for EBR 2025 - 2027	Change from EBR to 12 mo Avg cost per unit	Monthly average units for first 14 months of 23-25	Monthly average unit cost for first 14 months of 23-25
NURSING HOME	79,579	80,277	698	$329.27	$389.73	$60.46	80,152	$346.12
BASIC CARE	46,805	46,705	(100)	$55.38	$59.30	$3.92	47,450	$57.38
HCBS WAIVER	92,903	90,204	(2,699)	$28.91	$60.26	$31.35	107,823	$31.52
PACE PYMT ALL-INCL CARE ELDRLY	187	186	(1)	$4,986.75	$5,317.08	$330.33	189	$5,149.43
SPED	87,052	82,104	(4,948)	$10.20	$15.04	$4.84	90,703	$10.89
EXPANDED SPED	4,735	4,663	(72)	$11.01	$11.57	$0.56	4,827	$11.34
PERSONAL CARE SERVICES	243,831	237,919	(5,912)	$6.73	$9.78	$3.05	239,780	$7.35
TARGETED CASE MANAGEMENT	2,618	2,590	(28)	$18.77	$20.92	$2.15	2,804	$19.16
CHILDREN'S MED FRAGILE WAIVER	42	42	0	$342.54	$754.36	$411.82	49	$374.90
CHILDREN'S HOSPICE WAIVER	0	1	1	$0.00	$3,251.15	$3,251.15	-	$0.00
AUTISM WAIVER	989	27,746	26,757	$19.09	$1.72	($17.37)	1,712	$18.72

Savings Plan
Long Term Care

DESCRIPTION OF SAVINGS	GENERAL FUND	FEDERAL FUND	OTHER FUND
Quality Incentive Pool Nursing Facilities - Correct Funding	(8,000,000)		
Quality Incentive Pool Nursing Facilities - Partial Withhold	(4,000,000)	4,000,000	

Grants on a Walkthrough

Recommendation to the Governor

DESCRIPTION	2025-27 BASE BUDGET	COST TO CONTINUE	FMAP	SAVINGS PLAN	REDUCTION	TOTAL CHANGES	TO GOVERNOR
NURSING FACILITIES	$ 734,744,666	$ 24,671,318	$ (2,541,549)	$ (8,000,000)	$ -	$ 14,129,769	$ 748,874,435
BASIC CARE	72,887,128	(6,415,521)	-	-	-	(6,415,521)	66,471,607
PACE PYMT ALL-INCL CARE ELDRLY	29,356,221	(5,620,775)	-	-	-	(5,620,775)	23,735,446
AGED & DISABLED WAIVER	54,112,132	19,524,971	-	-	-	19,524,971	73,637,103
SPED	22,402,748	(628,766)	-	-	-	(628,766)	21,773,982
EXPANDED SPED	1,313,728	(3,237)	-	-	-	(3,237)	1,310,491
PERSONAL CARE SERVICES	33,664,038	7,277,064	-	-	-	7,277,064	40,941,102
TARGETED CASE MANAGEMENT	940,828	359,560	-	-	-	359,560	1,300,388
CHILDREN'S MED FRAGILE WAIVER	814,760	(434,562)	-	-	-	(434,562)	380,198
CHILDREN'S HOSPICE WAIVER	76,950	(5,425)	-	-	-	(5,425)	71,525
AUTISM WAIVER	10,906,545	963	-	-	-	963	10,907,508
AUTISM VOUCHER	-	-	-	-	-	-	-
TOTAL FUNDS	**$ 961,219,744**	**$ 38,725,590**	**$ (2,541,549)**	**$ (8,000,000)**	**$ -**	**$ 28,184,041**	**$ 989,403,785**
GENERAL FUND	**$ 484,992,253**	**$ 28,188,132**	**$ 15,974,519**	**$ (12,000,000)**	**$ -**	**$ 32,162,651**	**$ 517,154,904**

Governor's Recommendation to the House

DESCRIPTION	TO GOVERNOR	INFLATION 1.5% / 1.5%	SERVICES - COST TO CONTINUE	SVC - DOJ	TOTAL CHANGES	TO HOUSE
NURSING FACILITIES	$ 748,874,435	$ -	$ -	$ -	$ -	$ 748,874,435
BASIC CARE	66,471,607	1,502,258	-	-	1,502,258	67,973,865
PACE PYMT ALL-INCL CARE ELDRLY	23,735,446	536,421	-	-	536,421	24,271,867
AGED & DISABLED WAIVER	73,637,103	1,624,836	51,432,058	5,392,656	58,449,550	132,086,653
SPED	21,773,982	492,092	7,863,400	-	8,355,492	30,129,474
EXPANDED SPED	1,310,491	29,617	(15,134)	-	14,483	1,324,974
PERSONAL CARE SERVICES	40,941,102	925,269	14,913,272	-	15,838,541	56,779,643
TARGETED CASE MANAGEMENT	1,300,388	29,389	-	-	29,389	1,329,777
CHILDREN'S MED FRAGILE WAIVER	380,198	8,592	380,198	-	388,790	768,988
CHILDREN'S HOSPICE WAIVER	71,525	1,616	6,502	-	8,118	79,643
AUTISM WAIVER	10,907,508	246,763	(9,765,372)	-	(9,518,609)	1,388,899
AUTISM VOUCHER	-	-	-	-	-	-
TOTAL FUNDS	**$ 989,403,785**	**$ 5,396,854**	**$ 64,814,924**	**$ 5,392,656**	**$ 75,604,434**	**$ 1,065,008,219**
GENERAL FUND	**$ 517,154,904**	**$ 3,294,874**	**$ 36,977,113**	**$ 3,595,104**	**$ 43,867,091**	**$ 561,021,995**

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Grants on a Walkthrough

Governor's Recommendation to the House

DESCRIPTION	TO GOVERNOR	INFLATION 1.5% / 1.5%	SERVICES - COST TO CONTINUE	SVC - DOJ	TOTAL CHANGES	TO HOUSE
NURSING FACILITIES	$ 748,874,435	$ -	$ -	$ -	$ -	$ 748,874,435
BASIC CARE	66,471,607	1,502,258	-	-	1,502,258	67,973,865
PACE PYMT ALL-INCL CARE ELDRLY	23,735,446	536,421	-	-	536,421	24,271,867
AGED & DISABLED WAIVER	73,637,103	1,624,836	51,432,058	5,392,656	58,449,550	132,086,653
SPED	21,773,982	492,092	7,863,400	-	8,355,492	30,129,474
EXPANDED SPED	1,310,491	29,617	(15,134)	-	14,483	1,324,974
PERSONAL CARE SERVICES	40,941,102	925,269	14,913,272	-	15,838,541	56,779,643
TARGETED CASE MANAGEMENT	1,300,388	29,389	-	-	29,389	1,329,777
CHILDREN'S MED FRAGILE WAIVER	380,198	8,592	380,198	-	388,790	768,988
CHILDREN'S HOSPICE WAIVER	71,525	1,616	6,502	-	8,118	79,643
AUTISM WAIVER	10,907,508	246,763	(9,765,372)	-	(9,518,609)	1,388,899
AUTISM VOUCHER	-	-	-	-	-	-
TOTAL FUNDS	**$ 989,403,785**	**$ 5,396,854**	**$ 64,814,924**	**$ 5,392,656**	**$ 75,604,434**	**$ 1,065,008,219**
GENERAL FUND	**$ 517,154,904**	**$ 3,294,874**	**$ 36,977,113**	**$ 3,595,104**	**$ 43,867,091**	**$ 561,021,995**

House Recommendation to the Senate

DESCRIPTION	INFLATION 2% / 2%	TOTAL CHANGES	TO SENATE
NURSING FACILITIES	$ -	$ -	$ 748,874,435
BASIC CARE	505,184	505,184	68,479,049
PACE PYMT ALL-INCL CARE ELDRLY	180,389	180,389	24,452,256
AGED & DISABLED WAIVER	546,405	546,405	132,633,058
SPED	165,481	165,481	30,294,955
EXPANDED SPED	9,958	9,958	1,334,932
PERSONAL CARE SERVICES	311,152	311,152	57,090,795
TARGETED CASE MANAGEMENT	9,882	9,882	1,339,659
CHILDREN'S MED FRAGILE WAIVER	2,889	2,889	771,877
CHILDREN'S HOSPICE WAIVER	544	544	80,187
AUTISM WAIVER	82,984	82,984	1,471,883
AUTISM VOUCHER	-	-	-
TOTAL FUNDS	**$ 1,814,868**	**$ 1,814,868**	**$ 1,066,823,087**
GENERAL FUND	**$ 1,074,196**	**$ 1,074,196**	**$ 562,096,191**

Legislative Bills with Potential Budget Impact

- HB 1067 – disregards survivor benefits and court ordered child support for children on a waiver and extends the Autism Spectrum Disorder waiver age to 21.
- HB 1485 – increases personal needs allowance by $10.
- SB 2190 – mandates coverage of ABA services adults with Autism.
- SB 2231 – adds dental services for Medicaid Expansion members.
- SB 2271 – revises adults residential rate methodology.
- SB 2305 – continues paid family caregiving pilot.
- SB 2399 – requires HHS to modify PRTF rate methodology

Take-Aways

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

Contact information

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