Medical Services Budget- House Bill 1012 Expansion

Senate Appropriations

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NORTH Dakota | Human Services

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Medicaid Expansion Eligibility for Adults

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

$17,609 per year

$36,156 per year

$14,000 per capita in health care benefits

Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Rates

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

Medicaid Expansion Population

No MCOs

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

1 MCO

- North Dakota 20,369

Only State with 1 MCO

2 MCOs

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

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

Comparison Medicaid Expansion 2019 Churn Numbers

Medicaid Expansion 2019 Churn

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

Medicaid Expansion Reimbursement Comparison Per Capita Costs Per State

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

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

Medicaid Expansion Reimbursement Comparison

Provider Reimbursement % of Medicaid

Actual % of Medicaid*

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

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

Medicaid Expansion Reimbursement Comparison

Medicaid FFS Physician Index

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

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

Medicaid Expansion: Transition from Managed Care to DHS Administration

Issue: Administration

Comparison Medicaid Expansion Financial Arrangement

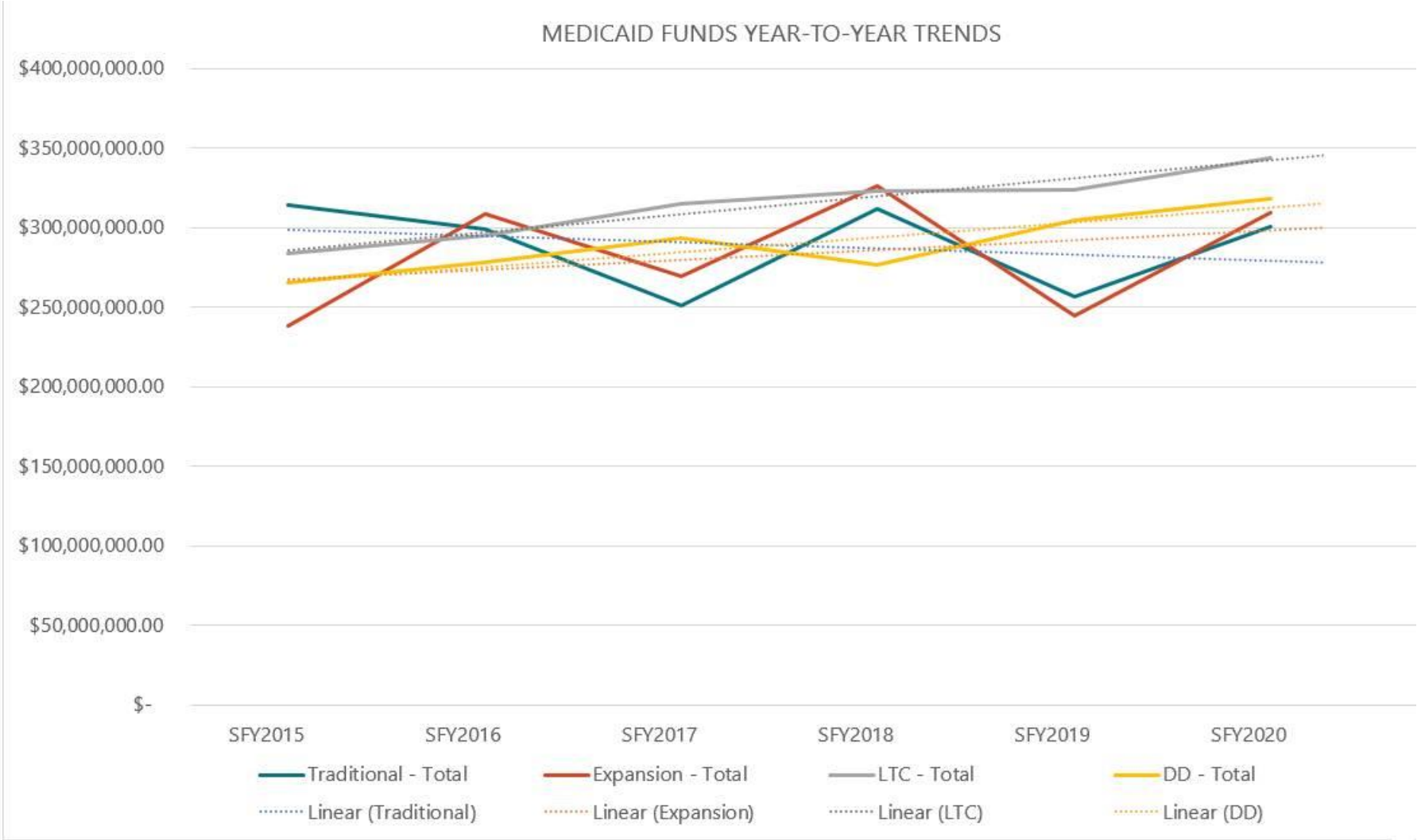
Why do State Medicaid Programs use MCOs?

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

Risk & Predictability

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

Comparing Has Medicaid Expansion Saved Money in North Dakota?



MEDICAL SERVICES
Medicaid Expansion Transition

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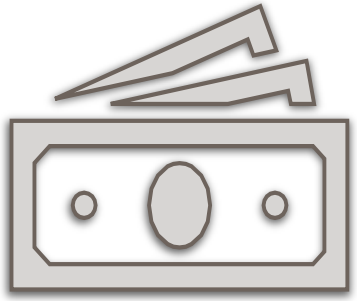
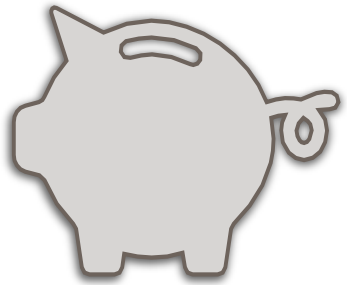
From MCO Administration to DHS In-House Administration

SAVINGS



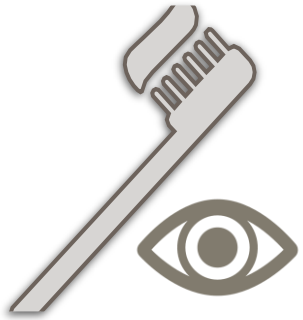
Transition from MCO to In-House Traditional (Grants)

$(11,017,190.00)



MCO Administrative PMPM Savings

$(1,573,182.00)



Addition of Dental and Vision Coverage

$1,169,714.00

DHS Administrative Expenses

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

$(10,749,572)

Medicaid Expansion: Transition from Managed Care to DHS Administration

Other Issues from Public Testimony

Proposed Solution
Health Homes

Transition from managed care to managed fee-for-service

- requires a more robust management program than current PCCM program

DHS brought in presenters from

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

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

Feedback from North Dakota Medicaid Stakeholders

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

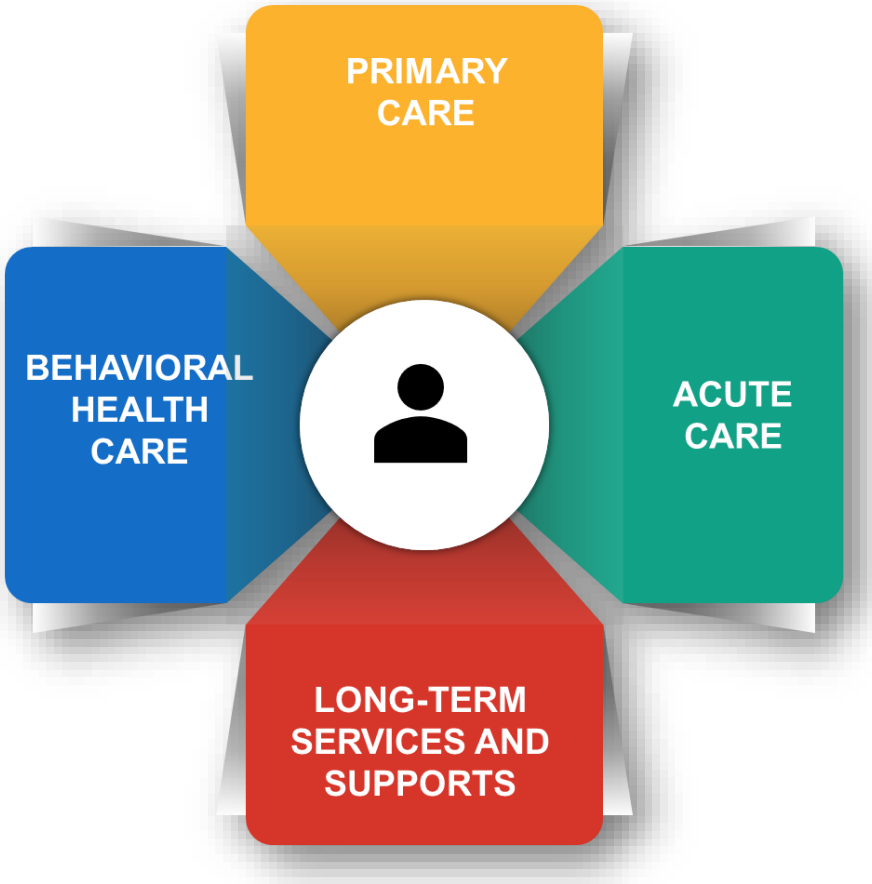
2021-2023 Executive Request

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

Proposed Solution
Health Homes

Medicaid Health Homes

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



Prior Testimony
Critical Access Hospital Impact

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

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

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

Prior Testimony Critical Access Hospital Impact

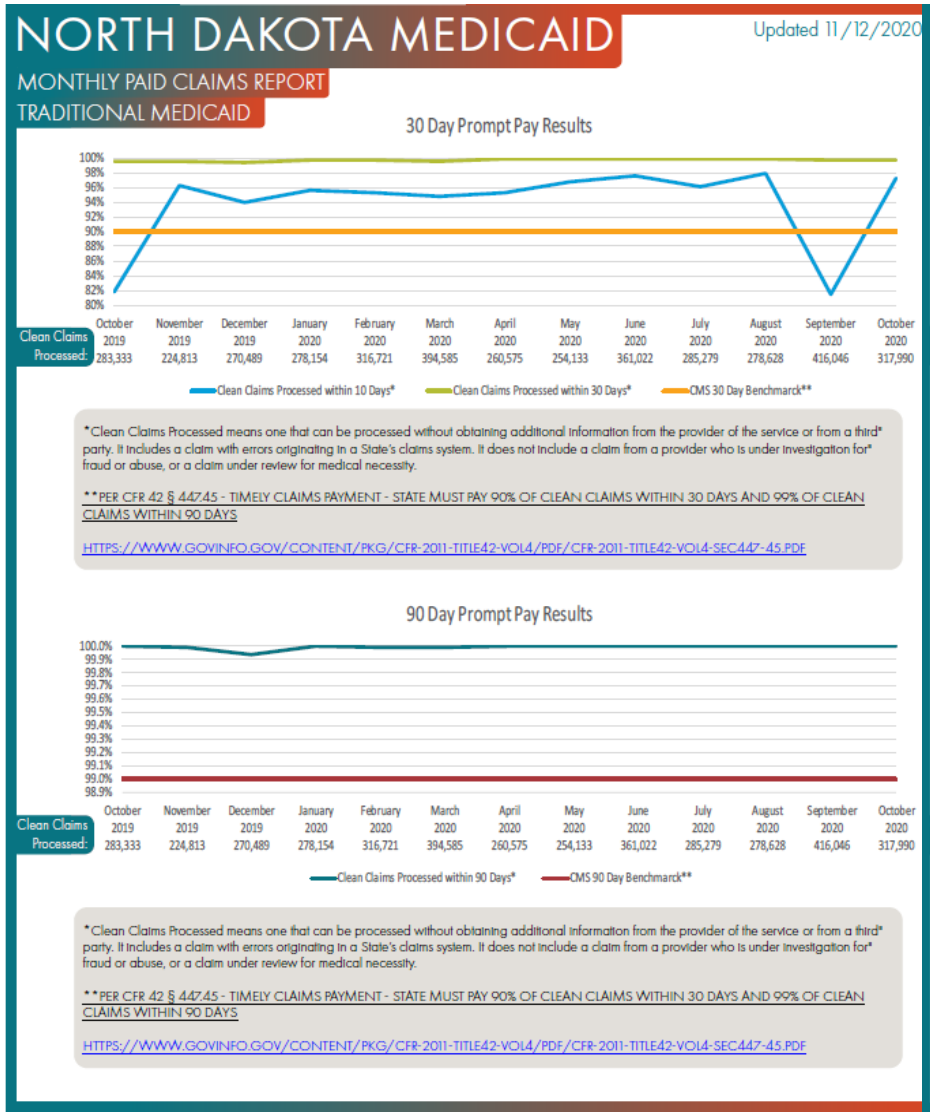
Prior testimony implied that critical access hospitals would close

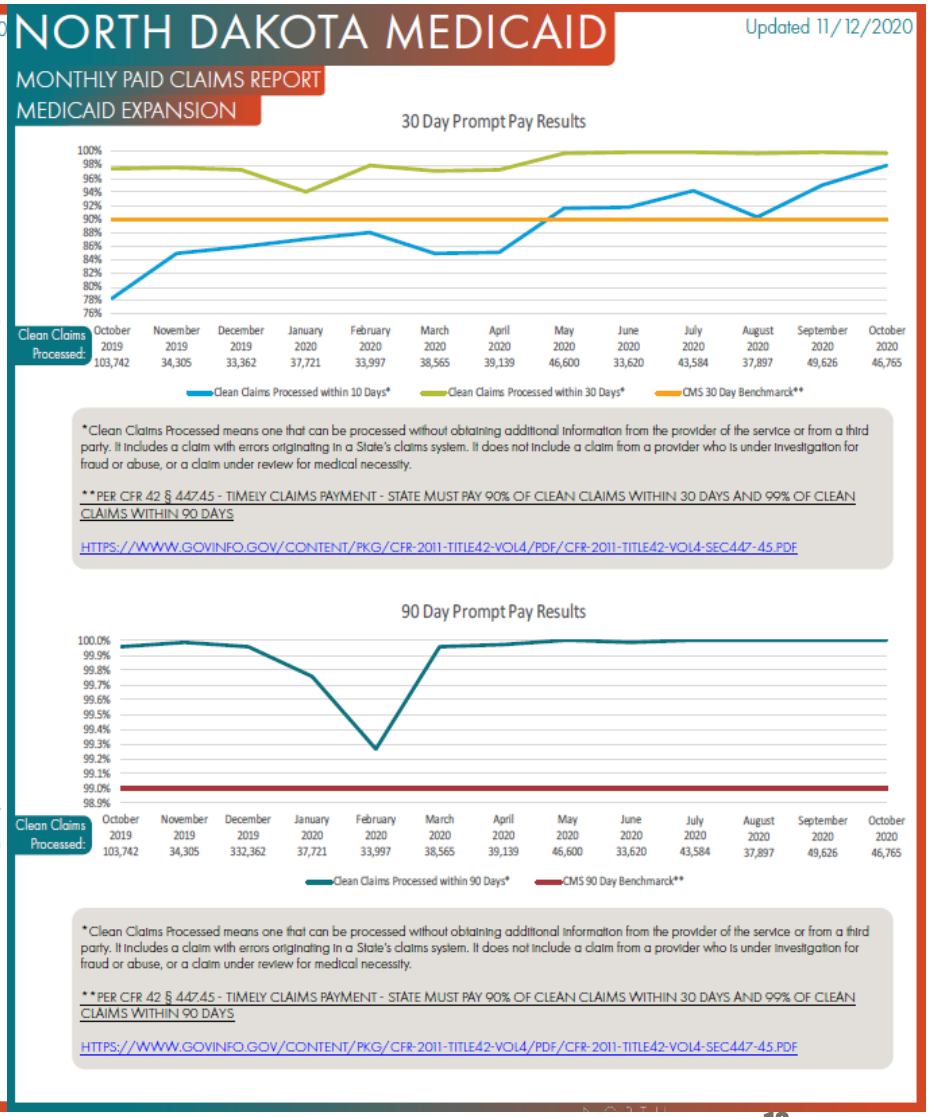
- **DOH record on hospital closures-**
  - **Dakota Heartland Health System**, Fargo closed in 2002 (PPS)
  - **Richardton Memorial Hospital and Health Center**, Richardton closed in 2009 (CAH)
  - **Red River Behavior Health Systems**, Grand Forks closed in Sept 2020 (Psych)
  - **Altru Rehabilitation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

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

Prior Testimony
Claims Payment Turn Around

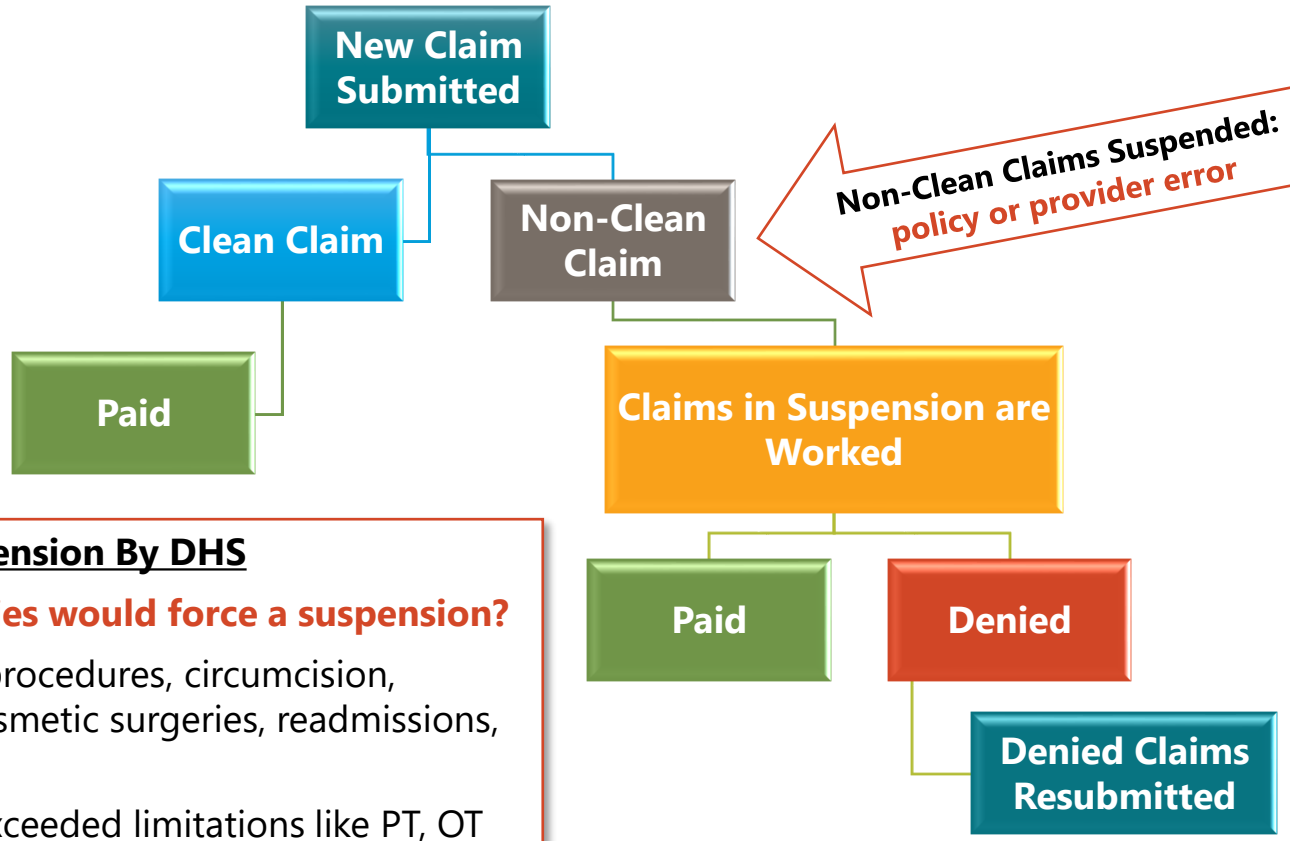
Clean Claim payment turnaround times between ND Traditional FFS Medicaid and MCO Medicaid Expansion





Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

What Medicaid policies would force a suspension?

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

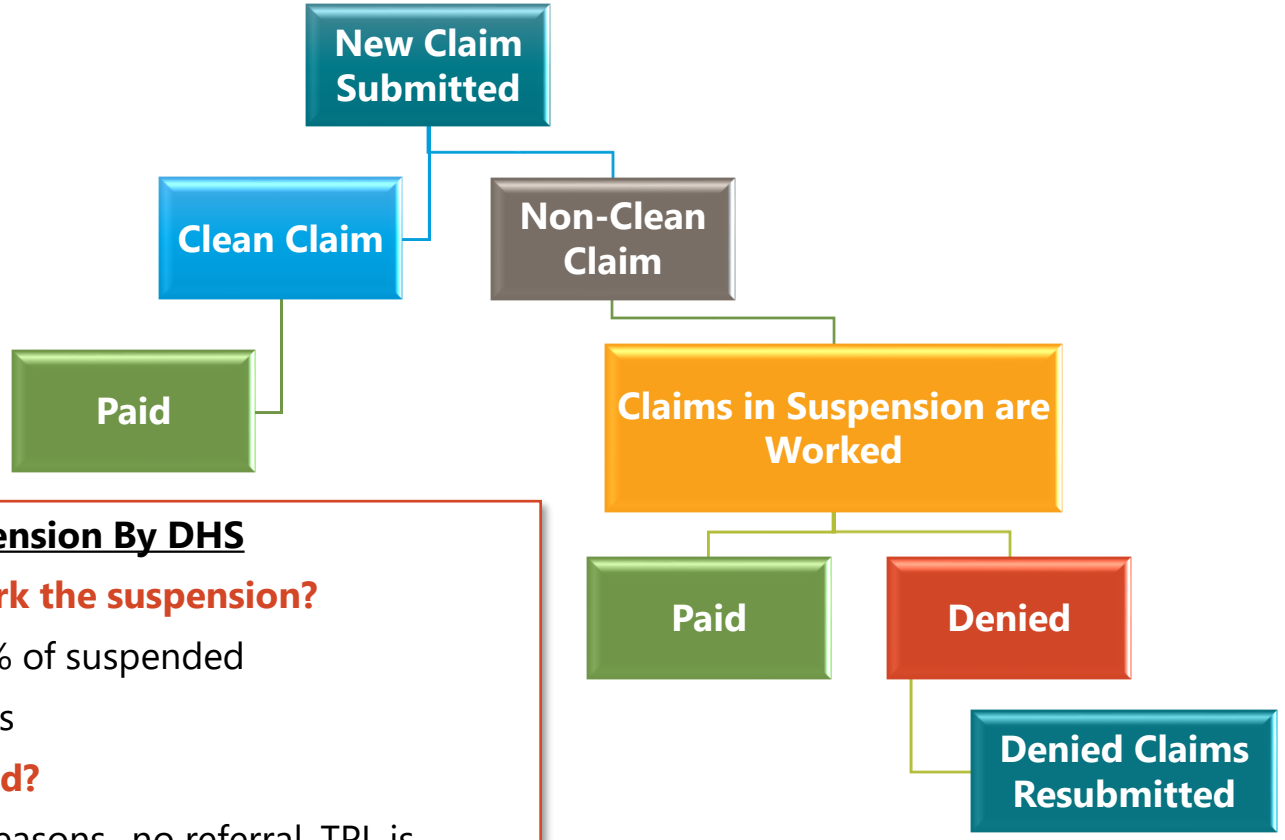
Prior Testimony Claims Payment Turn Around

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

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

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Suspension By DHS

How long to take work the suspension?

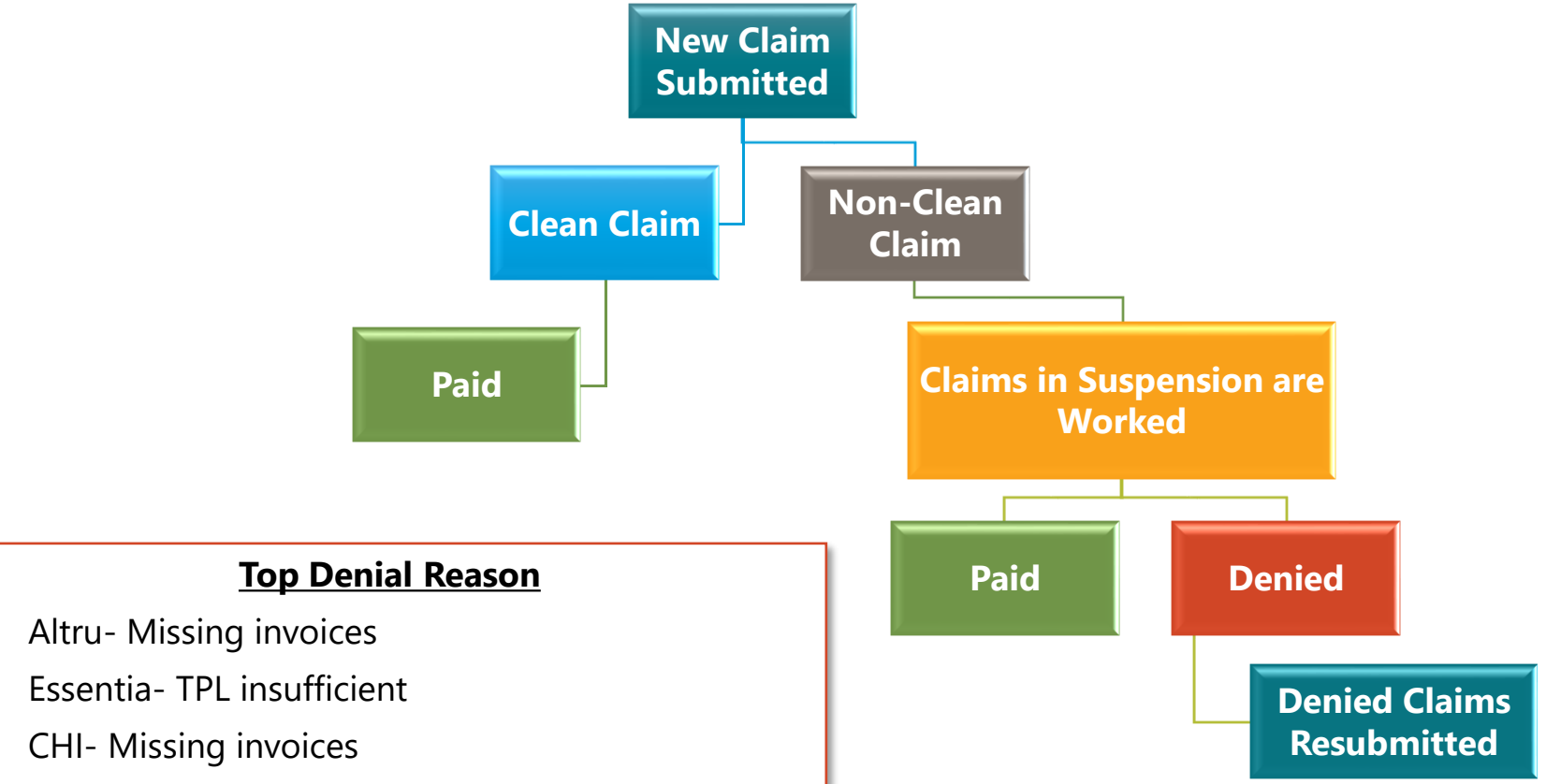
- Within 10 days 54% of suspended
- 84% within 30 days

Why are claims denied?

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

Prior Testimony Claims Payment Turn Around

Lifecycle of a Claim



Top Denial Reason

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

Prior Testimony
ND Medicaid Savings

RX Carve Out Savings

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

Expected Total Savings

- Claims = $3.018 million (> $2.1 million projected in 2019 session)
- IHS = $7.2 million **(*New savings)**
- Premiums = $3.4 million **(*New savings)**
- Admin = $3.441 million (< $3.991 million projected in 2019 session due to HIPF going away in 2021)

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

Prior Testimony ND Medicaid Savings

CHIP Savings (1Q20-3Q20)

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

Prior Testimony Commercial Premiums

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

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

The answer was NO

Literature cited:

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

Historical studies and articles:

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

Prior Testimony Not Taking Advantage of Federal Funds

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

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

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

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

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

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

Prior Testimony Not Taking Advantage of Federal Funds

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

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

100% General Fund or 50%/50%	90%/10%
Autism Voucher, Basic Care, AARP, Valley Senior Services, Alzheimer's Association, Independence Inc., Poppy's Promise, Red River Human Services Foundation, Enable Inc., Family Voices of ND, Mental Health America ND, Dacotah Foundation, Beyond Shelter, Cooper House, Edwin House, LaGrave on First, ShareHouse, Prairie St. John's, Northland PACE, ND Brain Injury Network, ND Brain Injury Advisory Council, ARC of ND, Nexus-PATH, Prairie Harvest Mental Health, Grand Forks Growth and Support, Development Homes, Poppy's Promise, Vocational Training Center, Designer Genes, Catholic Charities, Protection and Advocacy, ARC of North Dakota, HCBS, Nursing Homes, Dental, Vision, Pediatrics	Expansion

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

ND Medicaid
The Future

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

Thank you!

North Dakota Medicaid

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