

**Department of Human Services
Health Care Reform Review Committee
Representative George Keiser, Chairman
March 19, 2014**

Chairman Keiser, members of the Health Care Reform Review Committee, I am Julie Schwab, Director of Medical Services for the Department of Human Services (Department). I appear before you to provide an update on the implementation of the Medicaid Expansion. I will provide updates on enrollment, coverage, and network information. Maggie Anderson will provide an update on the risk sharing arrangement that is part of the Medicaid Expansion contract.

MEDICAID EXPANSION

Enrollment

For the first three months of 2014, the enrollments for the expansion were: January approximately 1,700 individuals, February approximately 3,109 individuals, and March approximately 5,080 individuals. The data for March shows that most enrollees are childless adults (there are some adults with dependent children), slightly over half of the expansion enrollees are female (53%), a little more than half (57%) are ages 19-44 and the majority (64%) are rural (urban covering only Burleigh and Cass counties). These trends have remained stable all three months.

Enrollment has continued to grow steadily.

The Department has also received applications that were assessed as eligible for "traditional" Medicaid via the Federal Marketplace. This is likely due to the "woodwork" effect where individuals who were previously eligible, but had not applied for Medicaid coverage, discovered by

applying at the marketplace that they were assessed as eligible for Medicaid (non-expansion).

Coverage under the Expansion with Sanford Health Plan

The Department, when it released the request for proposal in August for coverage of the Medicaid Expansion population, chose the Sanford Health Plan and added the Essential Health Benefits, and any required Medicaid services (such as non-emergency medical transportation). The coverage also complies with the Mental Health Parity and Addiction Equity Act.

Following is a comparison of coverage, showing how Medicaid Expansion differs from traditional Medicaid.

Traditional Medicaid

- Coverage provided by State.
- Must qualify for coverage groups (children, older/blind, etc.) and meet income criteria.
- Some coverage groups must meet asset limits.
- Applicants with significant assets may not qualify despite having low incomes.

Medicaid Expansion

- Coverage provided by managed care organization (private insurance company).
- Eligibility is based on household's Modified Adjusted Gross Income (up to 138% FPL).
- No asset criteria.
- Benefit plan differs from Traditional Medicaid. (Attachment A)

Sanford Health Plan reports to the Department weekly on the calls coming into the plan's call center. The calls are centered around coverage and benefits. To date, we have not had a complaint regarding coverage issues brought forward.

Medically Frail

According to final rules issued by CMS on July 15, 2013, individuals who are determined to be medically frail cannot be required to enroll in an Alternative Benefit Plan that does not contain all of the services available under the State's Medicaid Program. The Department has received medically frail questionnaires from recipients who think they may qualify as medically frail. To date, three of eighteen recipients have qualified and all chose traditional Medicaid rather than the Sanford Health Plan. All three individuals required long-term care services, which aside from temporary stays, are not covered benefits under the expansion.

Access and Network Considerations

Access

Sanford Health Plan continues to work on finalizing contract negotiations with a number of providers. Services are covered at billed charges for the access radius of 50 miles if there is no in-network provider available.

The access standards require that the Sanford Health Plan's (the plan) network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. The plan must also ensure that services are available 24 hours a day, seven days a week, when medically necessary.

Medicaid Expansion enrollees are to have wait times no greater than non-Medicaid enrollees.

The networks must be comprised of hospitals, providers and specialists in sufficient numbers to make available all covered services in a timely manner in accordance with medically appropriate guidelines and consistent with generally accepted practice parameters.

An adequate network would normally be considered to have access to primary care services that are generally no more than 30 miles in the urban areas, 60 miles in rural areas, and 100 miles in frontier areas from the enrollee's residence.

The plan must ensure that female enrollees have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative healthcare services.

The plan must require that the entity's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

The plan must implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the enrollee. The plan must inform network providers that the plan and network providers are subject to annual, external independent reviews of the quality outcomes, timeliness of, and access to the services covered under this plan.

Network

The access standards as required in the Request for Proposal are being met.

Sanford Health Plan has been working with the Public Health Units to establish in-network provider contracts. The following units have enrolled as in-network providers:

- Central Valley Health District (Stutsman & Logan)
- Custer Health (Morton & Logan)
- Dickey County Health District
- Fargo Cass Public Health
- LaMoure County Health Department
- Ransom County Public Health
- Walsh County Health District

Sanford Health Plan is establishing contracts with the eight Regional Human Service Centers and is in the process of credentialing the providers within the Human Service Centers.

Risk Sharing

Please refer to Attachment B and Maggie Anderson will address this document.

This concludes my testimony and I would address any questions that you may have.

**North Dakota Department of Human Services
Medicaid Expansion
Health Care Reform Review Committee
March 19, 2014**

Service	Traditional Medicaid	Medicaid Expansion
Inpatient Hospital	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Outpatient Hospital	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Lab X-Ray	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Nursing Facility Services for those age 21 and older	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Limited-up to 30 days
EPSDT for under age 21	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Family Planning Services and Supplies	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Physician Services	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Nurse Mid-Wife Services	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pregnancy-Related Services and services for other conditions that might complicate pregnancy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
60 Days Post-Partum Pregnancy Related Services	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Home Health Services(Nursing), including Durable Medical Equipment and Supplies	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Medical and Surgical Services of a Dentist	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Limited
Emergency Medical Transportation	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Dental	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Limited – for those 19 & 20 years old
Optical	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Limited – for those 19 & 20 years old
Non-Emergency Medical Transportation	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacy	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Indian Health Services	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

**North Dakota Department of Human Services
Medicaid Expansion
Overview of Risk Sharing Arrangement
Health Care Reform Review Committee
March 19, 2014**

From August 5, 2013 Request for Proposal:

J. Financial Considerations/Per Member Payment/Risk Sharing

Offerors are encouraged to thoroughly review Subpart J (Finance and Payment) of Attachment B (*CMS Checklist for Managed Care Contract Approval*). The Checklist is an internal document used by the Centers for Medicare and Medicaid Services in reviewing contracts between state Medicaid programs and Managed Care Organizations. The Checklist is dated 2003 and remains in “draft”; however, STATE is providing the Checklist to offer guidance. Offerors are encouraged to thoroughly review the Checklist as applicable provisions of the Checklist will be included in the contract(s) that result from this RFP. If an Offeror has objections to any requirement in the Checklist, they must raise the objection by the date noted in Section 1.03 RFP Schedule. Offerors are also cautioned that the Checklist does not contain all requirements that may have been enacted since the Checklist was issued as draft in 2003. **It is important for offerors to note that the eventual contract(s) must comply with all applicable federal and state requirements outlined in law, statute, regulation, and policy.**

A successful offeror must allow STATE and/or the United States Department of Health and Human Services to inspect and audit any financial records, including records of its subcontractors.

Offerors must submit a cost proposal for the fixed monthly per member payment in calendar year 2014. Bids are required for both urban and rural regions. (**Exception:** An offeror submitting a coverage proposal for Burleigh and Cass counties only (Metropolitan Statistical Areas) are not required to submit a rural Price Bid). STATE will establish a confidential rate range for both rural and urban areas prior to submission of the bids.

Each rating cohort within each region has its own actuarially sound rate range and, therefore, each rate must fall within the range specific to the cohort. To the extent that the proposed rate at the region/cohort level falls outside of the actuarially sound rate range, STATE and STATE-contracted actuaries will review the assumptions supplied in the Cost Proposal and will have further discussions with all the offerors at the same time. After the discussions, the offerors will be allowed to submit a revised Cost Proposal based on the guidance provided by STATE and STATE-contracted actuaries. If that proposed rate still results in a proposed rate that is below the lower bound, the proposed rate will be reset to the lower bound of the rate range developed by STATE-contracted actuary. Alternatively, if the cost proposal contains a proposed

rate that is above the upper bound of the rate range developed by STATE-contracted actuary, the proposed rate will be reset to the midpoint, which is defined as the average of the upper and lower bounds of the rate range developed by STATE-contracted actuary.

Once the rates are either accepted or reset as described above, the offeror's cost proposal will be scored accordingly.

The capitation (rates) paid to the Successful Offeror(s) must be certified by a qualified actuary who is a member of the American Academy of Actuaries. This is a requirement of the Centers for Medicare and Medicaid (CMS).

STATE may, at its option, utilize plan claims experience data in the bid for 2015, 2016, and 2017, or may subsequently require a new per member per month bid for those years.

Because STATE recognizes the uncertainty of the number of covered lives and the healthcare services to be used by the Medicaid expansion population, STATE will employ a risk corridor mechanism to adjust the final payments to the successful offeror(s). Due to the unknown characteristics of underlying acuity of the expansion population, the risk corridor will protect both the successful offeror(s) as well as STATE. The successful offeror(s) and STATE will share the financial risk both in terms of any potential losses or gains for medical expenditures for Calendar Year 2014 based on a calculation of the Adjusted Medical Expenditures for all enrollees.

Adjusted Medical Expenditures shall be determined by STATE and STATE-contracted actuary based on Encounter Data and plan financial data submitted by the successful offeror(s) pursuant to the requirements of MCO Reporting Template (MRT), located in the Quality, Reports, Encounter Data, External Quality Review and Sanction 'Reports' section below. Adjusted Medical Expenditures excludes Non-State Plan services.

STATE reserves the right to audit medical expenditures. The data used by STATE and STATE-contracted actuary for the reconciliation will be the routine Encounter Data. STATE and the successful offeror(s) agree that, to the extent there are differences between medical expenditures as reflected in the encounter data and the financial data submitted by the successful offeror(s), STATE and the successful offeror(s) will confer and make a good faith effort to reconcile those differences before the calculation of the Final Settlement as described below in Risk Sharing Final Settlement.

The risk sharing procedures may include a review of the successful offeror(s) Routine Encounter Data and an audit, to be performed by STATE or its authorized agent, to verify that all paid claims for the Enrollee by the successful offeror(s) are reimbursed in amounts that do not exceed the amounts allowed in the Medicaid fee schedule.

The administrative percentage is multiplied by the adjusted medical expenditure. The administrative percentage will be consistent with the percentage used for setting the Total Capitation Rates for the Calendar Year 2014 period.

Risk Sharing Final Settlement

STATE shall perform a settlement of the payments made by the successful offeror(s) to STATE or by STATE to the successful offeror(s). The settlement is the calculated gain or loss determined as the Total Capitation Rates paid to the successful offeror(s) less the Total Adjusted Expenditures (sum of the Adjusted Medical Expenditure plus the administrative amount). This amount is subjected to the risk-sharing corridor to determine the final settlement amount.

Within 180 days following the end of the Calendar Year 2014, the successful offeror(s) shall provide STATE with a complete and accurate report of Actual Medical Expenditures, by category of service, for enrollees, based on claims incurred for Calendar Year 2014 including 5 months of claims run-out, and its best estimate of any claims incurred but not reported (IBNR) for Claims run-out beyond 5 months, and any applicable IBNR completion factor. The report will be a detailed claim-level record.

Prior to 10 months following Calendar Year 2014, STATE shall provide the successful offeror(s) with a final reconciliation under the risk share program for Calendar Year 2014. Any balance due between STATE and the successful offeror(s), as the case may be, will be paid within 60 days of receiving the final reconciliation from STATE.

In the event the successful offeror(s) may require risk mitigation efforts before the end of Calendar Year 2014, STATE may consider interim financial arrangements to ensure solvency and continued successful operation of the successful offeror(s).

From Attachment F of the Contract between Sanford Health Plan and the Department:

The Risk Corridor Percentage is calculated as a blended statewide figure for total Adjusted Medical Expenditures divided by one (1) minus _____ percent for the MCO to cover administrative costs, divided by the Total Capitation Rate, for the Contract Year 2014 period.

The Risk Sharing Corridor Percentage is calculated as follows:

$$\text{(Adjusted Medical Expenditures)/(1-Administrative Percentage)} / \text{(Total Capitation Rate)}$$

The Risk Corridor Percentage calculation begins at 100% and move either up or down until it reaches the Risk Corridor Percentage.

The Risk Sharing Corridor is defined as follows:

Risk Corridor Minimum Percentage		Actual Risk Corridor Percentage		Risk Corridor Maximum Percentage	MCO share	State/Federal Share
	<		<	__%	__	__%
__%	≤		<	__%	__%	__%
__%	≤		<	__%	__%	__%
__%	≤		<	__%	__%	__%
__%	≥			-	__%	__%

Note: Certain information has been redacted as it is proprietary to the Sanford Health Plan and confidential under North Dakota Century Code section 44-04-18.4.