APPENDIX C

Health Care Reform Review Committee - May 2016

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Medicaid Expansion Enrollment Information

As of March 31, 2016 - 19, 389 Individuals Enrolled	
55% Female	45% Male
77% Childless Adults	23% Adult with Children
57% Rural Residence	43% Urban Residence

49% Age 19 to 35		18% Age 36 to 44		33% Age 45 to 64	
57% Female	43% Male	56% Female	44% Male	52% Female	48% Male
72% Childless	28% Children	64% Childless	36% Children	90% Childless	10% Children
53% Rural	47% Urban	58% Rural	42% Urban	63% Rural	37% Urban

Medicaid Expansion Background

- The Affordable Care Act (ACA) as enacted included a mandate, effective January 1, 2014, to expand the Medicaid program to cover all individuals under the age of 65 (including "childless adults") with incomes below 138 percent of the federal poverty level (133 percent plus a 5 percent income disregard).
- On June 28, 2012, the United States Supreme Court upheld the 2014 Medicaid expansion; however, they **struck down the mandate** indicating that the federal government could not withhold all federal Medicaid funding if a state chooses to not expand Medicaid. Therefore, the decision about whether to expand the Medicaid program was **left to each state**.

Medicaid Expansion Background

- The 2013 Legislative Assembly authorized implementation of Medicaid Expansion, via House Bill 1362.
- 2013 House Bill 1362 called for the coverage to be provided by a private carrier or through the federal marketplace:
- Subsection 2 of Section 1 of 2013 HB 1362: "The department of human services shall inform new enrollees in the medical assistance program that benefits may be reduced or eliminated if federal participation decreases or is eliminated. The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange."
- 2013 House Bill 1362 includes a sunset for the Medicaid Expansion:
- **SECTION 5. EXPIRATION DATE.** Section 1 of this Act is effective through July 31, 2017, and after that date is ineffective.

Medicaid Expansion Background

- The Department issued a request for proposal in August 2013 and on December 31, 2013 the Department contracted with Sanford Health Plan for coverage of individuals eligible under Medicaid Expansion.
- Medicaid Expansion coverage started in North Dakota on January 1, 2014
- The Department of Human Services estimated that up to **20,500** individuals would be eligible for coverage under Medicaid Expansion. As of March 31, 2016, **19,389** individuals were eligible for Medicaid Expansion (For reference: 68,287 individuals were eligible for traditional Medicaid).

Medicaid Expansion Background

- The Affordable Care Act (ACA) requires that eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP) follow modified adjusted gross income (MAGI) methodologies beginning January 1, 2014. North Dakota previously used net income for Medicaid and CHIP eligibility determinations. The ACA requires that MAGI methodologies no longer allow for disregards or deductions from income. Instead, the MAGI methodologies require an income limit that, at a minimum, is a gross income equivalent to the net income limit.

Medicaid Expansion Background

- FOR MEDICAID EXPANSION –
- FEDERAL FUNDING for "TRULY NEWLY"

Calendar Year	FMAP
2014	100 Percent
2015	100 Percent
2016	100 Percent
2017	95 Percent
2018	94 Percent
2019	93 Percent
2020 →	90 Percent

- FMAP is Federal Medical Assistance Percentage

Contract Information

- The contract with Sanford Health Plan for Medicaid Expansion is renewed annually. The contract period is each Calendar Year.
- The 2013 Request for Proposal included six renewal options and one twelve-month extension option.
- If Sanford Health Plan wants to terminate the contract without cause, they must provide a minimum of 90 days notice to the Department.
- If the Department terminates the contract without cause, we must provide a minimum of 60 days notice to Sanford Health Plan (SHP).

Current Efforts – Medicaid Expansion

- As a result of the allotment, the Department is working with SHP to:
  - Increase the revenue provided to the Human Service Centers through Medicaid Expansion.
  - Analyze reductions to fee schedule used by SHP to pay providers who render services to the Medicaid Expansion population.
  - Analyze the impact of re-contracting efforts completed by SHP.

Current Efforts – Medicaid Expansion

- CONTINUED: As a result of the allotment, the Department is working with SHP to:
- Decrease the cost of 19/20 year olds who are enrolled in the Medicaid managed care program. (Many in this group are matched at 50/50 (previously eligible), and have low health care costs. Paying a monthly premium vs. paying for actual medical expenses.)
- BACKGROUND:
  - Effective January 1, 2014 with the Implementation of the Patient Protection and Affordable Care Act (ACA) the definition of a child changed FROM an individual under age 21 (or under age 18 if the child is disabled) TO 'individual under age 19'. Based on this, North Dakota must cover 19 and 20 year olds under the new adult group.
  - The 'new adult' group created as a result of the ACA is defined as 'age 19 or older and under age 65'. The 100%* FMAP is only available for 'newly eligible' individuals defined as 'an individual who, on the date of enactment of the ACA, is not eligible under the State plan.'
  - Prior to January 1, 2014, the North Dakota Medicaid State Plan included coverage for children age 19 and 20 with MAGI converted income at or below 90% of the Federal Poverty Level (FPL). The 100%* FMAP for 19 and 20 year olds is only available for those who have MAGI converted income above 90% of the FPL. For 19 and 20 year olds who have MAGI converted income below 90% of the FPL, since we covered them under the State Plan at the time ACA was implemented, we only receive 50% FMAP.
- SOLUTION:
  - The Department's actuary is finalizing the analysis to move this population under traditional Medicaid. This will result in cost savings.
    - SHP has agreed to this transition
    - The Department is working with CMS for all of the necessary steps needed to make this change.

Medicaid Expansion Benefit Package

- A benchmark option must be selected and the benefit package would need to be analyzed to ensure consistency with the Essential Health Benefits which include the following ten benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. In addition, the Mental Health Parity and Addiction Equity Act (MHPAEA) applies to Alternative Benefit Plans.

North Dakota Medicaid Coverage

The table below offers a comparison between
ND Traditional Medicaid and the ND Medicaid Expansion Alternative Benefit Plan coverage.

BENEFITS	ND Traditional Medicaid ALL Out-of-State Services Require Prior Approval (Except Emergent Services)	ND Medicaid Expansion Sanford Health Plan ALL Out-of-Network Services Require Prior Approval (Except Emergent or Family Planning Services)
Medical Office Visit (such as Visits to Physicians, Nurse Practitioners, or Physician Assistants)	• Covered • Prior-Approval NOT Required	• Covered • Prior-Approval NOT Required
Rural Health Clinic Visit Federally Qualified Health Center Visit Indian Health Service Visit	• Covered • Prior-Approval NOT Required	• Covered • Prior-Approval NOT Required
Diagnostic Tests (such as X-rays, Blood Work, or MRIs)	• Covered • Prior-Approval NOT Required	• Covered • Prior-Approval NOT Required
Podiatry Visit	• Covered • Prior-Approval NOT Required	• Covered • Prior-Approval NOT Required
Chiropractic Care	• Covered for Spinal Manipulations • Prior-Approval NOT Required • 12 Visit Limit per Calendar Year	• Covered for Spinal Manipulations • Prior-Approval NOT Required • 20 Visit Limit per Calendar Year
Outpatient Surgery	• Covered • Certain Services Require Prior-Approval	• Covered • Certain Services Require Prior-Approval
Emergency Room Visit	• Covered • Prior-Approval NOT Required	• Covered • Prior-Approval NOT Required

BENEFITS	ND Traditional Medicaid	ND Medicaid Expansion Sanford Health Plan
Inpatient Hospital Stay Includes Hospitalization for Short Term Acute Care Facilities, Long Term Acute Care Facilities, and Acute Rehabilitation Facilities	• Covered • Certain Services Require Prior-Approval • 30 Day Limit for each admission for Acute Inpatient Rehab Stay	• Covered • Certain Services Require Prior-Approval
Mental or Behavioral Health Services: Includes Hospital Stays, Psychiatric Residential Treatment Facilities (PRTF), Chemical Dependency (CD) Treatment Programs, and Partial Hospitalization Includes Psychiatrist and Psychologist Office Visits	• Covered • Certain Services Require Prior-Approval • Certain Services are Age Restricted • Limits on number of visits and services • 21 Day Limit for Psychiatric Inpatient Stay (45 Days per Calendar Year) for those 21 and older	• Covered • Certain Services Require Prior-Approval NOTE: Coverage for ages 21 or above at a Residential Treatment Facility excludes Room & Board
Dental Office Visits	• Covered • Certain Services Require Prior-Approval • Certain Services are Age Restricted • Limit on number of visits and services	• Covered - ONLY 19 or 20 year olds • Certain Services Require Prior-Approval • Limit on number of visits and services NOTE: NO COVERAGE for ages 21 or above
Eye Exam Office Visit Includes Optometrists & Ophthalmologists	• Covered • Certain Services Require Prior-Approval • Limit on number of visits and services	• Covered - ONLY 19 or 20 year olds • Certain Services Require Prior-Approval • Limit on number of visits and services NOTE: Coverage for ages 21 or above only includes non-routine vision exams relating to eye disease or injury
Hospice Care	• Covered • Services Require Prior-Approval	• Covered • Services Require Prior-Approval
Home Health Care	• Covered • Some Limits Apply	• Covered • Services Require Prior-Approval

BENEFITS	ND Traditional Medicaid	ND Medicaid Expansion Sanford Health Plan
Personal Care Services –Provided In Home or Residential Setting	• Covered • Must Meet Functional Assessment Criteria • Services Require Prior-Approval	• Not Covered
Nursing Facility Services or Swing Bed Services	• Covered • MUST Meet Level of Care Criteria	• Covered – Skilled Level of Care ONLY • Services Require Prior-Approval • 30 Day Limit (Consecutive 12 month period)
Intermediate Care Facilities for Individuals with Intellectual Disabilities	• Covered • MUST Meet Level of Care Criteria	• Not Covered
Habilitation & Rehabilitation Services Physical Therapy (PT) Office Visit Occupational Therapy (OT) Office Visit Speech Therapy (ST) Office Visit Habilitative Therapy Office Visit	• Covered – except Habilitative Therapy • Limit on number of visits and services	• Covered • Limit on number of visits and services
Durable Medical Equipment and Prosthetic Devices	• Covered • Certain Services Require Prior-Approval • Limits on certain services	• Covered • Services Require Prior-Approval
Prescription Drugs	• Covered – Drugs listed on the ND Medicaid Formulary (Drug Manufactures must participate in the Medicaid Drug Rebate Program) • Certain Drugs Require Prior-Approval	• Covered – Drugs listed on the Sanford Health Plan Formulary ONLY (No Coverage for Drugs NOT Listed on Formulary)
Emergency Transportation Includes Ground & Air Ambulance Services	• Covered	• Covered
Non-Emergency Medical Transportation Only for Recipient's Medical Services	• Covered • Services Require Prior-Approval	• Covered • Services Require Prior-Approval

Dental and Vision Coverage - Expansion

- Cost for Adding Dental and Vision Coverage for those covered under Medicaid Expansion 21 years of age and older.
  - Note: currently 19 and 20 year olds must be provided dental and vision coverage
- ESTIMATED increased cost per member per month would range from $36.57 - $52.10
  - These estimates would need to be refined and calculated once all work related to the allotment and 2017-2019 budget preparations is complete.

Administrative Costs

Managed Care

- The Administrative costs are part of the monthly per member per month (PMPM) payment made to Sanford Health Plan.

Traditional Medicaid

- The current Traditional Medicaid enrollment is around 68,000. Increasing the enrollment by about 1/3 would increase administrative staffing needs such as:
- Utilization review
- Care management
- Claims processing

Administrative Costs

Managed Care

- Because the administrative costs are part of the PMPM, the federal match is at Medicaid Expansion match.
- SHP has a member center as part of their administrative services. ND Medicaid does not have this.

Traditional Medicaid

- Administrative costs would be at the traditional Medicaid administrative match rates.
- Would no longer need actuarial services or External Quality Review.
- Would increase transaction contracts (e.g. ID cards, third-party liability, prior authorization, certificate of need)

Other Considerations

- With a continued managed care contract, the Department of Human Services would need to make change to the Medicaid Management Information System (MMIS). The necessary changes are estimated to cost $3.4 million (these changes would be eligible for 90/10 funding).
- Compliance with April 25, 2016 final rules from the Department of Health and Human Services "modernizing Medicaid managed care". The provisions of the rule will be implemented over the next three years, starting July 1, 2017.

Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

- Federal Guidance Issued February 26, 2016
- IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent.

At a minimum, care coordination will involve:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
- (2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
- (3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
- (4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

- To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services "received through" an IHS/Tribal facility.

  The documentation must be sufficient to establish that
- (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner;
- (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care;
- (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and
- (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

- https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

Questions??