

Department of Human Services
Health Care Reform Review Committee
Representative George Keiser, Chairman
January 15, 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 Medicaid provisions in the Affordable Care Act (ACA), including the implementation of Medicaid Expansion.

At your November meeting, Maggie Anderson provided an overview of all of the projects that were part of the implementation of Medicaid Expansion. The past two months have been filled with the many activities necessary to implement the Medicaid Expansion in North Dakota.

Medicaid Expansion

Enrollment

For the month of January, approximately 1,700 individuals are enrolled for coverage in the North Dakota Medicaid expansion. While we will finalize and trend the age, gender, and location cohorts over the next three months, the early data shows that most enrollees are childless adults (there are some adults with dependent children), slightly over half of the expansion enrollees are female, a little more than half are ages 19-44 (remainder ages 45-64), and most are rural (urban covering only Burleigh and Cass counties).

While this number is less than the 20,500 the Department estimated as being potentially eligible, the Department did not have any expectations about enrollment for January 1 coverage, and anticipated enrollment

would grow over time. As we have indicated before, eventual enrollment will be dependent upon the choice of individuals surrounding coverage and motivation about the individual mandate and penalties.

Since the last week of December, the number of calls to the Department's call center has increased, which has also increased the number of applications taken over the telephone. Both of these are indicators that more people are reaching out to explore options and apply for coverage. We expect the Medicaid Expansion enrollment to continue to increase.

During testimony throughout the 2013 legislative session, the Department also projected an increase to the "traditional" Medicaid enrollment. This population is often referred to as the "woodwork" group. These are individuals who were previously eligible, but had not applied, for Medicaid coverage. The increase was expected as a result of outreach and people going to the marketplace and finding out they were eligible for Medicaid (non-expansion). While we continue to determine the increase in enrollment as a result of the woodwork group, we are seeing an increase and should be able to quantify a trend by early spring. (Medicaid enrollment for the month of November 2013 was 66,050.)

Contract with Private Insurer (Health Plan)

As we have previously reported, a Request for Proposal (RFP) for the coverage for the Medicaid Expansion was issued August 5, 2013.

Proposals were received from Sanford Health Plan and Blue Cross/Blue Shield of North Dakota (BCBSND). On November 13, 2013, the Department issued a notice of intent to award coverage contracts to both Sanford Health Plan and BCBSND.

As part of the requirements for operating a Medicaid managed care program, the State (through its actuary) was required to set a rate range for the population to be covered. The State's actuary established a certified rate range, which was submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. The Department, our contracted actuary (Optumas), CMS, and the two health plans had many conversations about the rate ranges and risk. In addition, the Department anticipated the unknown risks of the Medicaid Expansion population, and proposed a risk-sharing approach in the RFP. However, in the end, BCBSND was not able to accept the rate levels that CMS would approve and on December 19, 2013, BCBSND withdrew their proposal.

While the Department intended to award contracts to both plans, once BCBSND withdrew their proposal, we quickly adjusted our approach to ensure coverage was in place by January 1. The Sanford Health Plan meets all of the access requirements set forth in the RFP and is addressing any providers that need to be part of the network (eg. federally qualified health centers and Human Service Centers). To date, there have been no access or member services concerns expressed to the Department.

Activities Toward Implementation

In November we provided a list of activities that needed to be finalized to implement Medicaid Expansion coverage on January 1. Following is a brief overview of the status of the required activities:

1915b waiver - needed because we are enrolling Medicaid expansion enrollees into a managed care plan. The waiver was approved by CMS on December 20, 2013.

Rate certification approval - needed from the CMS Office of the Actuary for the rate ranges for the per member per month premiums to be paid to the health plan. The rate certification was approved on December 31.

Contract approval - needed for the contractual requirements, including general provisions, special provisions, coverage, quality strategy, managed care reporting, and rate methodology. The contract was approved by CMS and signed by DHS and the Sanford Health Plan on December 31, 2013.

Quality strategy - needed to document expectations for the health plan to develop, monitor, and improve quality measures for the Medicaid Expansion population. The draft quality strategy has been reviewed by CMS and has been posted on the Department's website for comments. The draft quality strategy can be viewed at:

<http://www.nd.gov/dhs/info/pubs/docs/medicaid/draft-quality-strategy-plan.pdf>

Administrative Rules - needed to implement a process for individuals who felt they may be medically frail to be identified and offered the option of traditional Medicaid within the expansion population, and to ensure the rules accommodate the changes needed to switch from 'net' income determinations to 'modified adjusted gross income'. Emergency Rules were submitted to Legislative Council on December 31, 2013.

State Plan Amendments - various amendments needed for coverage, eligibility changes, and federal funding for the expansion population. All state plan amendments required to be submitted prior to December 31,

2013, have been submitted. All state plans that required approval prior to January 1,2014, have been approved. There are still a number of state plans that need to be submitted or approved prior to March 31,2014, and the Department anticipates no difficulties.

Coverage

In the RFP, the Department indicated that the Sanford Health Plan (the commercial Health Maintenance Organization with the largest insured commercial, non-Medicaid enrollment in the state) is the benchmark selected for the Medicaid Expansion population. The coverage for the Medicaid Expansion population (known as the Alternative Benefit Plan) would be the Sanford Health Plan, plus the Essential Health Benefits, and any required Medicaid services (such as non-emergency medical transportation). The Alternative Benefit Plan also complies with the Mental Health Parity and Addiction Equity Act.

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 continues to finalize the process to identify and approve individuals as medically frail and ensure their coverage meets all requirements.

Eligibility Process

In November, the Department, along with the Information Technology Department, recognized that we needed to implement a contingency solution because the eligibility and enrollment system under development was not going to be completed in time to accept applications and make eligibility determinations. At that time, the Department issued an RFP for

a vendor to operate a call center and perform eligibility application processing. The Department awarded the contract to Automated Health Systems (AHS) who began operating the call center in late November and started processing applications in December. AHS takes phone calls from prospective applicants, takes applications over the telephone, assists applicants who have submitted incomplete applications, provides status information from applicants who are uncertain about their coverage, and makes eligibility determinations.

As I think everyone is aware, there have been issues with the federal marketplace, called HealthCare.gov. These issues have impacted the interactions with Medicaid, and our ability to make determinations on the applications filed through HealthCare.gov. After it became evident that the account transfer provisions would not be operational by January 1, the Department reached out to all individuals who had applied through HealthCare.gov and who had been assessed as eligible for Medicaid. We encouraged people to apply directly with us, so we could make determinations. Some individuals did so, and some did not. In December, CMS offered a waiver to states to use the information from the federal file to enroll individuals for coverage, for up to 90 days, until the full eligibility determination is made. In order to ensure that people who were assessed as being eligible for Medicaid by the marketplace had coverage on January 1, the Department requested this waiver and enrolled individuals from the federal file. After we receive a complete account transfer file (from the marketplace), each individual that was enrolled will have a full determination completed. The full determination may change an individual's eligibility status; applicants have been informed of this possibility and will be notified of the final determination in writing.

Last week, the Department trained county staff on using the contingency eligibility determination solution. Counties will begin to make determinations and the Department intends to continue the contract with AHS until the counties are able to support the eligibility effort.

Estate Recovery and Assets

An issue that was raised in the days leading up to January 1 implementation was estate recovery. It became evident that there were no provisions in the ACA to exclude the expansion population from estate recovery. Our legal staff has reviewed N.D.C.C. and the Department will analyze potential changes prior to the 2015 session. We also understand that CMS intends to issue guidance soon that will help clarify the issue of estate recovery and how it relates to their being no asset test for the expansion population. We can update the Committee after the CMS guidance is received.

Continued Outreach

In November, the Department conducted stakeholder meetings across North Dakota, for the purpose of informing grass roots organizations and advocacy organizations about the Medicaid Expansion and how they can assist individuals with learning about coverage and applying for coverage. The Department has also produced brochures, flyers, and public service announcements and these items are available on the Department's website at <http://www.nd.gov/dhs/>. The Department continues to collaborate with the Indian Affairs Commission to ensure eligible American Indians are aware of the expanded coverage.

Other ACA Provisions

Not related to the Medicaid Expansion, but part of the ACA, there are also impacts to coverage provided children:

1. Children's Health Insurance Program (CHIP) to Medicaid

(approximately 784 children): children from ages 6 to 19 and who are between 100% and 133% of the federal poverty level must be transitioned from CHIP to Medicaid. Families were offered the opportunity to switch on January 1 or wait until their annual renewal period. We received requests to transfer 14 children on January 1; the others will remain on CHIP until their renewal anniversary in 2014.

2. Medicaid to CHIP (approximately 3,100 children): children on Medicaid who would no longer be eligible for Medicaid due to the loss of the income deductions. The ACA calls for these children to be transferred to CHIP for one year. At the time of their next renewal, these children, if no longer eligible for CHIP or Medicaid, would need to go to the federal marketplace for coverage. CMS has offered an option to states to keep these children on Medicaid. The Department has been working with the CHIP health plan to determine the impact of this transfer and we are in discussions with CMS about how the transfer of these children would impact the Department's annual CHIP allotment. We expect to finalize the decision about transitioning this group by March 1.

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