

**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.