1. What is Medicaid Expansion?
The Affordable Care Act (ACA) created a new Medicaid group, called “Medicaid Expansion.” These newly eligible individuals must meet the following criteria:

- Are between the ages of 19 through 64;
- Have incomes below 138% FPL (for a single person, that’s an annual income of $15,856);
- Are legal citizens;
- Are not incarcerated; and
- Are not entitled to Medicare.

The expansion opens the program up to an estimated 20,000 residents in North Dakota so they can have health insurance. Currently, only children, pregnant women and families (i.e. parents/caretaker/relatives of dependent children) are eligible for Medicaid. In April 2013, North Dakota lawmakers signed legislation expanding Medicaid.

2. Who is administering the new Medicaid Expansion Program?
The North Dakota Department of Human Services has contracted with Sanford Health Plan to provide benefits to this new group of Medicaid Expansion recipients, beginning on January 1, 2014.

3. How do individuals apply for coverage?
Individuals have two ways of applying:

- Through the federal Marketplace online at www.healthcare.gov or
- Through the county social service office:
  - Online at http://apply.dhs.nd.gov;
  - By paper application which can be completed online, printed and mailed;
  - By telephone (855) 794-7308 (ND Relay TTY 1-800-366-6888); or
  - In-person at a county social service office.

All eligibility determinations are done by the North Dakota Department of Human Services, not Sanford Health Plan. Once the State determines eligibility, they send a file to Sanford Health Plan with a list of enrollees. Sanford Health Plan then issues ID cards to the enrolled members.

4. How will I know if patients are enrolled with the North Dakota Medicaid Expansion Program?
The patient will have an ID card as shown below. Product information can be verified on the front of the member's ID card under the Group number.

Eligibility can also be verified online at www.sanfordhealthplan.com through your myHealthPlan provider portal account. Covered members will have Medicaid Expansion listed in their eligibility screens as the “employer group”. Questions for eligibility, benefits and authorizations on these members can also be answered through your myHealthPlan provider portal account in the eligibility screens or by calling 1-855-305-5060 for Eligibility and 1-855-276-7214 for Prior-Authorizations.
5. **How do I get signed up for an online provider account with myHealthPlan?**
   You must request a myHealthPlan account by following these simple steps:
   - Go to Sanford Health Plan’s website [www.sanfordhealthplan.com](http://www.sanfordhealthplan.com)
   - Hover over the blue tab on the right called “myHealthPlan login”
   - Click on the link “Providers”
   - Click “Provider Sign-up” link and follow the next 5 steps to create your own username and password.

   If you have any questions or need help signing up, please contact your Provider & Payor Relations Representative or the Provider & Payor Relations Department at 1-800-601-5086 or email [ppr@sanfordhealth.org](mailto:ppr@sanfordhealth.org).

6. **What are the cost-sharing responsibilities for the Medicaid Expansion members?**
   The Medicaid Expansion members do not have a deductible, or coinsurance. However, they are responsible for paying certain copays when receiving healthcare services or getting prescription drugs. Please refer to the attached schedule of benefits for Medicaid Expansion members.

7. **When will Medicaid Expansion coverage be effective?**
   Medicaid Expansion coverage can begin as early as January 1, 2014 and individuals are able to continue to sign up for coverage throughout the year.

8. **Do Medicaid Expansion Members have to use a certain provider network for services?**
   Yes, Medicaid Expansion members must use Sanford Health Plan’s Provider network for services. There is no coverage for out-of-network services. A Provider Directory is available online at [www.sanfordhealthplan.com](http://www.sanfordhealthplan.com).

9. **I already have a contract with Sanford Health Plan; do I need to do anything different in order to be a participating provider for the North Dakota Medicaid Expansion Program?**
   No, you do not have to do anything additional in order to be reimbursed for treating Medicaid Expansion members. If you already have a contract with Sanford Health Plan, then you are currently in the Sanford Health Plan network.

10. **How will participating providers be reimbursed for the services they provide to Medicaid Expansion members?**
    Services will be reimbursed according to the contractual agreements you currently have in place with Sanford Health Plan. Members are expected to pay their copays at the time of service.

11. **Do Medicaid Expansion members have out-of-network benefits?**
    No, Medicaid Expansion members do not have out-of-network benefits. They need to seek care from participating providers in order for benefits to be covered.

12. **I am not participating today as a Sanford Health Plan provider, how do I become a provider in the network?**
    If you are interested in becoming a participating provider with Sanford Health Plan, please contact our Provider & Payor Relations Representatives at 1-800-601-5086 or email [ppr@sanfordhealth.org](mailto:ppr@sanfordhealth.org).

13. **Do Medicaid Expansion Members have to use certain pharmacies for prescription drug coverage?**
    Yes, Medicaid Expansion members must use Sanford Health Plan’s pharmacy network for all prescription drugs. A Pharmacy Directory is available online at [www.sanfordhealthplan.com](http://www.sanfordhealthplan.com). Express Scripts Inc. is the Pharmacy Benefit Manager for Sanford Health Plan. If a pharmacy already has a contract with Express Scripts, then it is currently in the Sanford Health Plan network.

14. **What do I need to know about “presumptive eligibility?”**
    Presumptive eligibility provides enrollees immediate access to health services by giving them temporary health insurance through the Medicaid Expansion Program if they appear to be eligible. Enrollees are then able to get health services immediately, instead of waiting several weeks for paperwork to be processed.
Under Section 2202 of the Affordable Care Act, each hospital participating in the ND Medicaid program can choose to be a qualified entity that makes presumptive eligibility determinations for the Medicaid Expansion Program. This short-term coverage encompasses all ND Medicaid services, including inpatient, outpatient and ambulatory care and is available from the date of service, whenever that falls within the month. As a result, a hospital need not forgo revenue while the patient awaits full determination and enrollment.

The key points of presumptive eligibility are:

- It allows individuals to begin the eligibility determination process at the point of service.
- It allows enrolled Medicaid providers to be paid for covered services provided during the temporary eligibility period.
- Individuals verify their income by attestation of their family circumstances. The State will provide hospitals access to an online system to verify the income for the individual.
- If the hospital determines presumptive eligibility, the individual can stay enrolled until the end of the month following the month when the presumptive eligibility determination was made. During that time, an individual should complete the full enrollment application and receive a full eligibility determination to avoid losing coverage when the temporary eligibility period ends.
- Enrolled Medicaid providers will be paid for covered services provided during the temporary eligibility period, even if the individual is subsequently found ineligible for Medicaid Expansion.

The ND Department of Human Services will be hosting a presumptive eligibility training session in the near future at a date yet to be determined. Please contact Julie Schwab by telephone at 701-328-1603 or by e-mail at jfschwab@nd.gov if you would like to participate in the training session.

15. How does Sanford Health Plan know who’s enrolled under presumptive eligibility and do I get paid differently for these individuals?
Sanford Health Plan receives daily electronic files from the Department of Human Services that identifies eligible individuals for Medicaid Expansion.
- Sanford Health Plan will issue ID cards to all individuals identified in the State’s enrollment file, including those enrolled under presumptive eligibility.
- ID Cards do not differentiate between members enrolled under presumptive eligibility or full determination.
- Providers are not reimbursed differently based on whether or not the member is enrolled under presumptive eligibility.
- If it is eventually determined that the patient is not eligible for Medicaid Expansion, then coverage is terminated at the end of the month in which the State Department of Human Services has made the full determination.
- Providers should regularly check the member’s eligibility status through Sanford Health Plan’s myHealthPlan provider portal at www.sanfordhealthplan.com.

16. How do I submit my claims for patients who have Medicaid Expansion coverage?
Claims are submitted the same way you submit claims for other Sanford Health Plan members, preferably electronically using Payor ID 91184 which is located on the back of the member’s card or it can be submitted via paper to Sanford Health Plan, PO BOX 91110, SIOUX FALLS, SD 57109-1110.

17. Does Sanford Health Plan have billing rules or clinical practice guidelines specific to North Dakota Medicaid Expansion?
No. Sanford Health Plan is applying our normal billing rules and clinical practice guidelines to the Medicaid Expansion population. Please view the Provider Manual which can be obtained through your myHealthPlan account under the Provider Resources tab.

18. What services require prior-authorization for Medicaid Expansion members?
Since Sanford Health Plan is applying our normal clinical practice guidelines to the Medicaid Expansion population, the list of services that require prior authorization is the same as what is required for all Sanford Health Plan members. You can view the list in the attached schedule of benefits or through your myHealthPlan provider account.
19. How will I get communication updates from Sanford Health Plan?
We strive to keep providers up to date with the most current information; to achieve this we use the
myHealthPlan online provider portal. Below is a summary of the information posted on your provider account:

- Clinical Practice Guidelines
- Code Updates
- Forms
- Clinical Toolbox
- Disease Management Programs
- Pharmacy Benefits /Formulary

\textit{myHealthPlan} also provides these additional features:
- View deductibles, coinsurance, copayment and out-of-pocket expense totals for members
- View two years’ of member eligibility information
- View check numbers and track posted payments
- Register under multiple Tax IDs
- Email Express Requests for prior-authorization requests and receive a reply within one business day

- Prior Authorizations: How to prior authorize and what needs prior authorizations
- Provider Manual
- Provider News
- Quality Improvement Activities and reporting
Medicaid Expansion Members are responsible for the following copayments unless the following criteria are met:

- Members ages 19 and 20, are exempt from all copayments
- Pregnant women are exempt from all copayments
- Getting birth control drugs or devices do not require a copayment
- A Native American member who can get, or is eligible to get, services from Indian Health Services (IHS) or through referral by Contract Health Services (CHS) is exempt from all copayments
- Members are exempt from copayments if they are residing in institutions such as:
  - Nursing Facility, long term care
  - Swing bed, long term care
  - Intermediate Care Facility for the Intellectually Disabled (ICF/ID)
  - State Hospital

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage Description</th>
<th>In-network Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum Limit for each calendar year</strong></td>
<td>This is the most a member would pay out of pocket each year. Members will receive a letter telling them when they have reached this limit.</td>
<td>5% of the household’s countable earnings.</td>
</tr>
<tr>
<td><strong>Medical Office Visit</strong></td>
<td>Includes visits to physicians, nurse practitioners and physician assistants</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Rural Health Clinic Visit</strong></td>
<td>Federally Qualified Health Center Visit</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Preventive Care Office Visit</strong></td>
<td>Includes health screenings, prenatal and postnatal care, and immunizations</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Diagnostic Tests</strong></td>
<td>Includes x-rays, blood work, MRIs</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Stay</strong></td>
<td></td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>You must call to get prior-approval.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>You must call to get prior-approval.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Services</strong></td>
<td>You must call to get prior-approval.</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Mental or Behavioral Health Services</strong></td>
<td>Includes alcohol and drug treatment</td>
<td>Covered.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment and Prosthetic Devices</strong></td>
<td>You must call to get prior-approval.</td>
<td>Covered.</td>
</tr>
<tr>
<td>Benefits</td>
<td>Coverage Description</td>
<td>In-network Copayment</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td>Hospice Care</td>
<td>Covered. You must call to get prior-approval.</td>
<td>$0</td>
</tr>
<tr>
<td>Habilitation &amp; Rehabilitation Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical therapy office visit</td>
<td>30 visits per therapy per calendar year</td>
<td>$2.00 for each visit</td>
</tr>
<tr>
<td>Occupational therapy office visit</td>
<td>30 visits per therapy per calendar year</td>
<td>$2.00 for each visit</td>
</tr>
<tr>
<td>Speech therapy office visit</td>
<td>30 visits per therapy per calendar year</td>
<td>$2.00 for each visit</td>
</tr>
<tr>
<td>Habilitative therapy office visit</td>
<td>30 visits per therapy per calendar year</td>
<td>$2.00 for each visit</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>Covered for spinal manipulations. Limited to 20 visits per calendar year</td>
<td>$1.00 for each visit</td>
</tr>
<tr>
<td>Dental Office Visits</td>
<td>Covered for 19 and 20 year olds.</td>
<td>$0 for each office visit</td>
</tr>
<tr>
<td></td>
<td>No coverage for members 21 and older.</td>
<td></td>
</tr>
<tr>
<td>Eye Exam Office Visit</td>
<td>Covered for 19 and 20 year olds.</td>
<td>$0 for each office visit</td>
</tr>
<tr>
<td>Includes optometrists and ophthalmologists</td>
<td>Covered for members 21 and older for non-routine vision exams relating to eye disease</td>
<td>$2.00 for each office visit</td>
</tr>
<tr>
<td></td>
<td>or injury of the eye.</td>
<td></td>
</tr>
<tr>
<td>Foot Exam Office Visit</td>
<td>Covered.</td>
<td>$3.00 for each office visit</td>
</tr>
<tr>
<td>Includes podiatrists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Covered. Copay if member is admitted to the hospital.</td>
<td>$3.00 for each emergency room</td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td>Includes ground and air ambulance services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>Covered. You must call to get prior-approval.</td>
<td>$0</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Covered.</td>
<td></td>
</tr>
<tr>
<td>Drugs listed on the formulary</td>
<td>Generic Drugs</td>
<td>$0 copay per 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Diabetic Supplies</td>
<td>$0 copay per 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Brand Name Drugs</td>
<td>$3 copay per 30-day supply</td>
</tr>
<tr>
<td>Drugs not listed on the formulary</td>
<td>Not covered</td>
<td>Member pays all costs.</td>
</tr>
</tbody>
</table>