Frequently Asked Questions
on North Dakota Medicaid Expansion

What is changing 01/01/2018 for ND Medicaid Expansion?
There are two changes that affect providers in the Medicaid Expansion Program:

1. The network has been redefined and focused to:
   - Providers who are contracted with Sanford Health Plan; and
   - Providers who are located within the state of North Dakota or one of the bordering counties in Minnesota, Montana, or South Dakota that adjoin the North Dakota state line.
   - Due to a new federal law, network providers must enroll with the ND Department of Human Services (DHS) Medicaid program as being affiliated with Sanford Health Plan.

   Exceptions are only made for emergent/urgent care or medically necessary situations which are prior-authorized by SHP.

Details of enrollment requirement:
Due to a new federal law, starting January 1, 2018, all In-Network providers, pharmacies, suppliers and transportation providers must be enrolled with the ND Department of Human Services (DHS) Medicaid program to receive payment from Sanford Health Plan (SHP) for any claims specific to North Dakota (ND) Medicaid Expansion recipients. Please note that the traditional Medicaid program, and the program administered by SHP (known as North Dakota Medicaid Expansion), operate under different systems. The new federal law [42 CFR §438.602(b)] requires Managed Care Organizations (SHP) to confirm enrollment with the Department prior to payment for dates of service on or after January 1, 2018.

If a provider is enrolled as a traditional Medicaid provider, there is no requirement for a new application with the North Dakota DHS . The North Dakota DHS will add the SHP network to your enrollment, via a roster provided by SHP. No action is required if you are currently an enrolled and active provider with traditional Medicaid and contracted with SHP. If a provider is not enrolled as a traditional Medicaid provider, an application with DHS will be required.

Do Medicaid Expansion Members have to use a certain provider network for services?
Yes. Medicaid Expansion members must use Sanford Health Plan's North Dakota Medicaid Expansion provider network for health care services. The NDME medical service area/network will only include providers that are contracted with Sanford Health Plan, enrolled with the ND DHS Medicaid program and located in the state of North Dakota or the contiguous counties. The pharmacy service area/network includes ESI pharmacies that are enrolled with ND DHS Medicaid program and located in ND, South Dakota, Minnesota and Montana.

There is no coverage for out-of-network services unless the Member experiences an emergency, is getting family planning services, or SHP prior-authorizes the services. Coverage must also be rendered in the United States.

How can I view which providers are in the 2018 NDME network?
To access the provider directory, go to sanfordhealthplan.com.

1. On the home page, click on "Providers - Find a Provider" and select "Learn More."
2. On the provider directory home page, enter the first 9 digits of the patient's Member ID number and last name OR select Individual-2018 ND Medicaid Expansion from the drop down menu.

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.

Do Medicaid Expansion Members need to use certain pharmacies for prescription drug coverage?

Yes. Medicaid Expansion members must use a pharmacy in Sanford Health Plan's NDME pharmacy network to receive coverage of their prescription drugs. A Pharmacy Directory is available online at sanfordhealthplan.com. On the provider directory home page, enter the first 9 digits of the patient's Member ID number and last name OR select Individual-2018 ND Medicaid Expansion from the drop down menu.

I already have a contract with Sanford Health Plan and am inside the newly defined service area; do I need to do anything different in order to be a participating provider for the North Dakota Medicaid Expansion Program?

Yes. As of January 1, 2018, you will need to also be enrolled with the ND Department of Human Services in order to be reimbursed for treating Medicaid Expansion members. Due to this new federal law effective January 1, 2018, we anticipate there will be a back-log provide of applications for the ND DHS to enroll. Go to https://mmis.nd.gov/portals/wps/portal/ProviderEnrollment to submit your application or go to www.sanfordhealthplan.com/providers/2018-NDME-Network-Changes to learn more.

How will in-network providers be reimbursed for 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.

I am not contracted as a provider today with Sanford Health Plan, how do I become a provider in the network?

If you are interested in becoming a participating provider with Sanford Health Plan, contact Provider Contracting at (855) 263-3544 or email sanfordhealthplanprovidercontracting@sanfordhealth.org.

How do I submit my claims for patients who have Medicaid Expansion coverage?

Claims are submitted the same way for all members; preferably electronically using Payor ID 91184, which is located on the back of the member's card. Paper claims can also be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Out of network providers are NOT required to submit claims on behalf of patients.

Are there billing rules or clinical practice guidelines specific to North Dakota Medicaid Expansion?

No. Sanford Health Plan applies our normal billing rules and clinical practice guidelines to Members enrolled in Medicaid Expansion. More information on billing and clinical practice guidelines may be found in the Provider Manual, available online at www.sanfordhealthplan.com/providers.

What services or medications require prior authorization for Medicaid Expansion members?

Click here to view of list a services and here to view a list of medications that require prior authorization. Authorization requests can be submitted through the Provider Portal or by faxing your request:

- Medical authorization requests to Utilization Management (605) 328-6813
- Pharmacy authorization requests to the Pharmacy Department at (701) 234-4568.

If you need to refer a Medicaid Expansion member to a provider outside of the network, network, a prior-authorization needs to be obtained from SHP in order for the services to be processed in-network.

Who determines member eligibility for Medicaid Expansion?

Eligibility determinations are done by the North Dakota Department of Human Services. Once the State determines someone is eligible for Medicaid Expansion coverage, they send a file to Sanford Health Plan to enroll members with the plan. Sanford Health Plan will issue ID cards and membership materials after the enrollment process is complete.

Which individuals are eligible for Medicaid Expansion?

Individuals eligible for coverage must meet the following criteria:

- Be between the ages of 19 and 64;
- Have an annual household income below 138% of the Federal Poverty Line (FPL) (for an individual, that's $16,243);
- Be a U.S. citizen or legal permanent resident in the state of North Dakota;
- Not be currently incarcerated; and
- Not be entitled to or enrolled in Medicare or Supplemental Security Income (SSI).

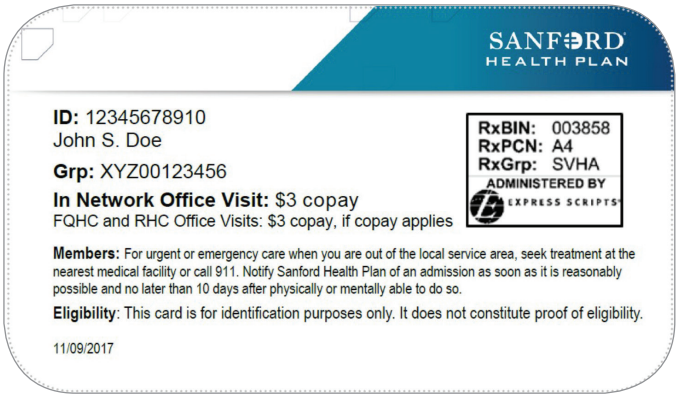
How can an individual in North Dakota apply for Medicaid Expansion coverage?

- Online at apply.dhs.nd.gov
- By printing and mailing a paper application, which can be found online at www.nd.gov/eforms/Doc/sfn01909.pdf
- By calling toll-free (877) 543-7669 or TTY: (800) 366-6888
- In-person at a County Social Service Office

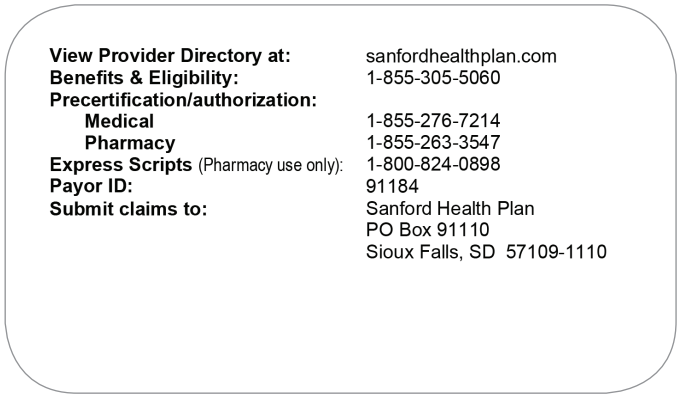
How will I verify if a Member participates in the North Dakota Medicaid Expansion Program?

The Member ID card will display the group name "ND Medicaid Expansion". Enrollment information can be verified on the front of the Member's ID card.

Front of ID Card



Back of ID Card



When will Medicaid Expansion coverage be considered effective; after a Member receives a letter that they are eligible?

Once Sanford Health Plan receives the Member's information from the state of North Dakota, it may take up to 7 business days for our system to reflect the Member's active enrollment. Members are encouraged to wait until they have Sanford Health Plan Member ID cards before seeking health care services or prescriptions. ID cards should be received within 7 to 10 business days after enrollment is processed.

How will providers get communication updates from Sanford Health Plan?

To keep you updated, we distribute a newsletter called Fast. If you are not currently receiving the newsletter, you can sign up online, or click here [http://www2.sanfordhealth.org/health-plan-providers/Newsletter-Signup.htm] You can view past newsletters online at www.sanfordhealthplan.com/providers

What can be done in the Provider Portal and how do I sign up?

In the portal, you can:

- View Member eligibility, benefits and accumulators
- Check claim status & obtain copies of explanation of payments
- Ask a question through a secure portal
- Submit medical & pharmacy prior authorizations
- View policies

To set up an account:

- Go to Sanford Health Plan's website sanfordhealthplan.com
- Click 'Login' in the upper right corner & select 'Provider'
- Click 'Create an Account' and follows the prompts to create an account.

If you have any questions or need help signing up, contact Provider Relations at (800) 601-5086.

Important Contact Information

Department	Questions about...	Phone number(s)
Medical Service Division North Dakota Department of Human Services	Eligibility, household income, how to apply for coverage	(701) 328-2321 (877) 543-7669 TTY/TDD: (800) 366-6888
Provider Contracting	Requests to join the network and contract related questions, fee schedule negotiation, provider credentialing	(855) 263-3544
Provider Relations	Assistance with the provider portal, fee schedule inquiries, check adjustments & reconciling a negative balance, request explanation of payment (EOP), claim reconsideration requests, W-9 forms, update provider information, provider education	(800) 601-5086
Customer Service Monday-Friday 8 a.m. to 5 p.m. CT	Eligibility & benefits, claim status, provider directory, complaints, appeals, report member discrepancy information	(855) 305-5060 TTY/TDD: (877) 652-1844
Pharmacy Management	Preauthorization/precertification of prescriptions or formulary questions	(855) 263-3547
Utilization Management	Preauthorization/precertification for medical services	(855) 276-7214

What are the cost-sharing responsibilities for Medicaid Expansion Members?
Medicaid Expansion members do not have a deductible or coinsurance, but they are responsible for paying certain copays when receiving health care services or receiving prescription drugs. Refer to the attached schedule of benefits for Medicaid Expansion members. This schedule is only a summary and should not be relied on for benefit determinations.

Medicaid Expansion Cost Sharing Information
Medicaid Expansion Members are responsible for the following copayments unless the member is:

- Age 19 or 20.
- Pregnant.
- Receiving birth control drugs or devices.
- A Native American enrolled in a recognized Native American Tribe and eligible to get care from Indian Health Services (IHS) or through referral, Contract Health Services (CHS)
    - Members must contact the North Dakota Department of Human Services Medical Service Division and be determined eligible by the State to receive this benefit. The North Dakota Department of Human Services Medical Service Division may be reached toll-free at (877) 543-7669 | ND Relay TTY: (800) 366-6888.
- Live in an institution such as:
    - Nursing Facility, long term care
    - Swing bed, long term care
    - Intermediate Care Facility for the Intellectually Disabled (ICF/ID)
    - State Hospital
    - Anne Carlsen Center for Children

Medicaid Expansion Benefit Overview

Medicaid Expansion Benefits	Member Cost For In-Network Providers	
	If member is age 21 and older	If member is age 19 or 20
Out-of-Pocket Maximum This is the most Members would pay out-of-pocket each calendar year. Once the limit is reached, a Member doesn't have copays for the rest of the year. Members will receive a letter telling them when this limit is reached.	5% of household's countable earnings	5% of household's countable earnings
Medical Office Visit Includes visits to physicians, nurse practitioners, and physician assistants	$2 per office visit	$0 per office visit
Rural Health Clinic (RHC) Office Visit	$3 per office visit	$0 per office visit
Federally Qualified Health Center (FQHC) Office Visit	$3 per office visit	$0 per office visit
Indian Health Services (IHS) Office Visit Includes visits to Urban Indian Health, and referrals through Contract Health Services (CHS)	$0 per office visit	$0 per office visit
Preventive Care Office Visit Includes health screenings, prenatal and postpartum care, and routine immunizations	$0 per office visit	$0 per office visit
Diagnostic Tests Includes x-rays, blood work, MRIs	$0	$0
Inpatient Hospital Stay Prior authorization required.	$75 per stay	$0 per stay
Outpatient Surgery Prior authorization required.	$0	$0
Home Health Care Prior authorization required.	$0	$0
Skilled Nursing Facility Services Prior authorization required.	$0	$0
Outpatient Mental Health and Substance Use Disorder Services Includes office visits to physicians, nurse practitioners, physician assistants, clinical psychologists, licensed clinical social workers, licensed chemical dependency counselors, intensive outpatient/partial hospitalization programs (day treatment).	$2 per office visit $2 per course of treatment for all other services, including partial hospitalization/ intensive outpatient programs	$0 per office visit $0 per course of treatment for all other services, including partial hospitaliza-tion/intensive outpatient programs
Inpatient Mental Health and Substance Use Disorder Services Members must call to get prior-approval. Including alcohol and drug treatment. Includes overnight hospital stays, residential care.	$75 per stay Benefit limited to certain facilities only.	$0 per stay

Medicaid Expansion Benefits	Member Cost For In-Network Providers	
	If member is age 21 and older	If member is age 19 or 20
Durable Medical Equipment and Prosthetic Devices Prior authorization required for some services and supplies.	$0	$0
Hospice Care Prior authorization required.	$0	$0
Habilitation & Rehabilitation Services *30 visits per therapy per calendar year for Members ages 21 and older only.*	*30 visits per therapy per calendar year for Members ages 21 and older only.*	
Physical therapy office visit	$2 per visit	$0
Occupational therapy office visit	$2 per visit	$0
Speech therapy office visit	$1 per visit	$0
Habilitative therapy office visit	$2 per visit	$0
Chiropractic Care Covered for spinal manipulations. Limited to 20 visits per calendar year.	$1 per visit	$0
Dental Office Visits Routine visits covered for Members ages 19 and 20 only.	Covered only when medical dental exam needed for acute injury of the natural tooth. *Routine dental exams are not covered.*	$0 per office visit
Eye Exam Office Visit Office visit includes optometrists and ophthalmologists	$2 per office visit Covered only when medical vision exam needed for eye disease or injury of the eye. *Routine eye exams are not covered.*	$0 per office visit Includes routine eye exams.
Foot Exam Office Visit Includes podiatrists	$3 per office visit	$0 per office visit
Emergency Room Visit	$0	$0
Emergency Transportation Includes ground and air ambulance services.	$0	$0
Non-Emergency Transportation Members must call to get prior approval and schedule rides. For medical reasons only.	$0	$0
Prescription Drugs Drugs listed on the formulary and/or prior authorized by the Plan		
Generic Drugs & Generic Diabetic Supplies	$0 copay per prescription per 30-day supply	$0 copay per prescription
Brand-Name Drugs & Brand Name Diabetic Supplies	$3 copay per prescription	$3 copay per prescription
Drugs not listed on the formulary and not prior authorized	Member pays all costs. Members CANNOT be directly reimbursed by SHP.	Member pays all costs. Members CANNOT be directly reimbursed by SHP.

SANFORD HEALTH PLAN