DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

December 31, 2013

Julie Schwab, Director
North Dakota Department of Human Services
600 East Boulevard Avenue Department 325
Bismarck, ND 58505-0250

Dear Ms. Schwab:

This letter is to inform you that the Centers for Medicare and Medicaid Services (CMS) approves Federal Financial Participation (FFP) for the managed care organization (MCO) contract between the North Dakota Department of Human Services and Sanford Health Plan, State contract # 415-09524. This new MCO contract and rates are effective on January 1, 2014 through December 31, 2014. CMS approves this managed care contract with the understanding that additional contract amendments may be warranted based on the final approval of relevant benefit State Plan Amendments (SPAs).

This new MCO contract operates under North Dakota's new 1915(b) Waiver for Managed Care Enrollment of Medicaid Expansion of the New Adult Group, Waiver number ND-04.

CMS found that the submitted contract met the requirements in federal regulations at 42 CFR 438, and that the rates met the requirements at 42 CFR 438.6(c). This approval for the contracted rates is limited to the period for which the rates were actuarially certified, beginning January 1, 2014 and ending December 31, 2014. CMS received an actuarial certification establishing that the rate ranges were developed in accordance with accepted actuarial principles and practices, and were appropriate for the Medicaid populations covered, and Medicaid services included in the contract.

As you know, CMS has been providing technical assistance and consultation to the State since October, 2013. We identified a number of concerns about the State's rate-setting approach, including:

- Original assumptions that an MCO delivery system would cost more than unmanaged fee-for-service – even though national studies show that managed care delivery systems result in cost savings;
- Assumptions of provider payments rates that reflect commercial rates rather than Medicaid fee-for-service rates; and
- Unusually large adjustments for adverse health status of the newly eligible population – one of the largest in the country

Taken together, these assumptions and adjustments are estimated to lead to managed care rates for the newly eligible adults that are roughly twice as large as the fee-for-service costs of current adult enrollees. In response to these concerns, you and your staff have worked with us to address them to the maximum extent possible. Specifically, your actuaries have modified the 'managed care savings' assumptions to reflect a slight savings off current costs, and used Current Population Survey (CPS) data and appropriate benefit costs to modify the acuity assumptions in the capitation rates.

While the rates continue to reflect what you expect your MCO to pay their providers, we have required you to gather actual paid claims, utilization and financial data from your MCO in 2014 so that those assumptions can be tested and revised, as necessary, in the 2015 rates. We have also required you to implement a risk corridor with narrow risk bands to provide protection for all parties involved.

We expect to engage in additional consultations when you are beginning the rate-setting process for 2015. We would like to thank you and your staff for the cooperation we received during the review process. If you have any questions regarding this approval please contract Sophia Hinojosa at Sophia.Hinojosa@cms.hhs.gov or (303) 844-7129.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Cc: Scott Manning, CMS
Robin Preston, CMS
Camille Dobson, CMS
Rebecca Burch Mack, CMS
Maggie Anderson, North Dakota
Cynthia Sheldon, North Dakota

TABLE 3A-10. Medicaid Payments to DSH Hospitals as a Share of Costs, by State, SPRY 2014 T 3A-10

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Total	**44%**	**79%**	**12%**	**13%**	**103%**	**68%**	**10%**	**11%**	**88%**
Alabama	56	73	19	33	**125**	55	14	25	**95**
Alaska	12	110	–	4	**114**	89	–	3	**92**
Arizona	39	44	27	5	**75**	39	24	4	**67**
Arkansas	6	74	18	25	**116**	60	14	20	**95**
California[1]	10	88	6	35	**129**	76	5	30	**112**
Colorado	72	69	30	8	**107**	60	26	7	**93**
Connecticut	15	77	3	4	**84**	75	3	4	**82**
Delaware	8	93	–	26	**119**	78	–	22	**100**
District of Columbia	23	89	0	15	**104**	84	0	15	**99**
Florida	28	91	15	4	**110**	75	13	3	**90**
Georgia	79	92	4	10	**106**	71	3	8	**82**
Idaho	53	99	2	4	**104**	84	1	4	**89**
Illinois[2]	26	77	28	11	**116**	67	24	10	**101**
Indiana	31	97	–	18	**116**	81	–	15	**96**
Iowa	6	84	6	10	**100**	78	6	10	**94**
Kansas	41	77	9	7	**93**	63	7	6	**76**
Kentucky	81	88	6	7	**101**	77	5	6	**89**
Louisiana	31	70	2	63	**134**	51	1	46	**98**
Maryland	13	107	–	12	**119**	89	–	10	**99**
Michigan	71	68	27	5	**100**	63	26	5	**94**
Minnesota[3]	35	85	6	1	**92**	82	6	1	**89**
Mississippi	53	83	19	15	**117**	68	16	12	**97**
Missouri	74	104	–	17	**120**	85	–	14	**99**
Montana	52	80	13	6	**100**	63	11	5	**79**

TABLE 3A-10. (continued)

State	Share of hospitals in the state included in analysis	Medicaid payments as a share of costs for Medicaid-enrolled patients				Medicaid payments as a share of costs for Medicaid-enrolled and uninsured patients			
		Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments	Base payments	Non-DSH supplemental payments	DSH payments	Total Medicaid payments
Nebraska	23%	79%	0%	4%	83%	66%	0%	3%	69%
Nevada	42	72	11	9	**91**	56	8	7	**71**
New Jersey	65	84	5	25	**114**	62	4	19	**85**
New Mexico	13	89	13	5	**107**	74	11	4	**89**
New York	91	77	3	14	**94**	72	3	13	**88**
North Carolina	53	71	34	9	**113**	57	27	7	**92**
North Dakota[2]	6	117	–	2	**119**	105	–	2	**107**
Ohio	68	84	6	8	**98**	77	6	7	**90**
Oklahoma	32	76	29	4	**110**	64	24	3	**91**
Oregon	90	98	3	3	**104**	89	3	3	**94**
Pennsylvania	91	59	14	9	**81**	49	11	7	**67**
Rhode Island	80	85	1	14	**100**	79	1	13	**93**
South Carolina	72	90	3	19	**112**	72	2	15	**89**
Tennessee[3]	43	85	24	1	**110**	72	20	1	**93**
Texas	29	80	23	18	**120**	58	16	13	**87**
Utah	69	87	32	4	**123**	68	25	3	**96**
Vermont	81	80	–	10	**90**	76	–	9	**86**
Virginia[3]	22	88	11	10	**108**	69	8	8	**85**
Washington	56	82	(0)	8	**89**	75	-0	7	**82**
Wisconsin	67	75	16	1	**93**	68	15	1	**84**
Wyoming	38	78	12	1	**90**	54	8	0	**63**

Notes: DSH is disproportionate share hospital. SPRY is state plan rate year, which often coincides with state fiscal year and may not align with the federal fiscal year. This analysis includes 44 states and the District of Columbia and excludes Hawaii, Massachusetts, Maine, New Hampshire, South Dakota, and West Virginia. Institutions for mental diseases were also excluded. Base Medicaid payments include fee-for-service as well as managed care payments for services. Non-DSH supplemental payments include upper payment limit payments in fee-for-service Medicaid, graduate medical education payments, and supplemental payments authorized under Section 1115 demonstrations (except for delivery system reform incentive payments, which are not reported on DSH audits). DSH payments and non-DSH supplemental payments may also be used to offset non-Medicaid costs, such as unpaid costs of care for uninsured patients. Costs for uninsured patients are uncompensated care costs for uninsured patients, net of payments received from them. Payment levels shown do not account for provider contributions to the non-federal share; these contributions may reduce net payments. Numbers do not sum due to rounding.

TABLE 3A-10. (continued)

— Dash indicates zero; 0 indicates a non-zero amount less than 0.5 percent.

[1] California public hospitals are eligible to receive DSH payments up to 175 percent of the hospital's Medicaid uninsured costs.

[2] Illinois and North Dakota reported SPRY 2014 DSH payments that exceeded hospital uncompensated care costs for Medicaid and uninsured patients on their as-filed DSH audits. Because DSH payments to an individual hospital cannot exceed hospital uncompensated care costs, some of these payments may be recouped when these states' DSH audits are finalized.

[3] Two DSH hospitals in Minnesota, all DSH hospitals in New Hampshire, three DSH hospitals in Tennessee, one DSH hospital in Virginia, and all DSH hospitals in West Virginia did not include payments from third-party payers when calculating Medicaid shortfall, so they are excluded from this analysis.

Source: MACPAC, 2019, analysis of SPRY 2014 as-filed Medicaid DSH audits.