CONTRACT #415-12208
AMENDMENT C

AMENDMENT TO NORTH DAKOTA MEDICAID EXPANSION

MANAGED CARE ORGANIZATION CONTRACT

On or about June 25, 2021, the State of North Dakota, acting through its North Dakota Department of Health and Human Services, Medical Services Division (STATE) and Blue Cross Blue Shield of North Dakota (MCO) entered into a Contract for operation and administration of the Medicaid Managed Care Program for North Dakota.

The parties agree that certain parts of that Contract and Amendments A and B should be changed:

1. Section 2.4.7, titled Enrollee Orientation, as amended by Amendment B, is further amended to add the following language under sub-section (A):

   (1) In cases of retroactive enrollment sent past the time of active coverage, an ID card is not required to be distributed.

2. Section 2.5.3, titled Enrollee Call Center Performance Standards, is amended to delete sub-section (A)(1) in its entirety and replace it with the following:

   (1) Maintain a hold time plus speed of answer of three (3) minutes or less or direct the call to an automatic call pickup system with IVR options;

3. Section 2.6.4, titled Allowable Marketing Activities, as amended by Amendment B, is further amended to delete sub-section (D) in its entirety and replace it with the following language:

   (D) Provide promotional giveaways that do not exceed $100 value to current Enrollees only on an annual basis for activities, including, but not limited to, participation in the member advisory committee, health screenings, or other activities as approved by STATE;

4. Section 2.8.12, titled Claims and Provider Payment, is amended to delete sub-section (J) in its entirety and replace it with the following language:

   (J) Claims Reprocessing

   If MCO discover errors made by MCO when a claim was adjudicated, MCO shall make corrections and reprocess the claim within thirty (30) calendar days of discovery. Exceptions may be granted by STATE. MCO shall automatically recycle all impacted claims for all Providers and shall not require the Provider to resubmit the impacted claims.

Furthermore, in Section 2.8.12, delete sub-section (P) in its entirety and replace it with the following language:

(P) Claims Payment Accuracy Report

(1) On a monthly basis, MCO shall submit a claims payment accuracy percentage report to STATE. The report shall be based on an audit conducted by MCO. The audit shall be conducted by an entity or staff independent of claims management. A minimum sample consisting of one hundred seventy-five (175) claims per month shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission. A minimum of fifty (50) Institution claims, a minimum of seventy (70) Professional claims, a minimum of thirty (30) Denied claims, a minimum twenty-five (25) NEMT claims, and a minimum of twenty (20) other claims will be reviewed monthly.

(2) The MCO will determine stratification and sample allocation that align with other claim audit programs. Industry standard claim stratification and sampling methods will be used for sample allocation.

(a) Four financial stratums will be used to determine claim payment accuracy. Stratums 1 and 2 will consist primarily of professional claims and Stratums 3 and 4 will consist primarily of institutional claims.

(b) A zero-dollar stratum of denied claim samples will be reviewed to determine claims payment incident accuracy.

(3) Additional focused audits will be completed by MCO as requested by STATE on a quarterly basis. Sample size and scope will be agreed upon per audit request between MCO and STATE.

(4) The minimum attributes to be tested for each claim selected shall include:

(a) Claim data is correctly entered into the claims processing system;

(b) Claim is associated with the correct Provider;

(c) Proper authorization was obtained for the service;

(d) Enrollee eligibility at processing date correctly applied;

(e) Allowed payment amount agrees with contracted rate;

(f) Duplicate payment of the same claim has not occurred;

(g) Denial reason is applied appropriately;

(h) Co-payments are considered and applied, if applicable;

(i) Effect of modifier codes correctly applied; and

(j) Proper coding.

(5) The results of testing at a minimum should be documented to include:

(a) Results for each attribute tested for each claim selected;

(b) Amount of overpayment or underpayment for each claim processed or paid in error;

(c) Explanation of the erroneous processing for each claim processed or paid in error;

(d) Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and

(e) Claims processed or paid in error have been corrected.

(6) If MCO subcontracted for the provision of any Covered Services, and the Subcontractor is responsible for processing claims, then MCO shall submit a claims payment accuracy percentage report for the claims processed by the Subcontractor.

5. Section 2.11.3, titled Timing of Service Authorization Decisions, is amended to delete sub-section (A) in its entirety and replace it with the following language:

(A) Standard Service Authorization

(1) Requests received after 3 p.m., Central Time, will not count as the first business day.

(2) MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.

(3) The service authorization decision may be extended up to fourteen (14) additional calendar days if the Enrollee or Provider requests the extension, or MCO justifies to STATE a need for additional information and how the extension is in the Enrollee's interest.

(a) If MCO extends the timeframe for the authorization decision, MCO must:

(i) Give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to File a Grievance if he or she disagrees with that decision; and

(ii) Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

(4) MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required. Concurrent review is not required for inpatient hospital services under the diagnosis related group (DRG) payment methodology.

6. Section 2.12.3, titled Appeal Requirements, as amended by Amendment B, is further amended to delete sub-section (B) in its entirety and replace it with the following language:

(B) The Enrollee, Provider, or authorized representative may file an Appeal of an Adverse Benefit Determination either orally or in writing to MCO within sixty (60) calendar days from the date on MCO's written Notice of Adverse Benefit Determination. With STATE approval, exceptions to this timeline will be allowed only if MCO or STATE causes a delay impacting the ability for the provider to submit the appeal timely. [42 C.F.R. §438.402(c)(2)(ii), 42 C.F.R. §438.402(c)(3)(ii)]

7. Section 2.12.5, titled Format and Content of Notice of Appeal Resolution, is amended to delete sub-section (B) in its entirety and replace it with the following language:

(B) In the case of making a determination on the same day or appeal receipt acknowledgement, the Notice of Appeal Resolution and acknowledgement notification to Enrollee can be combined.

8. Section 2.12.7, titled Process for State Fair Hearings, is amended to delete sub-section (D) in its entirety and replace it with the following language:

(D) MCO shall submit an evidence packet to STATE and to the Enrollee, free of charge, within ten (10) business days from the time MCO receives notification of the hearing. The evidence packet shall be submitted to STATE in accordance with any prehearing instructions. The evidence packet shall include all necessary documents, including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents and/or records considered or relied upon by MCO and supporting MCO's Adverse Benefit Determination and Appeal resolution. Additional evidence or information pertaining to the hearing that was not known at the time of the initial denial decision may be presented at this time as part of the evidence packet.

9. Section 2.13.2, titled Quality Assessment and Performance Improvement (QAPI) program, is amended to delete sub-section (A)(2) in its entirety and replace it with the following language:

(2) Collection and submission of Performance Measurement data quarterly, including any required by STATE or CMS. [42 C.F.R. §438.330(b)(2); 42 C.F.R. §438.330(c); 42 C.F.R. §438.330(a)(2)]

Furthermore, in Section 2.13.2, delete sub-section (D) in its entirety and replace it with the following language:

(D) MCO must report the status and results of each performance improvement project to STATE quarterly as required in Appendix D: MCO Compliance, Operations, and Quality Reporting, consistent with 42 C.F.R. §438.330(d)(1) and (3).

10. Section 2.14.1, titled Performance Evaluation, is amended to delete the section its entirety and replace it with the following language:

2.14.1 Performance Evaluation

MCO shall:

(A) Annually measure and report to STATE on its performance, using the standard measures required by STATE, including, but not limited to, identified HEDIS and Adult Core Set measures, and submit data specified by STATE, which enables STATE to calculate MCO's performance using the standard measures identified by STATE as required in 42 C.F.R. §438.330(c)(1) and (2), including, but not limited to, reports identified in **Appendix D: MCO Compliance, Operations, and Quality Reporting**.

(B) Contract with an NCQA-certified HEDIS auditor to validate the processes of MCO in accordance with NCQA requirements. Audited HEDIS results shall be submitted to STATE, NCQA Interactive Data Submission System (IDSS), and STATE's EQRO annually according to NCQA's data submission timeline for health plans to submit final Medicaid HEDIS results.

(C) Report quality measure results overall and stratified for both Native Americans/Alaskan Native Enrollees and non-Native American/Alaskan Native Enrollees using data obtained from STATE eligibility information on Enrollees.

(D) Have processes in place to monitor, self-report, and implement CQI on all performance measures.

(E) Annually measure and report to STATE and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Databases Submission System on Enrollee satisfaction with MCO utilizing the most recent CAHPS survey and methodology. MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

(F) Participate in two (2) to four (4) quality assurance and improvement meetings per year with STATE, pursuant to requirements in this Contract and the North Dakota Medicaid Expansion Quality Strategy.

(G) Participate in collaborative quality improvement projects, as directed by STATE.

(H) Participate in the development of annual quality improvement (QI) goals with STATE.

(I) Actively participate in an annual quality assurance and improvement goal meeting with STATE prior to June 30, for the primary purpose of reviewing progress toward the achievement of annual improvement goals in the prior Calendar Year and applicable Contract requirements, including, but not limited to, progress made toward performance measures and objectives.

(1) For purposes of such annual meetings, MCO shall provide to STATE, no later than fourteen (14) calendar days prior to each QI goal meeting, a written update detailing MCO's progress toward meeting applicable Contract requirements and annual QI goals; and explain its performance regarding applicable Contract requirements and the annual QI goals.

(J) Meet with STATE in person if STATE determines that MCO is not in substantial compliance with the Contract, including any aspect of quality assurance and quality improvement.

11. Section 2.15.1, titled General Requirements, is amended to delete sub-section (C)(6) in its entirety and replace it with the following language:

(6) Accept electronic claims by Network Providers, and non-Participating Providers; paper claims are allowed from NEMT Network Providers or otherwise approved by STATE;

12. Section 2.15.9, titled Encounter Data, is amended to delete sub-section (B)(8)(f) in its entirety and replace it with the following language:

(f) Provider NPI numbers;

13. Section 3.9, titled National Correct Coding Initiative Edits, is amended to delete sub-section 3.9.1 in its entirety and replace it with the following language:

STATE will share with MCO, as they become available, certain National Correct Coding Initiative (NCCI) edits, subject to the Medicaid NCCI Technical Guidance manual, revised January 1, 2020, which is made a part of this Contract by its reference here, and specifically Sections 7.1.1 and 7.1.2 which require terms of confidentiality that may change from time to time. STATE will share these quarterly state Medicaid NCCI edit files with MCO to use in its processing of claims data. MCO will identify and apply necessary edit modifications through comparing STATE provided files to CMS files. MCO will deliver a quarterly report, by the 20th of the first month of the quarter, to STATE indicating differences. STATE shall impose penalties, up to and including loss of contract, for violations of any confidentiality requirements relating to use of the Medicaid NCCI edit files.

14. Section 4.20.3, titled Alternative Payment Methodologies, as amended by Amendment B, is further amended to delete sub-section (A)(2) in its entirety and relace it with the following language:

(2) Increase the percentage of members attributed to a category three APM provider, as defined by the LAN APM Framework

(a) 25% of members in Year 4 of the Contract

15. Section 5.8, titled Notice, as amended by Amendment B, is further amended to delete MCO's address in sub-section 5.8.1 in its entirety and replace it with the following language:

Blue Cross Blue Shield of North Dakota
4510 13th Ave S
Fargo, ND 58121

16. APPENDIX D: MCO COMPLIANCE, OPERATIONS, AND QUALITY REPORTING, as amended by Amendments A and B, is further amended to delete the table in its entirety and replace it with the following table:

Report Title	Description
Administration and Contract Management	
Notification of Termination	Within five (5) business days, notice of MCO's termination of any Material Subcontractor, or notice by any Material Subcontractor of intention to terminate a contract
Staffing	Annually by 31 December and upon request from STATE, a copy of the current organizational chart with reporting structures, names, and positions
Key Personnel Changes	As relevant, changes to MCO personnel in key positions
Enrollment	
Enrollment Discrepancy Report	Monthly report of Enrollees identified on NDMA's file but not enrolled in MCO's plan, Enrollees not identified on NDMA's file but enrolled in MCO's plan, and other information potentially impacting eligibility such as Enrollee's address, death, or obtaining pharmacy services outside of ND or its contiguous states
Enrollment Timeliness Report	Monthly report of outbound 834 transactions not processed within twenty-four (24) hours of receipt from STATE and timeline for completion of transactions
Enrollee Services	
Telephone Statistics Report	Quarterly report detailing weekly telephone answer statistics (e.g., number of calls received, number/percentage of calls abandoned, number/ percentage calls answered w/in thirty (30) seconds, average speed of answer)
Enrollee Inquiries	Semiannual report identifying the number and type of the top ten (10) inquiries received, due 31 March and 30 September
Covered Services	
Mental Health and Substance Use Parity	Annual report documenting compliance with the Mental Health Parity and Addiction Equity Act of 2008 due 1 June
Value-Added Benefits	As relevant, any changes to value-added benefits offered
Value-Added Benefits	Annually, a report on the impact of its value-added benefits due 1 June
Provider Networks, Contracts and Related Responsibilities	
Credentialing Policy	As relevant, changes to credentialing policies and procedures
Service Area Expansions	As relevant, proposed Service Area expansions including, #/type of Providers included by specialty and town/city, rationale, quality and access standards used to select Providers, description of methods to assure compliance with federal/state laws and Contract, distance from city/town center to each PCP, and Specialist by Specialty Type

Report Title	Description
Provider Suspension and Termination Notification	Immediate notice of any independent action taken by MCO to suspend or terminate Network Provider
Provider Suspensions and Termination Report	Annual list of Providers that MCO suspended or terminated upon notice of suspension or termination MCO, and list of provides suspended or terminated by MCO independently due 15 January
Report of Suspended/Terminated Providers	Weekly report of compliance with MCO Provider suspensions and terminations requirements and report
Provider Handbook	Annual, Provider Handbook which includes specific information about MCO Covered Services, non MCO Covered Services, and other requirements relevant to Provider responsibilities due 31 December
Provider Complaints Report	Annual report that includes all Provider complaints received, and MCO actions to address them due 1 June
Claims Summary Report	Monthly report on paid and denied claims by claim type
Claims Payment Accuracy Report	Monthly report on claims payment accuracy based on an audit conducted by MCO
Network Development and Management Plan	Annual plan describing MCO's Network development and Network management activities and results, including findings of Provider non-compliance and any corrective action plan and/or measures taken by MCO to bring Provider into compliance, and Enrollee access to Provider types where STATE has granted MCO an exception to a time or distance or appointment accessibility standard due 15 February
Network Adequacy	
PCP Geographic-Access Report	Semi-annual report of percent of Enrollees by County with access to open PCPs within the network accessibility standards in Appendix C due 31 March and 30 September
PCP to Enrollee Ratio Report	Semi-annual report of open PCPs per number of Enrollees by geographic region as defined by STATE (includes data collection methodologies) due 31 March and 30 September
Top 5 High Volume Specialists Geographic Access Report	Semi-annual report of Enrollee's geographic access to top five (5) high volume specialty types by geographic region as defined by STATE due 31 March and 30 September
Significant Changes in Provider Network Report	Immediate notice and Semi-Annual Summary report due 31 March and 30 September of significant changes in Provider Network that will affect the adequacy and capacity of services
Summary Access and Availability Analysis Report	Annual report of key findings from all access reports and data sources (e.g. Grievance system, telephone contacts with access/availability associated reason codes, Provider site visits, use of Out-of-Network alternatives due to access/availability, use of limited Provider agreements, care management staff experiences with scheduling appointments) due 1 July
Care Management	
Care Management	Annually report on care management program due 1 August
Utilization Management	
Service Authorization and Utilization Review Report	Quarterly report regarding services authorized and denied
Network Provider Profiling	Quarterly utilization review of like Specialists across Provider Network to determine if services billed are Medically Necessary
Emergency Department (ED) Visits	Annual report on ED visits and the volume of distribution by ED with top ten (10) diagnosis codes due 1 July

Report Title	Description
Potentially Avoidable ED visits and Inpatient Readmissions	Quarterly report on potentially avoidable hospital ED visits and inpatient readmissions.
Provider Preventable Conditions	Annual report on Provider Preventable Conditions due 1 July
Grievance Systems	
Enrollee Grievances	Quarterly report identifying the number and type of administrative Grievances received from an Enrollee or his/her Appeal representative (quality of care, access, attitude/service, billing/finance), the action taken for the Grievances for which trends are observed, the average time frame for resolution of Grievances in each category
Report of number and types of complaints and Appeals filed by Enrollees	Monthly report of complaints and Appeals, including reporting on how and in what time frame the complaints were resolved
Quality Management and Quality Improvement	
HEDIS® Final Audit Report	Annual report, prepared by an external HEDIS auditor of Performance Measurement due 15 July
CAHPS AHRQ Database Submission	Annual file submission of CAHPS survey results to AHRQ database due 30 June
CAHPS® Survey	Annual report of CAHPS® survey results due to the STATE by 31 July
Quality Assessment and Program Improvement goal report	Quarterly reports of progress toward QAPI goals including status and outcomes of performance improvement projects
Health Plan Accreditation Report	As relevant, copy of final accreditation report for each accrediting cycle
Performance Evaluation and External Quality Review	
Report of mandatory EQR activities Program	External Quality Review Organization report of validation of performance improvement projects, Validation of Performance Measures, and Compliance with strategy standards information reported due 1 July
Data Management and Information Systems	
Encounter data	Monthly by the fifteenth (15th) of the following month for all claims paid in the previous month
Program Integrity and Operational Audits	
Fraud & Abuse Report	Immediate reporting of Provider and Enrollee Fraud and Abuse
Fraud & Abuse Report	Quarterly report regarding any areas of Provider and Enrollee Fraud and Abuse
Coordination of Benefits/Third Party Liability	
Benefit Coordination Plan	As relevant, benefit coordination plan and proposed changes submitted for review and approval
Financial	
MLR Reports	Annually, within twelve (12) months of the end of the MLR Reporting Year as defined in in this Contract.
Managed Care Reporting Template	Semi-annual due on 1 May and 1 August
Cash Flow Statement	Annually and upon request, cash flow statements to demonstrate compliance with requirement to maintain sufficient cash flow and liquidity to meet obligations
Audited Financial Statements	Annual copies of NDID financial reports due 31 December
Third Party Liability	Monthly report indicating the claims where MCO has billed or made a recovery of a claim subject to TPL
Alternative Payment Methodology Report	Annual report on use of APMs including a list of APM models used with Network Providers, list of APM Provider agreements and the Network

Report Title	Description
	providers, PCMHs and ACOs involved in such agreements, the quality measures and range of performance benchmarks used in APMs by Provider type, and total amount paid to Providers for all Provider agreements due 30 June

17. APPENDIX E: PAYMENT METHODOLOGY, MLR, AND CAPITATION RATES, as amended by Amendments A and B, is further amended to delete sub-section (D) of Article 2: Capitation Rates in its entirety and replace it with the following language:

(D) For the period of January 1, 2024, to a date when the final Public Health Emergency data is known and sound actuarial rates can be determined, rates, not factoring in the performance withhold, are as follows. Updated rates will be calculated to incorporate more recent information, and will remain at the same position in the final actuarially sound capitation rate range relative to the initial actuarially sound capitation rate range:

Capitation Rates	Age Cohort	Gender	Urban	Rural
Child/Childless Adults	21-44	M	$821.28	$826.95
Child/Childless Adults	21-44	F	$762.55	$767.82
Child/Childless Adults	45-64	M	$1,553.87	$1,564.61
Child/Childless Adults	45-64	F	$1,256.05	$1,264.73
Retroactive Only, Not Currently Eligible	N/A	N/A	$2,551.41	$2,551.41

Furthermore, Article 3: Performance Withhold Arrangement is amended delete sub-section (A) in its entirety and replace it with the following language:

(A) Pursuant to 42 C.F.R. §438.6(c) and Article 4.17 of this Contract, STATE has elected the withhold percent to be [redacted] percent in relation to the following clinical measures:

	Measure	Weight
(1)	Initiation and Engagement of SUD (IET-AD)	10%
(2)	Follow up after ER Visit for SUD (FUA-AD	10%
(3)	Follow up after ER Visit for Mental Illness (FUM-AD)	10%
(4)	Follow up after hospitalization for Mental Illness (FUH-AD)	10%
(5)	Controlling high blood pressure (CBP)	10%
(6)	Diabetes A1C (poor control and high) (HBD)	10%
(7)	Breast Cancer Screening(BCS-AD)	10%
(8)	All-Cause Readmissions (PCR-AD)	10%
(9)	Cervical Cancer Screening (CCS)	10%
(10)	Colorectal Screening (COL)	10%

Furthermore, in Article 3, delete sub-sections (E) through (H) in their entirety and replace them with the following language:

(E) Once MCO's clinical measure performance results are known, MCO shall provide notification to STATE which shall include MCO's results along with NCQA benchmark, and supporting documentation as requested by STATE as applicable.

(F) Within 90 days or a mutually agreed upon alternative date following receipt of the final notification and supporting documentation, STATE shall provide MCO with a performance withhold reconciliation for calendar year 2023. Any balance due to MCO will be paid within 60 days or a mutually agreed upon alternative date upon acceptance by STATE and MCO.

(G) For the period of January 1, 2024, to a date when the final Public Health Emergency data is known and sound actuarial rates can be determined, rates net of the performance withhold are as follows.

Capitation Rates	Age Cohort	Gender	Urban	Rural
Child/Childless Adults	21-44	M	$804.85	$810.41
Child/Childless Adults	21-44	F	$747.30	$752.46
Child/Childless Adults	45-64	M	$1,522.79	$1,533.32
Child/Childless Adults	45-64	F	$1,230.93	$1,239.44
Retroactive Only, Not Currently Eligible	N/A	N/A	$2,500.38	$2,500.38

18. APPENDIX F: VALUE-ADDED BENEFITS AND APPROVED IN LIEU OF SERVICE, as amended by Amendments A and B, is further amended to delete sub-section (A) in its entirety and replace it with the following language:

(A) MCO shall provide the following Value-Added Services to all Enrollees served under this Contract:

- Online Wellness Portal (WebMD). A $15 incentive will be provided to enrollees who complete the online health risk profile. This amount is not included in annual $100 enrollee giveaway limit.
- Learn2Live application to provide support to Enrollees with behavioral health needs.

As part of Readiness Review, MCO shall demonstrate to State how it will make these VAS available to Enrollees.

All other terms and conditions remain as previously written.

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

By Dan Conrad 2/20/2024
DATE

Its Dan Conrad President & CEO

STATE OF NORTH DAKOTA

NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES

By Sara E. Stolt 2/27/2024
SARA STOLT DATE
INTERIM COMMISSIONER

By Sara E. Stolt 2/27/2024
KYLE J. NELSON DATE
CONTRACT OFFICER
Approved for form and content