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CONTRACT #415-12208
AMENDMENT B

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 Amendment A should be changed:

1. Section 1.1, titled Definition of Terms, as amended by Amendment A, is further amended to include the following language:

   Emergency Room Care means services provided in an emergency room for any health care service provided to evaluate and/or treat any medical condition that a prudent layperson believes requires immediate unscheduled medical care, regardless of presenting problem or primary diagnosis as defined under 42 C.F.R. §438.10(c)(4)(i).

   Excluded Service means health care services that the MCO does not pay for or cover, services or benefits that are not covered by the MCO as set forth in 42 C.F.R. §438.10(c)(4)(i).

   Furthermore, in Section 1.1, delete the Medication Therapy Management definition in its entirety and delete the Provider Performance Incentive definition in its entirety and replace it with the following:

   Provider Performance Incentive means any payment or other compensation granted to or withheld from a Provider as a result of engagement, or lack of engagement, in a targeted behavior, such as compliance with guidelines and other quality improvement initiatives, including APMs. All MCO Provider Performance Incentives must comply with CMS requirements for Physician Incentive Plans.

2. Section 2.4.7, titled Enrollee Orientation, is amended to delete subsection (A) in its entirety and replace it with the following language:

   (A) MCO shall ensure that Enrollee ID card(s) are distributed to each Enrollee within ten (10) business days after MCO has been notified through the eligibility transmission of the Enrollee's enrollment in MCO.

3. Section 2.6.3, titled Education Activities, as amended by Amendment A, is further amended to delete sub-section (B)(3) in its entirety and replace it with the following language:

   (3) MCO shall audit Provider directory information for accuracy in accordance with this Contract for a statistically valid sample size of PCPs, mental health, and SUD Providers at least quarterly, and audit at least a statistically valid sample size of its Provider directory information on a more frequent, periodic basis. Documentation of such audits shall be retained and made available to STATE upon request.

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

   (D) Provide promotional giveaways that do not exceed $100.00 value to current Enrollees only;

5. Section 2.7.5, titled In Lieu of Services, is amended to delete sub-section (A)(4) in its entirety and replace it with the following language, and then renumber the sub-sections as follows:

   (4) All ILOS applications will be submitted using the appropriate submission form as supplied by STATE. All ILOS submission forms are due to STATE by either:
   (a) July 1st of each calendar year; or
   (b) Other identified submission date as agreed upon by the State.

   (5) The STATE approved ILOS is authorized and identified in **Appendix F: Value-Added Benefits and Approved In Lieu of Services** of this this Contract.

6. Section 2.7.6, which is amended to be titled Value-Added Benefits (VAB), is amended to delete sub-section (A) in its entirety and replace it with the following language:

   (A) MCO may offer additional benefits beyond the Covered Services at no additional cost to STATE, as permitted under 42 C.F.R. §438.3(e)(1). However, these additional benefits must be pre-approved by STATE and cannot be included within the Claims experience for future rate calculations. Such services, if processed through MCO's claim system, shall be identified as value-added benefits in Encounter data, as described in **Article 2.15.9**.

   Furthermore, in Section 2.7.6, delete subsection (D) in its entirety and replace it with the following language:

   (D) MCO shall provide an annual report to STATE of the impact of its value-added benefits and may propose to change its value-added benefits on an annual basis as pre-approved in writing by STATE. All VAB applications will be submitted using the appropriate submission form as supplied by the State. All VAB submission forms are due to STATE by either:

   (1) July 1st of each calendar year; or

   (2) Other identified submission date as agreed upon by the State.

7. Section 2.8.3, titled Credentialing and Recredentialing, as amended by Amendment A, is further amended to delete sub-sections (J)(3)(b) through (J)(3)(d) in their entirety and replace them with the following language:

   (b) A site assessment of private Practitioner offices and other patient care settings, conducted in-person, when a complaint has been lodged against the specific Provider. This reassessment must be completed within 60 calendar days of the complaint.

8. Section 2.10.5, titled Care Coordination, as amended by Amendment A, is further amended to delete sub-section (C)(1) in its entirety and replace it with the following language:

   (1) Ensure follow-up with an Enrollee within seventy-two (72) hours of when the Enrollee is discharged from any type of emergency department visit, through a home visit, in-office appointment, telehealth visit, or phone conversation, as appropriate, with the Enrollee;

9. Section 2.11.1, titled General Requirements, as amended by Amendment A, is further amended to delete sub-section (D)(10) in its entirety and replace it with the following language:

   (10) Development of plans for collaborating with the Department of Corrections and local criminal justice systems to facilitate access to and/or continuation of prescribed medication and other Behavioral Health care services for Enrollees, including referral to community Providers and coordination of care, prior to re-entry into the community, including, but not limited to, Enrollees in the Medicaid pre-release program. A plan shall be developed by December 31, 2022, and submitted to STATE for approval.

10. Section 2.12.3, titled Appeal Requirements, is amended to delete sub-section (E) in its entirety and replace it with the following language:

    (E) MCO shall acknowledge and document receipt of the Appeal submitted by the Enrollee, provider, or authorized representative, either orally or in writing, and explain the process that must be followed to resolve the Appeal. [42 C.F.R. §438.406(b)(1)]

11. Section 4.4.1, titled Errors and Adjustments in Capitation Payments, is amended to delete sub-section (A) in its entirety and replace it with the following language:

    (A) Pursuant to 42 C.F.R. §438.608(c)(3), if MCO discovers errors in Capitation Payments made by STATE within the past sixty (60) days, MCO shall notify STATE. MCO shall supply supporting documentation for STATE's review. If appropriate, STATE shall adjust MCO's payment. No adjustments will be made if the error, discovered by MCO, is older than sixty days unless the adjustment is delayed on the part of STATE.

12. Section 4.9, which is amended to be titled Payment to Indian Health Care Providers (IHCP), is amended to delete sub-sections (A) and (B) in their entirety and replace them with the following language:

    (A) When an IHCP is enrolled in FFS as a FQHC but not a participating provider of MCO, it must be paid an amount equal to the amount MCO would pay a FQHC that is a Network Provider but is not an IHCP, including any supplemental payment from STATE to make up the difference between the amount MCO pays and what the IHCP FQHC would have received under FFS. [42 C.F.R. 438.14(c)(1)]

    (B) When an IHCP is not enrolled in FFS as a FQHC, regardless of whether it participates in the MCO's Provider Network, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Services (IHS), or in the absence of a published encounter rate, the amount it would

receive if the services were paid under the Medicaid State Plan's FFS payment methodology. [42 C.F.R. 438.14(c)(2)]

13. Section 4.14.2, titled Pay and Chase, and Cost Avoidance, is amended to delete sub-section (G)(1) in its entirety and replace it with the following language:

    (1) MCO shall provide to STATE, on a monthly basis, a report indicating the claims where MCO has billed or made a recovery up to the 120th day from adjudication of a claim that is subject to TPL. After one hundred twenty (120) calendar days, STATE will attempt recovery for any claims in which MCO did not attempt recovery and will retain, in full, all funds received as a result of any STATE initiated TPL billing. MCO will be precluded from attempting to bill for any recovery after one hundred twenty (120) calendar days from claim adjudication date. Any collections by MCO billed after one hundred (120) calendar days from the claim adjudication date must be sent to STATE. MCOs are to continue to cost avoid and cost recover where applicable.

14. Section 4.20.3, titled Alternative Payment Methodologies, is amended to delete sub-sections (A) and (B) in their entirety and replace them with the following language:

    (A) MCO shall implement Alternative Payment Methodologies (APMs) in its agreements with Network Providers and meet the following targets:

        (1) Increase the percentage of payments made through APM arrangements, using the collection methodology outlined by the Health Care Payment Learning and Action Network (LAN) APM Framework:

            (a) 60% of total payments to providers within APM agreements in Year 1 of the Contract.

            (b) 65% of total payments to providers within APM agreements in Year 2 of the Contract

            (c) 70% of total payments to providers within APM agreements in Year 3 of the Contract

            (d) 75% of total payments to providers within APM agreements in Year 4 of the Contract

        (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 3 of the Contract

            (b) 50% of members in Year 4 of the Contract

    (B) MCO shall develop an APM strategic plan which details how MCO will meet the APM targets in the first three years of the Contract. MCO shall share and discuss its APM strategic plan and progress with STATE on a quarterly basis. MCO submit its APM strategic plan no later than January 15, 2022, and annually by that date thereafter, consistent with STATE feedback and reporting requirements.

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

    ND Department of Health and Human Services
    Medical Services Division
    600 E. Boulevard Avenue
    Bismarck, ND 58501

16. Section 5.9.5, titled Liquidated Damages, is amended to delete the Program Issue description from item 8 of the table in sub-section (B) and replace it with the following language:

    Failure to disclose or comply with conflict of interest requirements as described in Article 2.1.2, Article 5.22, and Article 5.16 of this Contract

    Furthermore, in Section 5.9.5, delete the Program Issue description from item 12 of the table in sub-section (B) and replace it with the following language:

    Failure to review and update Provider directories within the timeframes specified by Article 2.6.3(B) of this Contract

17. APPENDIX B: MCO COVERED SERVICES is amended to include the following language:

    Medication Therapy Management: Covers a distinct service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients.

18. APPENDIX D: MCO COMPLIANCE, OPERATIONS, AND QUALITY REPORTING, as amended by Amendment A, 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 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	Weekly 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	

Report Title	Description
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
Covered Services	
Mental Health and Substance Use Parity	Annual report documenting compliance with the Mental Health Parity and Addiction Equity Act of 2008
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
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
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
Certification of Suspended/Terminated Providers	Weekly certification 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
Provider Complaints Report	Annual report that includes all Provider complaints received, and MCO actions to address them
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
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.
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)
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
Significant Changes in Provider	Immediate notice and Semi-Annual Summary report of significant changes

Report Title	Description
Network Report	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)
Care Management	
Care Management	Annually report on care management program
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
Potentially Preventable ED visits and Inpatient Readmissions	Quarterly report on potentially preventable hospital ED visits and inpatient readmissions.
Provider Preventable Conditions	Annual report on Provider Preventable Conditions
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® Clinical Topic Review (CTR)	Annual report, prepared by an external contractor of Performance Measurement
HEDIS® Clinical Topic Review (CTR) Satisfaction Survey	Annual report, prepared by an external contractor of Performance Measurement
CAHPS® Survey	Annual report of CAHPS® survey results
Quality Assessment and Program Improvement goal report	Semiannual 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	Validation of performance improvement projects, Validation of Performance Measures, and Compliance with strategy standards
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	

Report Title	Description
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
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
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 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

19. APPENDIX E: PAYMENT METHODOLOGY, MLR, AND CAPITATION RATES, as amended by Amendment A, 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, 2023, to December 31, 2023, 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	[redacted]	[redacted]
Child/Childless Adults	21-44	M	[redacted]	[redacted]
Child/Childless Adults	21-44	F	[redacted]	[redacted]
Child/Childless Adults	45-64	M	[redacted]	[redacted]
Child/Childless Adults	45-64	F	[redacted]	[redacted]
Retroactive Only, Not Currently Eligible	N/A	N/A	[redacted]	[redacted]

Furthermore, Article 3: Performance Withhold Arrangement is amended to change the withhold percent in sub-section (A) from [redacted] percent.

Furthermore, in Article 3, delete sub-section (D)(3) in its entirety and replace it with the following language:

(3) Tier 3 - ♦♦♦75% if MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet 90th percentile; or

Furthermore, in Article 3, delete sub-section (H) in its entirety and replace it with the following language:
(H) For the period of January 1, 2023, to December 31, 2023, rates net of the performance withhold are as follows.

Capitation Rates	Age Cohort	Gender		
Child/Childless Adults	21-44	M		
Child/Childless Adults	21-44	F		
Child/Childless Adults	45-64	M		
Child/Childless Adults	45-64	F		
Retroactive Only, Not Currently Eligible	N/A	N/A		

20. APPENDIX F: VALUE-ADDED BENEFITS AND APPROVED IN LIEU OF SERVICE, as amended by Amendment A, is further amended to include the following language in sub-section (B):

- Peer Support

Furthermore, in APPENDIX F, delete the following language:

As part of readiness review, MCO shall develop clear policies and procedures detailing when these In Lieu of Services shall be provided for the State's review and approval.

And replace it with the following:

All ILOS and VAB applications will be submitted using the appropriate submission form as supplied by the State. All ILOS and VAB submission forms are due to the State by either:

(A) July 1st of each calendar year; or

(B) other identified submission date as agreed upon by the State.

All other terms and conditions remain as previously written.

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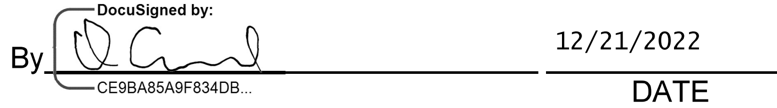
By  12/21/2022

DATE

Its President & CEO

STATE OF NORTH DAKOTA

NORTH DAKOTA DEPARTMENT OF HEALTH AND HUMAN SERVICES

By Christopher Jones (Dec 27, 2022 08:21 CST) 12/27/2022

CHRISTOPHER D. JONES DATE
EXECUTIVE DIRECTOR

By Kyle Nelson (Dec 27, 2022 08:55 CST) 12/27/2022

KYLE J. NELSON DATE
CONTRACT OFFICER
Approved for form and content