CONTRACT #415-12208
AMENDMENT A

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 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 should be changed:

1. Section 1.1, titled Definition of Terms, is amended to delete the Primary Care Physician or Provider (PCP) definition in its entirety and replace it with the following language:

   Primary Care Physician or Provider (PCP) means an individual or group of physicians, nurse practitioners, or physician assistants who accepts primary responsibility for the management of an Enrollee's health care. The Primary Care Provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a Specialist (secondary/tertiary care), or admit the patient to a hospital.

2. Section 2.3.7, titled Physical Presence in North Dakota, is amended to delete the section in its entirety and replace it with the following language:

   MCO shall not be located outside of the United States and no operations that include the use of PHI, including that of a Material Subcontractor, may be conducted outside of the United States. MCO shall have an Administrative Office located in North Dakota and within a three (3) hour drive of the North Dakota Department of Human Services, Medical Services Division's location in East Boulevard Avenue, Bismarck, North Dakota.

3. Section 2.3.9, titled Subcontracts and Delegation of Duty, is amended to delete sub-section (B)(2) in its entirety and replace it with the following language:

   (2) At least ninety (90) calendar days before the proposed effective date of the Material Subcontract or change, MCO shall make a request in writing and submit with that request a completed Material Subcontractor Checklist using the template provided by STATE in **Appendix A: Material Subcontractor Checklist** and three years of audited financials of the material subcontractor to demonstrate the Material Subcontractor's compliance with requirements as defined in this Contract. Failure to demonstrate compliance may result in STATE withholding approval of the Material Subcontract.

4. Section 2.4.2, titled MCO Assignment for New Enrollees, is amended to delete the section in its entirety and replace it with the following language:

   Potential Enrollees shall be assigned to MCO at the time eligibility is determined.

5. Section 2.4.4, titled Suspension of and/or Limits on Enrollments, is amended to delete sub-section (B) in its entirety.

6. Section 2.4.6, titled Eligibility File, is amended to delete sub-section (B) in its entirety and replace it with the following language:

   (B) MCO shall receive, process, and update outbound 834 enrollment files from STATE. Enrollment data shall be updated or uploaded in the order received to MCO's eligibility/enrollment database(s) within one business day of receipt from STATE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within one business day of receipt. MCO shall accept and maintain within its system all indicators included in the file received from STATE. MCO shall report to STATE, in a form and format to be provided by STATE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within one business day of receipt from STATE and/or persistent issues with high volumes of transitions that require manual upload may require MCO to initiate a Corrective Action Plan or resolution of the issues preventing compliance. If MCO has reason to believe they may not meet this requirement based on unusual circumstances, MCO must notify STATE and STATE may make an exception without requiring a Corrective Action Plan.

7. Section 2.5.2, titled Enrollee Call Center, is amended to delete sub-section (G) in its entirety and replace it with the following language:

   (G) MCO shall develop a contingency plan for hiring call center staff to address overflow calls, and to maintain call center access standards set forth for MCO performance. MCO shall develop and implement a plan to sustain call center performance levels in situations where there is high call volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses, and vacations.

8. Section 2.5.3, titled Enrollee Call Center Performance Standards, is amended to delete sub-section (A)(3) in its entirety and replace it with the following language:

   (3) Maintain an average hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this Contract includes: (1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and (2) the measure of time when a customer service representative places a caller on hold; and

9. Section 2.6.3, titled Education Activities, is amended to delete sub-section (A)(4)(a) in its entirety and renumber the sub-sections as follows:

   (a) Make materials available on both STATE and MCO's website in a location that is prominent and readily accessible;

   (b) Provide materials in an electronic form that can be electronically retained and printed;

(c) Ensure materials are consistent with the content and language requirements of 42 C.F.R. §438.10; and

(d) Inform the Enrollee that these documents are available in paper form, without charge, upon request and must be provided within five (5) business days of Enrollee's request.

Furthermore, in Section 2.6.3, delete sub-section (B)(6) in its entirety and replace it with the following language:

(6) MCO must include, in both electronic and print directories, a customer service member portal, telephone number, and/or electronic link that individuals may use to notify MCO of inaccurate Provider directory information.

10. Section 2.7.3, titled Prescription Drugs, is amended to delete sub-section (A)(3) in its entirety and replace it with the following language:

(3) MCO must ensure compliance with Medicaid managed care regulations at 42 C.F.R. §438.210 for prescription drug coverage, including requirements for covered outpatient drugs, pursuant to Section 1927 of the Social Security Act, and timely and complete reporting to STATE as specified in this Contract.

Furthermore, in Section 2.7.3, delete the last sentence in its entirety in sub-section (G)(2).

Furthermore, in Section 2.7.3, delete sub-section (G)(4) in its entirety and replace it with the following language:

(4) In the event that STATE retroactively terminates an Enrollee and MCO had previously identified such Enrollee as eligible for rebates under Section 1903(m)(2)(A)(xiii) of the Social Security Act, MCO must include the identified medical pharmacy Claims within the applicable quarterly post-adjudication history file with an indicator reflecting it as no longer being eligible for rebates or within a separate file using the same format as the post-adjudication history file(s).

Furthermore, in Section 2.7.3, delete the acronym "NCPDP" in sub-section (G)(6).

Furthermore, in Section 2.7.3, delete sub-section (I)(1) in its entirety and replace it with the following language:

(1) Pursuant to 42 CFR § 438.3(s)(4)-(5), STATE shall establish and operate a drug utilization review program that complies with the requirements at Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act and at 1927(g) of the Act, which includes prospective drug review, retrospective drug use review, and an educational program as specified in 42 CFR part 456, subpart K. MCO shall assist STATE in operating a drug utilization program.

Furthermore, in Section 2.7.3, delete sub-section (I)(3) in its entirety and replace it with the following language:

(3) MCO shall provide a detailed description of its drug utilization review program activities to STATE on an annual basis, if applicable.

11. Section 2.8.3, titled Credentialing and Recredentialing, is amended to delete the Section in its entirety and replace it with the following language:

(A) MCO shall be responsible for the credentialing and recredentialing of its Provider Network. MCO must submit documentation to STATE to demonstrate that its Network Providers are credentialed as required under 42 C.F.R. §438.214. [42 C.F.R. §438.206(b)(6)]

(B) If MCO has delegated credentialing and/or recredentialing to a Subcontractor, the agreement must ensure that all Providers are credentialed in accordance with MCO's and STATE's credentialing requirements, as described in **Article 2.8.3**.

(C) MCO shall completely process credentialing applications from all types of Providers (physical health and Behavioral Health Providers) within ninety (90) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Provider agreement. Completely process shall mean that MCO shall review, approve, and load approved applicants to its Provider files in its claims processing system or deny the application and assure that the Provider is not used by MCO.

(D) MCO shall use credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) or URAC. MCO must follow the most current version of the credentialing organization's credentialing requirements. MCO must also ensure that delegated credentialing Providers and Material Subcontractors meet these credentialing requirements.

(E) MCO must maintain a Credentialing Committee that:

(1) Meets at regular intervals;

(2) Is chaired by MCO's Medical Director or a designated physician;

(3) Includes a variety of participating Practitioners in its membership;

(4) Reviews credentialing files for Practitioners who do not meet the established criteria;

(5) Ensures credentialing files that meet criteria are reviewed and approved by the Medical Director or designated physician; and

(6) Ensures each credentialing file includes the date of the Credentialing Committee decisions.

(F) MCO shall verify and certify to STATE that all Network Providers are properly licensed in accordance with all applicable State laws and regulations, are eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by MCO and the North Dakota Insurance Department.

(G) MCO must ensure that all Network Providers are enrolled with STATE as Medicaid Providers consistent with the Provider disclosure, screening, and enrollment requirements of 42 C.F.R. part 455, subparts B and E. This provision does not require the Network Provider to render services to fee-for-service beneficiaries.

(H) MCO shall maintain a file for each Provider containing a complete Provider application including a signed attestation statement, a copy of the Provider's current license issued by STATE, a valid DEA or Controlled Dangerous Substances certificate, and such additional information as may be specified by STATE.

(I) In contracting with laboratory Providers and or any Provider who bills for laboratory services, MCO must ensure that all laboratory testing sites providing services under the Contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Provider attestation of CLIA certificate is not acceptable. MCO shall maintain copies of the CLIA certificate or waiver of the certificate of registration in the Provider's credentialing and recredentialing files.

(J) MCO shall develop written policies and procedures detailing the process for verification of Provider credentials and insurance and periodic review of Provider performance, which must be approved in writing by STATE as part of the readiness review prior to implementation. Credentialing policies and procedures must meet Federal and State requirements and shall include:

(1) The verification of the existence and maintenance of credentials, licenses, malpractice claims history, certificates, and insurance coverage of each admitting Provider from a primary source, site assessment, hospital admitting privileges, or admitting plan. Proof of this verification must be maintained within each Provider file.

(2) A methodology and process for recredentialing Providers every five (5) years.

(3) A process for conducting site assessments of moderate and high-risk Providers, including descriptions of:

(a) How the MCO will designate a Provider as moderate or high categorical risks to the Medicaid program, pursuant to 42 C.F.R. 435.432;

(b) The initial site assessment, prior to the completion of the initial credentialing process, of private Practitioner offices and other patient care settings conducted in-person during the Provider office visit;

(c) A site reassessment if the Provider location has changed since the previous credentialing activity; and

(d) A site reassessment 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.

(4) Procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges.

(5) Procedures for Practitioners to review the information submitted in support of the Practitioner's credentialing application, and to correct erroneous information.

(6) Process for making available to Practitioners MCO's confidentiality requirements to ensure that all information obtained in the credentialing process is confidential except as otherwise provided by law.

(7) Process for notifying a Practitioner of any information obtained during the credentialing process that varies substantially from the information provided to MCO by the Practitioner.

(8) Procedures for verifying the inclusion of Providers including but not limited to the following databases: HHS-OIG's List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of Excluded Providers.

(a) MCO shall conduct monthly searches of the SAM and LEIE databases to ensure that Providers are not restricted Providers, and shall maintain documentation showing that such searches were conducted.

(b) Within thirty (30) calendar days of either identifying an Excluded Provider or receiving exclusion information from a Network Provider, MCO shall notify STATE of the exclusion by electronically submitting the information on STATE's Disclosure of Excluded Provider Form to STATE.

(K) MCO shall notify STATE within ten (10) calendar days of MCO's denial of a Provider credentialing or recredentialing application either for program integrity-related reasons, due to limitations placed on the Provider's ability to participate for program integrity-related reasons, or MCO's decisions not to allow a Provider to participate in the Network.

(L) MCO must load Provider information into its claims processing system within thirty (30) calendar days of Provider agreement approval.

12. Section 2.8.11, titled Provider Services, is amended to delete sub-section (A) in its entirety and replace it with the following language:

(A) MCO shall provide, upon request, all PCPs with a current hard copy listing of referral Providers, including Behavioral Health Providers on a quarterly basis. MCO shall also maintain an updated electronic, web-accessible version of the referral Provider listing.

Furthermore, in Section 2.8.11, delete sub-section (C)(3) in its entirety and renumber the sub-sections as follows:

(1) MCO shall have trained Provider relations staff dedicated to this Contract and operate a Provider toll-free line to address Provider issues Monday through Friday from 8 a.m. to 6 p.m. Central Time and to handle non-routine Prior Authorization requests twenty-four (24) hours per day, seven (7) days per week.

(2) MCO shall have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of urgent or Emergency Services. MCO and its Providers shall not require such verification prior to providing Emergency Services.

(3) The telephone line shall include the ability for Providers to access interpreter services as described in the Enrollee Services Article of this Contract. The telephone line shall have the capability to track Provider call management metrics and comply with the Enrollee call center performance standards outlined in the Enrollee Services Article.

(4) MCO shall have in a place a process for measuring the quality of response from Provider relations staff and providing additional training to staff as necessary to address any shortcomings in ability to appropriately respond.

Furthermore, in Section 2.8.11, delete sub-sections (F)(4) and (F)(5) in their entirety and renumber the sub-sections as follows:

(1) MCO shall provide training to all Providers and their staff regarding the requirements of the Contract, including limitations on Provider marketing and identification of special needs of Enrollees. MCO shall conduct initial training within thirty (30) calendar days of placing a newly Contracted Provider, or Provider group, on active status. MCO shall also conduct ongoing training, as deemed necessary by MCO or STATE, in order to ensure compliance with program standards and the Contract.

(2) MCO shall submit a copy of the Provider Training Manual and training schedule to STATE for approval as part of readiness reviews. Any changes to the manual shall be submitted to STATE at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.

(3) MCO shall develop and offer specialized initial and ongoing training in the areas including, but not limited to, billing procedures and service authorization requirements.

(4) MCO shall provide at least seven (7) calendar days advance notice of all trainings to STATE, and STATE shall be invited to attend all Provider sessions. MCO shall maintain and provide upon STATE request all Provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees' lists, and organizations trained.

(5) Upon entering into Agreements, MCO shall provide its Network Providers adequate information about the Grievance, Appeal, and STATE Fair Hearing procedures and timelines so that the Provider can comply with the Grievance System's requirements including:

(a) The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;

(b) The Enrollee's right to file Grievances and Appeals;

(c) The requirements and timeframes for filing a Grievance or Appeal;

(d) The availability of assistance in the filling process;

(e) The toll-free numbers that the Enrollee can use to file a Grievance or Appeal by phone;

(f) The fact that, when requested by the Enrollee, disputed services will continue if the Enrollee files an Appeal or requests a State Fair Hearing within the timeframes specified for filing, and the Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and

(g) Any State-determined Provider Appeal rights to challenge the failure of MCO to cover a service.

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

(O) Payment Categories for Claims

(1) MCO shall provide written notification to a Provider of any payment that is recouped.

(2) The notification shall include:

(a) The patient's name and member identifier;

(b) The date(s) of Health Care Services rendered;

(c) A complete listing of the specific claims and amounts subject to the recoupment; and

(d) The specific reasons for making the recoupment for each of the claims subject to the recoupment.

(3) MCO shall develop and implement a safeguard for automated reviews to prevent subsequent reviews on a claim when the denial or exception reason is the same as a previous denial or exception reason. MCO and its Subcontractors shall not recover from a Provider via automated review for a claim for which an automated denial was reversed subsequent to Provider dispute, when the denials are for the same reason. For such claims, MCO shall ensure a complex review and consideration of the claim history or audit trail.

(4) At the Provider's request, MCO shall provide an independent review of claims that are the subject of an Adverse Determination by MCO.

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 twenty-five (125) claims per month shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

(2) MCO will determine stratification that aligns with the methodologies of other claim audit programs including:

(a) Monthly audit periods with monthly reporting.

(b) Use of the equal dollar method of claim stratification.

(3) 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.

(4) 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.

(5) 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.

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

(R) Paid Claims

(1) MCO shall provide individual explanation of benefits (EOB) notices to all Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 C.F.R. §455.20 and §433.116(e). In easily understood language, the required notice shall specify:

(a) Description of the service furnished;

(b) The name of the Provider furnishing the service;

(c) The date on which the service was furnished;

(d) The amount of the payment made for the service; and

(e) The method for notifying MCO of services not rendered.

(2) MCO shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be Enrollee education, Provider education, payment recovery, or referral to STATE. MCO shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

(3) Within three (3) business days, results indicating that paid services may not have been received shall be referred to MCO's Fraud, Waste and Abuse department for review and referral to STATE.

Furthermore, in Section 2.8.12, delete the word "quarterly" from sub-section (S)(4) and replace it with the word "annually".

14. Section 2.10.1, titled General Care Delivery Requirements, is amended to delete the words "twenty-four (24)" in their entirety from sub-section (B)(5) and replace them with "seventy-two (72)".

15. Section 2.10.5, titled Care Coordination, is amended to delete the extra period from the end of sub-section (D)(9).

16. Section 2.11.1, titled General Requirements, is 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.

17. Section 2.11.5, titled Informal Reconsideration, is amended to delete the Section in its entirety, including the Section title, and replace it with the following language:

2.11.5 Informal Peer-to-Peer Process

(A) As part of MCO's Appeal procedures, MCO shall include an informal peer-to-peer process that allows the Enrollee (or Provider/agent on behalf of an Enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing.

(B) In a case involving an initial determination or a concurrent review determination, MCO shall provide the Enrollee or a Provider acting on behalf of the Enrollee and with the Enrollee's written consent an opportunity to request an informal peer-to-peer review of an Adverse Determination by the physician or clinical peer making the Adverse Determination.

(C) The informal peer-to-peer process shall occur within one (1) business day of the receipt of the request and shall be conducted between the Provider rendering the service and a clinical peer designated by the medical director if the physician who made the Adverse Determination cannot be available within one (1) business day.

(D) The informal peer-to-peer process does not extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

18. Section 2.14.1, titled Performance Evaluation, is amended to delete the word "Bi-annually" in its entirety from sub-section (E) and replace it with "Annually".

19. Section 2.15.1, titled General Requirements, is amended to delete sub-section (D)(8) in its entirety and replace it with the following language:

(8) No later than July 1, 2022, MCO shall employ CMS mandated edits for Medicaid and nationally recognized clinical editing standards as outlined below:

(a) At a minimum, these edits shall be maintained and updated quarterly unless otherwise appropriate and apply to Practitioners, outpatient hospitals, and DME services.

(b) Edits shall be based on current industry benchmarks and best practices, including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Medicaid, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successor.

(c) These edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing shall include the ability to apply edits to the current claim as well as paid history claims when applicable.

(d) MCO shall attest annually that they are adhering to these requirements and are subject to periodic requests from STATE for validation of the edits.

(e) MCO shall update CMS mandated edits and NCCI edits quarterly as directed by CMS.

(f) MCO shall limit disclosure of files received from STATE to those responsible for implementation of the quarterly state Medicaid NCCI edit files.

(g) As it becomes available, MCO may disclose only non-confidential information contained in the Medicaid NCCI edit files that is also available to the general public found on the Medicaid NCCI webpage.

(h) MCO agrees to use any non-public information from the quarterly state Medicaid NCCI edit files only for any business purposes directly related to the implementation of the Medicaid NCCI methodologies.

(i) MCO shall not publish or otherwise share individuals, medical societies or any other entities unless it is a contracted party prior to the posting of the Medicaid NCCI edits on the Medicaid NCCI webpage.

(j) MCO agrees that implementation of a new, revised or deleted Medicaid NCCI edits shall not occur prior to the first day of the calendar quarter.

20. Section 2.15.9, titled Encounter Data, is amended to insert the words ", at minimum," into sub-section (B) after the words "Claim-level Enrollee Encounter Data".

21. Section 2.16.5, titled Reporting Incidences of Potential Provider-Related Fraud, Waste, and Abuse, is amended to delete sub-section (A) in its entirety and replace it with the following language:

(A) Pursuant to N.D.A.C. §75-02-05-06, if MCO or any subcontractor becomes aware of potential Provider-related Fraud, Waste, or Abuse, MCO shall report the incident utilizing STATE's secure web-based system. MCO must report to STATE all suspected Provider Fraud, Waste or Abuse within one (1) business day of discovery.

22. Section 2.16.6, titled Reporting Incidences of Enrollee-Related Fraud, Waste, and Abuse, is amended to delete sub-section (A) in its entirety and replace it with the following language:

(A) If MCO becomes aware of potential Enrollee Fraud, related to the Enrollee's eligibility for Medicaid (such as the potential Enrollee misrepresented facts in order to become, or maintain, Medicaid eligibility), MCO or Provider shall report the potential Enrollee Fraud to STATE using STATE's secure web-based system.

23. Section 2.16.8, titled Subrogation of Claims Arising from Fraud, is amended to change the Section number to 2.16.9, and a new Section 2.16.8, titled Rights of Review and Recovery by MCO and STATE, is added to the Contract as follows:

2.16.8 Rights of Review and Recovery by MCO and STATE

(A) MCO and its Subcontractors are responsible for investigating and reporting possible acts of provider fraud, waste, and abuse for all services under this Contract.

(B) MCO and its Subcontractors shall have the right to audit, review, and investigate providers and Enrollees within MCO's network for a one (1) year period from the date of payment of a claim via "automated" review. An automated review is one for which an analysis of the paid claims is sufficient to determine the existence of an overpayment, whereas no additional documentation is required to be submitted from the Provider to determine the existence of an overpayment.

(1) The collected funds from MCO's automated reviews are to remain with MCO.

(2) MCO shall not recover from Providers via automated review for claims older than one (1) year unless authorized by STATE.

(C) MCO and its Subcontractors shall have the right to audit, review, and investigate Providers and Enrollees within MCO's network for a five (5) year period from the date of service of a claim via "complex" review. A complex review is one for which the review of medical, financial, and/or other records, including those onsite, were necessary to determine the existence of an improper payment.

(1) The collected funds from MCO's complex reviews are to remain with MCO.

(2) All complex reviews shall be completed within eight (8) months (240 calendar days) of the date the case was opened unless an extension is authorized by STATE. This review period is inclusive of all Provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.

(D) MCO shall void or deny all claims, claim lines, and encounters associated with fraud, waste, and abuse for the purpose of reducing per-member, per-month rates, thereby returning overpayments to STATE.

(E) MCO shall confer with STATE before initiating a post-payment Provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include, at a minimum: Provider name, NPI, city, and Provider type, allegation or issue being reviewed, procedure codes or National Drug Codes under review, date range for dates of service under review, and amount paid. MCO and its Subcontractors shall not pursue recovery until approved by STATE.

(F) STATE or its designee will notify MCO when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services, or claims upon which the recoupment or withhold are based meet one (1) or more of the following criteria:

(1) The improperly paid funds have already been recovered by the state of North Dakota, either directly or as part of a resolution of a state or federal investigation, audit, and/or lawsuit, including, but not limited to, False Claims Act cases; or

(2) When the issues, services, or claims that are the basis of the recoupment or withhold are the subject of pending state or federal investigation, audit, and/or lawsuit.

(G) The prohibition described in the preceding section shall be limited to a specific Provider(s), for specific dates, and for specific issues, services, or claims. In the event that MCO obtains funds in cases where recovery, recoupment, or withhold is prohibited under this Section, STATE may recover the funds from MCO.

(H) MCO shall be prohibited from communicating with a Provider about suspected fraud, which MCO has identified and submitted a referral of fraud to STATE, Medicaid Fraud Control Unit, or other appropriate law enforcement agency, until approved by STATE.

(I) If MCO fails to collect at least a portion of an identified recovery after three hundred sixty-five (365) calendar days from the date of notice to STATE, unless an extension or exception is authorized by STATE, and MCO has documented recovery efforts deemed sufficient by STATE upon review, STATE or its agent may recover the overpayment from MCO and said funds shall be retained by STATE.

(J) STATE or its agent shall have the right to audit, review, and investigate providers and Enrollees within the Contractor's network via "complex" or "automated" review. STATE may withhold from MCO any overpayments identified by STATE or its agent and said recovered funds shall be retained by STATE. MCO may pursue recovery from the Provider as a result of STATE-identified overpayment withhold. STATE shall not initiate its own review on the same claims for a Network Provider which has been identified by MCO as under a review approved by STATE. STATE shall track open STATE and MCO reviews to ensure audit coordination. STATE shall not approve MCO requests to initiate reviews when the audit lead and timeframe is already under investigation by STATE or its agents.

(K) In the event STATE or its agent initiates a review on a Network Provider, a notification shall be sent to MCO. STATE notification of the intent to review shall include Provider name, NPI, city, and Provider type, allegation or issue being reviewed, procedure codes or National Drug Codes under review, date range for dates of service under review, and amount paid. MCO shall have ten (10) business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from STATE. If STATE does not receive a response from MCO within ten (10) business days, STATE may proceed with its review.

(L) In the event STATE or its agent investigates, reviews, or audits a Provider or Enrollee within MCO's Network, MCO shall comply with document and claims requests from STATE within twenty (20) calendar days of the request, unless another time period is agreed to by MCO and STATE.

(M) STATE shall notify MCO and the Network Provider concurrently of overpayments identified by STATE or its agents.

(N) Upon the conclusion of Provider rebuttals and appeals, if applicable, STATE, or its agent, shall notify MCO of the overpayment. MCO shall correct or initiate its own review on the identified encounters within fourteen (14) calendar days of notification from STATE. STATE shall submit confirmation that the corrections have been completed.

(O) MCO and its Subcontractors shall enforce STATE directives regarding sanctions on MCO Network Providers and Enrollees, including, but not limited to, termination or exclusion from the network.

(P) There shall be no STATE Provider improper payment recovery request of MCO applicable for the dates of service occurring before the start of the Contract period or for providers for which no MCO relationship existed.

(Q) MCO shall not remit payment to any provider for which the state-issued Medicaid Provider identifier number has been revoked or terminated by STATE.

24. ARTICLE 3: STATE RESPONSIBILITIES is amended to add the following Section:

3.9 National Correct Coding Initiative Edits

3.9.1 STATE will share with MCO, as they become available, certain National Correct Coding Initiative edits, subject to the Medicaid National Correct Coding Initiative 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 National Correct Coding Initiative edit files with MCO to use in its processing of claims data. STATE shall impose penalties, up to and including loss of contract, for violations of any confidentiality requirements relating to use of the Medicaid National Correct Coding Initiative edit files.

25. ARTICLE 4: PAYMENT AND FINANCIAL PROVISIONS, Section 4.17, titled Performance Withhold Arrangements, is amended to delete sub-section 4.17.6 in its entirety and and replace it with the following language:

4.17.6 To earn back the full withhold amount associated with each incentive-based measure, MCO performance must meet or exceed the target for that measure. Targets for HEDIS® incentive-based measure scores will be based on NCQA Quality Compass Medicaid National percentile values for the most recent applicable measurement year. Targets for non-HEDIS measures will be based on the Adult Core Set Chart Pack benchmark data for the most recent applicable measurement year.

26. ARTICLE 5: ADDITIONAL TERMS AND CONDITIONS, Section 5.24, titled Insurance, is amended to delete the words "of $250,000 per person and" in their entirety from sub-section 5.24.1(B).

27. APPENDIX D: MCO COMPLIANCE, OPERATIONS, AND QUALITY REPORTING is amended in its entirety to delete the table 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	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
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	Quarterly 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

Report Title	Description
	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 Network Report	Immediate notice and Semi-Annual Summary report 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)
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

Report Title	Description
	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	
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 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

28. APPENDIX E: PAYMENT METHODOLOGY, MLR, AND CAPITATION RATES, is 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, 2022, to December 31, 2022, 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		
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		

Furthermore, Article 3 is amended to change the Article number to 4, and add a new Article 3: Performance Withhold Arrangement to the Contract as follows:

Article 3: Performance Withhold Arrangement

(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] in relation to the following clinical measures:

Measure	[redacted]
(1) Initiation and Engagement of SUD (IET-AD)	
(2) Follow up after ER Visit for SUD (FUA-AD)	
(3) Follow up after ER Visit for Mental Illness (FUM-AD)	
(4) Follow up after hospitalization for Mental Illness (FUH-AD)	
(5) Controlling high blood pressure (CBP)	
(6) Diabetes A1C (poor control and high) (HBD)	
(7) Diabetes Eye Exam (EED)	
(8) All-Cause Readmissions (PCR-AD)	
(9) Asthma/COPD Admissions for Older Adults (PQI 05)	
(10) Diabetes Admissions (PQI 01)	

(B) The withhold percent will be included in the capitation rate development with STATE withholding the percentage from MCO's monthly Capitation Payment.

(C) The clinical measure performance results are on a year in arrears basis with 2023 results reflecting measurement year 2022.

(D) For the measures that are benchmarked against the NCQA Quality Compass, MCO earn back of the withhold percentage will be based on MCO's performance tiers as follows:

(1) Tier 1 - ♦ 0% if MCO rate is below the NCQA Quality Compass National average;
(2) Tier 2 - ♦♦ 50% if MCO rate is equal to or exceeds the NCQA Quality Compass National average, but does not meet 75th percentile;
(3) Tier 3 - ♦♦♦75% if MCO rate is equal to or exceeds the NCQA Quality Compass National average, but does not meet 90th percentile; or
(4) Tier 4 - ♦♦♦♦100% if MCO rate is equal to or exceeds the NCQA Quality Compass National 90th percentile

(E) For the measures that are benchmarked against the Adult Core Set Chart Pack, MCO earn back of the withhold percentage will be based on MCO's performance tiers as follows:

(1) Tier 1: 0% if MCO rate is below the national median.
(2) Tier 2: 50% if MCO rate is equal to or exceeds the national median, but not in the top quartile.
(3) Tier 3: 100% if MCO rate is equal to or exceeds the top quartile.

(F) 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.

(G) Within ninety (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 2022. Any balance due to MCO will be paid within 60 days or a mutually agreed upon alternative date upon acceptance by STATE and MCO.

(H) For the period of January 1, 2022, to December 31, 2022, rates net of the performance withhold are as follows.

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]

29. APPENDIX F: VALUE-ADDED BENEFITS AND APPROVED IN LIEU OF SERVICE, is amended to delete the first bullet point of sub-section (A) in its entirety and replace it with the following language:

    - Online Wellness Portal (WebMD). A $15 incentive will be provided to enrollees who complete the online health risk profile.

All other terms and conditions remain as previously written.

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

By Dan Conrad _____ October 31, 2021
DATE

Its CEO

STATE OF NORTH DAKOTA

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

By _____ 11-3-21
CHRISTOPHER D. JONES DATE
EXECUTIVE DIRECTOR

Kyle J. Nelson Digitally signed by Kyle J. Nelson Date: 2021.11.03 14:54:03 -05'00'

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