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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-CHIP SPA #11

This file contains the following documents in the order listed:

The complete title XXI state plan for North Dakota consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

APR 0 3 2015

Ms. Jodi Hulm
EPSDT & CHIP Program Administrator
ND Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0250

Dear Ms. Hulm:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number 11 submitted on August 1, 2014, with additional information submitted on March 27, 2015, has been approved. The SPA has an effective date of July 1, 2014.

Through this SPA, North Dakota updates its service delivery contractors to Blue Cross and Blue Shield of North Dakota (BCBS) and Delta Dental of Minnesota (DDMN), and proposes additional pharmacy benefits, with corresponding new cost-sharing requirements. In addition, this SPA increases the dollar limitation amounts for hearing aids, eyeglass frames and lens, and medical equipment and supplies, and provides new benefit coverage for routine circumcision.

As you are aware, North Dakota proposed a $5 copayment for preferred drugs and $10 copayment for non-preferred drugs. During review of the SPA, the Centers for Medicare & Medicaid Services (CMS) identified that in accordance with Section 2103(e)(3)(A) of the Social Security Act, cost-sharing charges for children in families earning under 150 percent of the federal poverty level (FPL) must be equal to or less than the amount permitted under Medicaid. In accordance with Medicaid regulations 42 CFR 447.53, the state has lowered the pharmacy copayments for all CHIP enrollees to the maximum allowable amounts for individuals in families with income at or below 150 percent FPL, which are $4.00 for preferred drugs and $8.00 for non-preferred drugs. North Dakota's plan to reimburse beneficiaries that incurred any erroneous cost sharing for the period of July 1, 2013 through February 28, 2015, when the higher copayment levels were in effect is outlined in the corrective action plan submitted by the state.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Telephone: (410) 786-3413
Facsimile: (410) 786-5882
E-mail: Joyce.Jordan@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jordan and to Mr. Richard Allen, Associate Regional Administrator in our Denver Regional Office. Mr. Allen's address is:

Denver Regional Office
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
1961 Stout Street
Room 08-148
Denver, CO 80294

If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at (410) 786-0719.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Eliot Fishman /

Eliot Fishman
Director

cc:
Mr. Richard Allen, ARA, CMS Region VIII, Denver

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

The stand alone CHIP in North Dakota provides a comprehensive array of services through a contract with ~~Noridian Mutual Insurance Company~~ Blue Cross and Blue Shield of ND (BCBS) and Delta Dental of Minnesota (DDMN) . ~~This company was~~ These companies were chosen to pay for necessary medical, dental and vision services through a competitive Request for Proposal process.

~~Noridian Mutual Insurance Company was formally known as Blue Cross/Blue Shield of North Dakota. They are~~ BCBS is the primary health insurance entity doing business in North Dakota. They cover more than 50% of all insured individuals in North Dakota. They have an extensive provider network throughout North Dakota. For this reason children eligible for Healthy Steps have excellent access to the services covered under the plan.

On July 1, 2013 a new contract with Delta Dental of Minnesota was initiated for dental coverage for the Healthy Steps children's population in North Dakota. As of May, 2014 there are currently 365 unique dentists providing care for this population, and 541 access points throughout the state. Recruitment will continue throughout 2014 to increase the number of providers participating in this program. Delta Dental of Minnesota reaches out to provider offices in a variety of ways including personal office visits to help maintain and grow the number of participating dentists in this important program.

~~North Dakota CHIP has developed an Alternate Payment Methodology (APM) with the Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). The APM will be reviewed on a periodic basis with the FQHC's and RHCs to ensure satisfaction.~~

~~For the CHIP APM, Blue Cross Blue Shield of North Dakota pays Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) based on a Fee For Service (FFS) basis. The State receives the CHIP claims data from Blue Cross Blue Shield of North Dakota. The State compares the payments made to the FQHC/RHC's from the Blue Cross Blue Shield of North Dakota fee schedule to what the FQHC/RHC's would have been paid under the Medicaid PPS rate.~~

~~If the facility was paid more than the Medicaid PPS rate, no additional payments are made. If the analysis demonstrates that what the FQHC/RHC's have been paid from the Blue Cross Blue Shield of North Dakota fee schedule was less than what they would have received with the Medicaid PPS, a supplemental payment, for the difference, is issued to the facility.~~

~~The claims data is obtained every four months from Blue Cross Blue Shield of North Dakota.~~

The contract is an indemnity product based on a monthly premium that is ~~adjusted every two years to coincide with the biennial budget~~ actuarially certified every year. The fee structure used by BCBS and DDMN is identical to what is used to pay for its other commercial insurance coverage. ~~Fee increases are determined actuarially by Noridian and the increases are reviewed and certified as reasonable by the North Dakota Department of Insurance.~~

We have executed three separate contracts ~~with Nordian~~ for medical, dental and vision coverage. The contracts detail the responsibilities of the insurance companyies to pay for all approved services in accordance with contract provisions. All non-covered services and limits on services are delineated in the contract and are made available to each enrolled family through coverage handbooks provided by the contractors.

The contracts include language that access to medical services must be available 7 days a week, 24 hours a day and requires the carrier to monitor access, service delivery, client satisfaction and quality assurance for enrollees. Surveys conducted by the contractors indicate excellent client satisfaction with the program.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The contractors for the Healthy Steps program performs utilization management functions approved by the department for the fee for service payment process. These functions will ensure that children receive health care that is appropriate, medically necessary and delivered in a cost effective and efficient manner.

The contractors conducts quality and utilization reviews that determine if services provided are medically necessary including but not limited to relationship edits for procedure and diagnosis codes. Any improper claims are denied and where appropriate overpayments will be recouped for claims that have already been paid.

The contractors conducts physician profiling. This process reviews the utilization of services of like specialties across the state. Each specialty is severity adjusted. A comparison and efficiency index is assigned on an episode case basis. If a physician is not within the normal limits of care provided within the specialty group as compared to peers, a review is conducted and if appropriate, an audit is conducted to determine if the services billed are medically necessary.

~~In addition, focused reviews will be completed in conjunction with studies being performed by the Department for the primary care case management program, aka North Dakota Access to Care Program, and reviews related to services provided by Managed Care Organizations.~~

Coverage is not available for any form of thermography for any use or indication.

Coverage is not available for acupuncture performed by any provider.

Coverage is not available for any outpatient provider for palliative or cosmetic foot care, foot support devices, except custom made support devices, or subluxation of the foot, care of corns, bunions, except for capsular or bone surgery, calluses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet, except that services are available for the care of corns, calluses and toenails when medically appropriate and necessary for children with diabetes or circulatory disorders of the legs or feet.

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

Covered for all necessary and appropriate medical procedures whether performed in an inpatient hospital, outpatient hospital, ambulatory surgical center, Indian Health Service Hospital or Clinic or Tribal Section 638 Facility or office setting in accordance with any requirements set forth in sections 6.2.1 and 6.2.2 relating to inpatient and outpatient hospital surgical services.

Coverage is not available for treatment leading to or in connection with sex change or transformation surgery and related complications.

Surgical services are covered without any cost sharing requirement unless they occur as part of an inpatient hospital stay or a hospital emergency room visit.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

Covered for all appropriate and necessary services for all certified Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services or Tribal Section 638 outpatient clinic services.

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

Covered for all appropriate and medically necessary prescription drugs that are authorized by a professional licensed to write prescriptions. Coverage for diabetic supplies, syringes, lancets and test strips are included in this benefit.

There is no coverage for any medication or device designed to prevent pregnancy including any oral or other forms of contraceptive drugs, contraceptive devices or appliances or delivery. Coverage is not available for any medications obtained without a prescription order or any charges for the administration of legend drugs or insulin that may be self administered.

~~A co-payment of $2 per prescription will be required for each prescription and refill dispensed under the insurance plan. American Indian children are exempt from this requirement.~~

A $2 co-payment will be applied for each allowable generic prescription drug; a $4 co-payment will be applied for each allowable preferred brand prescription drug; and a $8 co-payment will be applied for each allowable non-preferred prescription drug. The same co-pays apply to refills dispensed under the benefit package. American Indian children are exempt from this cost sharing.

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

Covered for all appropriate and necessary services that have been ordered by a physician or other practitioners within the scope of their practice as authorized by state law. There is no cost sharing for this service.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

Covers prenatal care provided by a physician or certified nurse/midwife, prenatal nutritional counseling limited to one visit per pregnancy and one ultrasound per pregnancy unless additional services are determined to be medically necessary.

There is no coverage for the cost of the delivery of a vaginal delivery or cesarean section for the hospital, physician, nurse midwife, birthing center or any other services directly associated with the birth of a child.

Coverage is not available for any costs associated with surrogate pregnancy, gestational carrier pregnancy, assisted conception or any other services related to conception or pregnancy in anything other than the genetic mother's uterus, donor sperm utilized for artificial insemination or any and all extraordinary procedures to induce fertilization or enhance conception with professional or technical assistance, including gamete intrafallopian transfer, zygote intrafallopian transfer, in vitro fertilization, peritoneal oocyte and sperm transfer, tubal ovum transfer or intracytoplasmic sperm injection.

Postnatal and interruptions of pregnancy including miscarriage is a covered service.