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State/Territory Name: North Dakota

State Plan Amendments (SPA) #: ND-18-0012-CHIP

This file contains the following documents in the order listed:

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

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

Children and Adults Health Programs Group

AUG 2 9 2019

Jodi Hulm
Administrator, Health Tracks and Healthy Steps
North Dakota Department of Human Services, Medical Services Division
600 East Boulevard Avenue, Department 325
Bismarck, ND 58505-0250

Dear Ms. Hulm:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), ND-18-0012-CHIP, submitted on June 29, 2018, with additional information submitted on August 22, 2019, has been approved. Through this SPA, North Dakota implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. This SPA has an effective date of October 1, 2017 with the exception of the changes described below.

Sections 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that financial requirements and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of section 2705(a) of the Public Health Service Act, in the same manner that such requirements apply to a group health plan. North Dakota demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations (NQTLs) and financial requirements to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

In order to comply with parity requirements, the state's managed care organization (MCO) made the following NQTL policy changes:

- Effective July 1, 2018, the MCO adopted InterQual guidelines for MH/SUD benefits, which are already applied to M/S benefits.

- Effective January 1, 2019, pre-certification of in-network inpatient and outpatient MH/SUD benefits is no longer required. Instead, retrospective reviews are applied to all MH/SUD inpatient admissions, consistent with the policies applied to inpatient M/S admissions.

This SPA approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

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
E-mail: Joyce.Jordan@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jordan and to Mr. Richard Allen, Director, Division of Medicaid Field Operations West. Mr. Allen's address is:

Centers for Medicare & Medicaid Services
1961 Stout Street
Room 08-148
Denver, Colorado 80294

If you have additional questions, please contact Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

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

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello
Director

cc:
Mr. Richard Allen, Director, Division of Medicaid Field Operations West

OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

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MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: North Dakota

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Maggie D. Anderson	Position/Title: Director, Medical Services
Name: Jodi Hulm	Position/Title: Healthy Steps Program Administrator
Name:	Position/Title:

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

1.2 ☒ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3 ☒ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Original SCHIP State Plan
Date Plan Submitted: July 24, 1998
Date Plan Approved: September 28, 1998
Effective Date: October 1, 1998

State Plan Amendment #1 –Establish Separate Child Health Program.
Effective Date: October 1, 1999
Implementation Date: October 1, 1999

State Plan Amendment #2 – Expand Eligibility, Eliminate Assets Test.
Effective date: January 1, 2002
Implementation date: January 1, 2002;

State Plan Amendment #3 –Compliance Plan.
Approval Date: September 27, 2002

State Plan Amendment #4 - Amended Section 4.
Effective date: July 1, 2005
Implementation date: July 1, 2005

This change will result in moving some families from the current private coverage option to the Medicaid Program. It will be advantageous to these families because they will no longer be subject to any co-payments and will have access to the full array of Medicaid program benefits that are more generous than the current private insurance option.

These children will be required to participate in the North Dakota Access to Care program. Each will be required to select a primary care provider who can be a primary care physician, a rural health clinic, a Federally Qualified Health Center or the Indian Health Service. The primary care provider will provide direct primary care and make referrals for specialty care and other specified medical services. All services are paid using a fee for service process. In addition, children residing in Grand Forks County may also select the "capitated" health plan known as AltruCare. The Department makes a monthly per member per month payment to this managed care plan who provides all appropriate medical services contained in the contract. Services not covered in the contract are covered through the regular fee for service payment process.

State Plan Amendment #5 – Amended Section 4.

Effective date: September 1, 2007
Implementation date: September 1, 2007

This amendment made revisions to Section 4.1.3 on income deductions and disregards.

Effective date: October 1, 2008
Implementation date: October 1, 2008

Increase Poverty Level from 140% to 150%.

State Plan Amendment #6 – Amended Section 4.

Effective date: October 1, 2008
Implementation date: October 1, 2008

This amendment will make revisions to Section 4.1.3 page 19, regarding wages paid by the Census Bureau for decennial temporary employment.

State Plan Amendment #7 – Amended Section 4.

Effective Date: July 1, 2009
Implementation Date: July 1, 2009

Increase Poverty Level from 150% to 160%.

State Plan Amendment #8 – Amended Section 4.

Effective Date: October 1, 2009
Implementation Date: October 1, 2009

Alternate Payment Methodology with FQHCs and RHCs.

State Plan Amendment #9 – Amended Section 6

Effective Date: July 1, 2011
Implementation Date: July 1, 2011

Add orthodontia services. Remove limits on mental health and substance abuse services. Update quality measures.

State Plan Amendment #10 – Amended Section 4

Effective Date: July 1, 2012
Implementation Date: July 1, 2012

This amendment implements provisions for temporary adjustments to redetermination policies for children in families living or working in Governor or federally declared disasters areas.

State Plan Amendment #11

Effective Date: July 1, 2014
Implementation Date: July 1, 2014

This amendment updates services based on a new contract.

State Plan Amendment #12

Effective Date: October 1, 2017
Implementation Date: October 1, 2017

This amendment incorporates the Mental Health Parity and Addiction Equity Act (MHPAEA) section.

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

TN No: 18-0100
Effective Date: October 1, 2017
Implementation Date: October 1, 2017

A letter was sent to all tribal leaders on June 8, 2018 describing the MHPAEA SPA that the state of North Dakota will be submitting to CMS. The tribal consultation letter was also posted on the Department of Human Services website on June 8, 2018.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination **(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

The Department has used a 1998 survey of the uninsured conducted in conjunction with the Robert Wood Johnson Foundation to estimate the number of insured and uninsured children in North Dakota. While this data is now more than three years old, it remains the most reliable information for North Dakota at this time. We have considered the use of other national data sources but have found that due to sampling errors for small states much of the information is not accurate. For example, the U.S. Census Bureau Health Insurance Coverage Status indicates that the number of children under 18 years of age in 2000 was 127,000. The actual 2000 census data indicates that North Dakota has 160,849 children under 18 years of age. This is a significant difference of more than 26%. This also makes suspect the number of insured and uninsured children because the sampling error for total number of children will also affect the estimated number of children without health insurance.

For the above reason we will continue to utilize the 1998 survey as an estimate of the number of uninsured children in North Dakota until a more accurate national survey tool

becomes available for small population states.

The following table provides information on the number of children 0 through 18 years of age residing in North Dakota in 1998, the number who were uninsured, the total number of insured, the number insured by Medicaid and the number of children insured by private plans. As noted above, the data was obtained through a 1998 survey that was conducted under the auspices of the Robert Wood Johnson Foundation Family Survey.

1998 Insured and Uninsured North Dakota Children by Poverty Level, Age, and Race/Ethnicity

Demographic Subgroups	Population Distribution	Number of Insured Children*	Number of Uninsured Children	Number of Children with Unknown Status	Number Insured by Medicaid	Number Insured by Private Plans	Number Covered by HIS, Military and Other
1998 North Dakota Population	175,822	160,448	14,633	710	14,833	134,791	24,131
Household Poverty Level	16,004	13,951	1,754	299	1,186	11,435	2,031
Unknown	17,689	14,448	2,975	266	7,694	5,253	4,664
<100	16,011	12,920	3,091	0	3,122	7,250	4,701
100% - 133%	32,868	29,309	2,558	0	1,881	25,534	5,014
134% - 200%	93,250	89,820	3,285	145	950	85,319	7,721
Overall 200% Total Children <=18							
Age Group							
Less than 1 Year	7,265	6,905	231	129	1,029	5,467	818
1 to 5 Years	38,992	35,673	3,203	115	4,791	28,501	5,408
6 to 12 years	66,971	59,976	6,818	177	6,271	50,189	8,567
13 to 18 Years	62,594	57,894	4,411	289	2,742	50,634	9,338
Total Children <=18							
Race/Ethnicity							
Unknown	838	607	199	32	30	295	314
White	158,462	144,641	13,200	620	9,995	128,532	13,545
Black	1,742	1,684	58	0	475	856	759
Native American	11,832	11,157	675	0	3,904	3,751	8,831
Asian/Pacific Islander	832	832	0	0	90	599	190
Other	2,116	1,527	531	58	339	758	492
Total Children <=18							

The survey indicates that 14,663 children where uninsured in 1998. Of that number, 2,975 children resided in families with income below 100% of the poverty level and 6,649 children resided in families with incomes between 100% and 200% of the federal poverty level. At the time Phase II of the State Children's Health Insurance Program was implemented in North Dakota on October 1, 1999, a total of 20,516 nondisabled children were enrolled in the Medicaid Program. As of May 31, 2002, the number of enrolled non-disabled children had increased to 22,916, an increase of 11.7% or 2,400 children. In addition, a total of 2,452 children were eligible for Phase II, Healthy Steps, of the Title XXI program. Therefore, after 31 months an additional 4,852 children or an increase of 16.3% were covered through Medicaid or Healthy Steps.

While the exact number of uninsured is unknown at this time because of the imprecise national data available to small states, the fact that 4,852 additional children have coverage when the number of children in North Dakota is declining indicates that the two programs have experienced success in reducing the number of uninsured children in North Dakota.

PUBLIC HEALTH COVERAGE

The Medicaid Program remains the primary public health insurance program available for families in North Dakota. It provides an array of services to individuals and families, who are eligible through the 1931 provision, individuals who are aged, blind or disabled and receive Supplemental Security Income if they meet 209b criteria established by the Department of Human Services. Coverage is also provided for children in foster care and subsidized adoption. In addition, aged, blind and disabled individuals and children and certain caretakers in families who have sufficient income to meet their basic maintenance needs, as defined by the State, (Medically Needy) may be eligible for Medicaid. North Dakota also provides poverty level coverage for pregnant women and children under 6 years of age in families with adjusted net income at or below 133% of the federal poverty level and children 6 through 18 years of age with adjusted net income at or below 100% of the federal poverty level. This group also includes 18-year-old children who are eligible for Medicaid by virtue of the initial SCHIP Medicaid expansion that was approved in October 1998.

Children, adult caretakers and pregnant women who are enrolled in Medicaid through the 1931 provision, poverty level, medically needy or SCHIP expansion categories are required to choose a primary care provider who delivers primary care services and makes referrals for many of the other medical services available through the program. Primary Care Providers receive a monthly administrative fee for managing care and providers receive a fee for service payment for services provided to Medicaid recipients.

In Grand Forks County, children in the above named categories are required to choose between the Primary Care Provider Program and a capitated Health Plan. As of July 1, 2001 a total of 18,500 children were enrolled in the Primary Care Provider Program and 365 children were enrolled in the Health Plan.

Beginning on January 1, 2002, the asset test for Medicaid was eliminated for the children and family coverage groups. Children in families with income within the Medicaid eligibility guidelines that were previously eligible for Healthy Steps because family assets exceeded the Medicaid limits are now eligible for the Medicaid Program. These children are included within the SCHIP Medicaid Expansion Group that was approved by CMS.

The second public program available to children is the Healthy Steps Program, Phase II of SCHIP in North Dakota. It provides private insurance coverage to about 2,450 children whose family net adjusted income is at or below 140% of the federal poverty level and who are not otherwise eligible for the Medicaid Program. The benchmark insurance coverage for this group is the coverage available for State Employees plus preventive dental and vision coverage. The insurance contractors make payments on a fee for service indemnity basis.

PUBLIC PRIVATE HEALTH INSURANCE PARTNERSHIPS

While not considered a true public/private partnership, the Department does cooperate with Blue Cross/Blue Shield of North Dakota who operates the Caring Program. This program provides limited health and dental coverage to children who are not eligible for Medicaid or Healthy Steps and have gross family income under 200% of the poverty level. Premiums for coverage come from corporate and private donations. If children are not eligible for Medicaid or Healthy Steps, the family is referred to the Caring Program for possible enrollment in that program. Conversely, the Caring Program will encourage families to apply for Medicaid or Healthy Steps if families who apply to that program appear eligible for the two government programs.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance): The following are the steps being taken to identify and enroll children who are eligible to participate in the North Dakota Medicaid Program and the Healthy Steps Program.

The Department has established partnerships with numerous other state and local programs that serve children and families. In addition, the Department has reached out to other public health programs to find children who may be eligible for public health programs.

The North Dakota Medicaid and Healthy Steps programs, Women, Infants and Children Program, (WIC), Community Healthcare Association, Maternal and Child Health (MCH), Immunization, Health Passport Smart Card Project, Optimal Pregnancy Outcome Project (OPOP) and the Children's Special Health Services (CSHS) have a statewide interagency agreement that allows exchange of information and coordination both on the state and local levels. This agreement allows the state to share common information that encourages easier access to services, such as eligibility information on behalf of children's health.

Public Health Programs - All 53 counties in North Dakota have local public health units that are enrolled Medicaid Providers. This gives them a direct link to the Medicaid program as providers and connects them to the local county social service offices that determine eligibility. If a child is referred and determined ineligible for Medicaid, the public health clinic refers them to other appropriate programs.
WIC - All local WIC programs are required to refer all potentially eligible recipients to Medicaid. Current WIC guidelines also denote Medicaid income guidelines. Those not participating in Medicaid, but appear potentially eligible are given program information along with the telephone numbers for referral to the nearest county social service agency. WIC will also make referrals to the Healthy Steps Program if families are not eligible for Medicaid. Other state WIC program mandatory contacts include County Social Service Agencies, Homeless and Ministerial health providers, Substance Abuse Centers, Food Pantries, Public Health Units and Indian and Migrant Health Services.

Children's Special Health Services (CSHS) - The CSHS program conducts a variety of outreach and enrollment activities through a network of state and local staff. The CSHS program serves children who may have a chronic or disabling condition. Medicaid and Healthy Steps status is monitored on the 1,700 children served through all areas of the program. For the 500 to 600 children served through the diagnostic and treatment programs, Medicaid eligibility is automatically checked. For children who are not eligible for Medicaid or private insurance, CSHS will link families to other resources such as Healthy Steps, Caring Program for Children and SSI.

The Caring Program for Children - Is a private initiative administered by Blue

Cross/Blue Shield that provides basic health coverage to children aged 18 and under. The program covers its costs with private donations. The Caring Program will refer families to Medicaid or Healthy Steps if individuals appear eligible for either program. Medicaid and Healthy Steps eligibility workers make referrals when a family is not eligible for those two programs.

Rural Health Clinics (RHC's) - North Dakota has approximately 110 Medicaid enrolled Rural Health Clinics that includes border state providers from Montana, South Dakota and Minnesota. The RHC's provide services on a sliding fee scale. Referrals are made to local county social service agencies if a family appears eligible for Medicaid and to the Department of Human Services if the family appears eligible for Healthy Steps.

Federally Qualified Health Center (FQHC) - North Dakota has one designated federally qualified health center in Fargo. The FQHC conducts a financial screen to determine when to refer to other public health insurance programs such as Medicaid and Healthy Steps.

Family Planning Clinics – Family Planning Clinics refer clients to appropriate providers for necessary services that are outside the scope of their practice. Included are referrals for clients in need of primary and preventive services and those who may be eligible for Medicaid, Healthy Steps, WIC and OPOP.

Indian Health Services (IHS) - There are four IHS facilities and one Indian Service Area facility in North Dakota. Each site uses a benefits coordinator to identify and refer potentially eligible children and families to the Medicaid and Healthy Steps Programs. IHS staff receive training designed to identify families who may need referral to other health care programs including Medicaid and Healthy Steps. This allows families to access health care information at different entry points within the IHS system at different times. Continued training occurs between the Department and Benefits Coordinators at Reservation sights.

Optimal Pregnancy Outcome Program (OPOP) - OPOP is a primary prevention program designed to empower pregnant women to make informed health and lifestyle choices for healthy babies. There are 10 OPOP sites in North Dakota. All sites are Medicaid enrolled providers and deliver nursing, dietitian and other appropriate health services to pregnant women. Target populations include pregnant adolescents who may be considered high risk. As part of the OPOP intake process, insurance status is identified and referrals made to the Medicaid or Healthy Steps Programs. Healthy Start of North Dakota –

The Healthy Start program is a Native American case management program located on the four reservations and the one area service unit in North Dakota. The program is

intended to prevent infant mortality in these areas and is funded by a federal grant. Part of the intake assessment for services of this program is to determine if there is Medicaid or Healthy Steps eligibility. The Healthy Start programs are enrolled Medicaid providers who provide certain services through Medicaid. Healthy Start has established referral protocols for both Medicaid and Healthy Steps as part of their case management activity to high-risk pregnant women. Migrant Health Centers –

Migrant Health Centers are located along the North Dakota/Minnesota border and they provide health services to seasonal migrant families. The health centers refer families to the local county social service agencies if it appears they may meet Medicaid eligibility guidelines or refer them to the Healthy Steps enrollment office if appropriate.

Head Start Programs - Local Head Start programs review income and insurance status of all children who apply for that program. They specifically ask if a child is Medicaid eligible. If the family is not currently enrolled, Head Start will refer the family to the local county social service office for an eligibility determination for Medicaid. Head Start also makes referrals to Healthy Steps and the Caring Program for Children if income is above Medicaid income guidelines.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

North Dakota does not have any public/private health insurance programs operating at this time.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

The only other public health insurance program available to citizens of North Dakota is Medicaid. We also coordinate outreach efforts with the Caring Program for Children operated by Blue Cross/Blue Shield of North Dakota.

Strategies to coordinate Medicaid with Healthy Steps include the following:

1. As of May 1, 2002, a joint application for Medicaid and Healthy Steps has been developed and is available to applicants. The application is designed to be used for all Medicaid children and family coverage groups including adults and the stand alone SCHIP Healthy Steps Program. In addition, we will continue to utilize the Healthy Steps only application but will no longer be printing any additional forms. When the Department receives an application, it is screened to determine if potential Medicaid eligibility exists. The family receives a notice that the application has been forwarded to the appropriate county social service board office that determines Medicaid eligibility. The Department sends all pertinent information to the appropriate county office. That office reviews the application and makes the final decision regarding Medicaid eligibility.

2. Supplying local county social service offices that determine Medicaid eligibility with outreach materials regarding the Healthy Steps Program.

3. Conducting statewide training forums for outreach partners including county staff who determine Medicaid eligibility.

4. Make referrals to the Caring Program if families are not eligible for Medicaid or Healthy Steps.

5. Through cooperative agreements, work closely with other agencies who have an interest in uninsured children such as the Title V Program to share information and coordinate outreach activities for all public insurance programs and the Caring Program. (Additional details regarding these relationships are detailed in 2.1 above).

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 Blue Cross and Blue Shield of ND (BCBS) and Delta Dental of Minnesota (DDMN) . These companies were chosen to pay for necessary medical, dental and vision services through a competitive Request for Proposal process.

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.

The contract is an indemnity product based on a monthly premium that is 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.

We have executed three separate contracts for medical, dental and vision coverage. The contracts detail the responsibilities of the insurance companies 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.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **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 5.

4.1 The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102(b)(1)(A)) (42 CFR 457.305(a) and 457.320(a))**

4.1.1 ☒ Geographic area served by the Plan: The plan is available to all eligible children on a statewide basis.

4.1.2 ☒ Age: The plan is available to children zero through 18 years of age. Coverage for children who are 18 years of age will continue through the end of the month in which they turn 19 years of age.

4.1.3 ☒ Income:

Healthy Steps program will cover children whose family adjusted gross income is no more than 160% of the federal poverty level.

Financial responsibility will be based on spouse for spouse and parents for children. The income of the spouse and parents are considered available to the child. Natural and adoptive parents, but not stepparents are treated as parents. Under North Dakota law, a stepparent has no legally enforceable obligation to support stepchildren. Therefore, the stepparent's own personal income cannot be considered available in determining Healthy Steps eligibility for a stepchild. To determine eligibility, the stepparent's net income must first be applied against the appropriate income level for the stepparent, spouse and the stepparent's children or children in common. If the stepparent's income is adequate to meet their needs, the natural parent's net earned income is considered in relation to the children for whom the Healthy Steps application is being made.

Except as noted below, all earned income of each family member is in a Healthy Steps household must be counted when calculating adjusted gross income including, but not limited to, wages, salaries, commissions, tips, self-employment income and income received under a contract.

Except as noted below, all gross income of each family *member of a Healthy Steps household* must be counted when calculating adjusted gross income.

The following income is excluded from family income:

1. Income which is required to be excluded under other federal statues and by Public Law;

2. Occasional small gifts;

3. In-kind earned income, except in-kind income received in lieu of wages;

4. Educational loans, scholarships, grants, awards, Workforce Safety & Insurance vocational rehabilitation payments, fellowships or gifts used to 767 pay the cost of tuition and fees at educational institutions, and work study received by a student. A student is described as an individual who regularly attends and makes satisfactory progress in an elementary or secondary educations environment, college, university, vocation or trade school. A child must be a student at the time of application or if the application occurs during a summer vacation period must intend to return to school in the fall;

5. Income earned by a child who is a full-time student or a part-time student who is not employed more than 100 hours per month. Student status must be established as described in paragraph four of this section;

6. Money payments made by the Department of Human Services including foster care or subsidized adoption, subsidized guardianship, temporary assistance for needy families payments, vocational rehabilitation training funds, family subsidy program and the low income home energy assistance program;

7. Loans from any source that are subject to a written agreement requiring repayment by a household member;

8. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home;

9. County General Assistance payments;

10. Income Tax refunds; earned income credits or homestead tax credits;

11. Non-recurring unearned lump sum payments;

12. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce investment Act (WIA), and through the Job Opportunities and Basic Skills program;

13. Housing allowance received from United State Department of Housing and Urban Development or rent supplements or utility payments provided through the housing assistance program;

14. Refugee cash assistance or grant payments;

15. Americorps income other than the living allowance portion;

16. Income of an individual living in the parental home if the individual is not included in the Healthy Steps unit;

17. Extra checks received by individuals who are paid weekly or bi-weekly;

18. Supplemental Security Income (SSI);

19. Compensation received by volunteers participating in the action program as stipulated in the Domestic Volunteer Service Act of 1973, including foster grandparents, older American Community Service program, Retired Senior Volunteer Program, Service Corps of retired Executives, Volunteers In Service to America (VISTA), and University Year for Action;

20. Payments made to recipients under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

21. All income, allowance, and bonuses received as a result of participation in the Job Corps Program;

22. Payments received for the repair or replacement of lost, damaged, or stolen assets,

23. The Medicare Part B premium refunded by the Social Security Administration;

24. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program;

25. Training stipends provided to victims of domestic violence by private, charitable organizations, for attending their educational programs;

26. Crime Victims Reparation payments;

27. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other Federal statute, because of a presidentially declared disaster (but not disaster assistance unemployment compensation), and interest earned on that assistance;

28. The first $2,000 per year of lease payments deposited in IIM accounts;

29. Interest or dividend income earned on liquid assets;

30. Additional pay received by military personnel as a result of deployment to a combat zone;

31. Up to fifty dollars per family, per month, of current child support received on behalf of children in the Health Steps unit;

32. Reimbursement from an employer, training agency or other organization for past or future training, or volunteer related expenses ; and

33. All wages paid by the Census Bureau for temporary employment related to decennial census activities.

Income Standard:

Adjusted gross countable family income must be equal to or less than 160% of the federal poverty guidelines based on family size.

Calculating Adjusted Gross Income:

After all countable gross income is determined; the following adjustments will be allowed to determine the adjusted gross income for each Healthy Steps household:

1. For family members with earned income, the actual mandatory payroll deductions including federal, state and social security taxes mandatory retirement and mandatory union dues, or $90 per month, whichever is greater.

2. Reasonable child care expenses, not otherwise reimbursed by other third parties if necessary to engage in employment or training.

3. Court ordered child and spousal support payments if actually paid by a member of the family on behalf of an individual who is not a member of the Healthy Steps household.

4. With respect to each individual in the unit who is employed or in training, $30 may be deducted as a work or training allowance, but only if the

individual's income is counted in the eligibility determination.

5. The cost of premiums for health insurance may be deducted in the month paid or prorated and deducted in the months for which the premium affords coverage.

6. the cost of medical expenses for necessary medical or remedial care for members of the unit who are not eligible for Health Steps coverage.

Determination of Adjusted Income for Self-Employed Individuals:

The following method will be used to calculate adjusted gross income for self-employed individuals as prescribed by State statue.

1. For all self employed individuals, calculate the average net income after expenses based on either the average of the previous three years of adjusted gross income or the previous year's adjusted gross income, whichever is most advantageous to the applicant, which means the adjusted gross income as computed for an individual for Federal Income Tax purposes under the Internal Revenue Code. If a household has been in business for less than three consecutive years, use the actual number of year(s) the individual was in business and calculate the average yearly income. If the family is currently self employed, but has not previously filed any self employment Federal Income Tax report in the last year, use the best information available to calculate estimated revenue and business expenses to calculate adjusted gross self-employment income.

   Budgeting:

   The department shall determine family income prospectively for each 12-month certification period at the time of application and at each renewal to determine if eligibility can continue. Gross countable income of all family members is counted as family income. An adjusted gross income amount is then calculated based on the disregards and deductions described previously. Unearned income that is received less often than monthly will be prorated over the months the income is intended to cover

to determine average monthly income. Earned income that is intended to cover more than one month will be prorated over

Farm and other self-employment income will be divided by 12 to determine the monthly income for the upcoming certification period. If an individual started a business in the previous year that did not cover an entire year, the pro-ration of the monthly income will be based on the actual number of months the business operated during the previous year.

If a family has self-employed income and other earned or unearned income, the two must be added together to arrive at total adjusted gross income. The monthly income from self-employment income should first be calculated. If the average self-employment income is a negative amount, that amount will be subtracted from other earned or unearned income to arrive at total adjusted gross income.

4.1.4. ☒ Resources (including any standards relating to spend downs and disposition of resources): There will be no resource test for Healthy Steps eligibility.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):

1. To be eligible to receive Healthy Steps benefits, an individual must be a citizen of the United States or a qualified alien as defined in Public Law 104-193 (401) through (423), (431) and (435), and amended by Public Law 105-33 (5302)(b) and (c), (5303), (5305)(b), (5306), (5562), (5563) and (5571).

2. A qualified alien as defined in Public Law 104-193, as amended, may receive Healthy Steps insurance coverage.

3. Unless ineligible for benefits under section 403 of Public Law 104-193, as amended, a qualified alien may receive Healthy Steps insurance coverage after five years have passed from the child's date of entry into the United States, if the child can be credited with 40 qualifying quarters of social security coverage.

State Residency:

1. To be eligible to receive benefits from Healthy steps, a child must

be a resident of the state of North Dakota.

2. An individual is considered a resident of North Dakota if they are temporarily absent from North Dakota for purposes of employment, schooling, vacation or medical treatment.

4.1.6 ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility): Disability is not a determining factor when establishing eligibility for Healthy Steps and coverage will be provided to children no matter what type of disability or medical condition a child may have.

4.1.7 ☒ Access to or coverage under other health coverage: A child who is covered under a group health plan or a single family plan or under other health insurance coverage including coverage which is available through a parent's or legal guardian's employer, as defined by HIPAA, is ineligible for Healthy Steps insurance coverage. A child will not be eligible if the parent of the child is a State employee unless the parent does not have access to State health insurance coverage. Any child that meets current Medicaid eligibility criteria is not eligible for Healthy Steps except that children who would otherwise be eligible for the medically needy program with a recipient liability, the family may choose to enroll in the Healthy Steps program.

4.1.8 ☒ Duration of eligibility: The eligibility period in accordance with State law will begin the first day of the month following the date eligibility is established and will end on the last day of the 12th calendar month after the month in which enrollment in Healthy steps started or the end of the month a child reaches its 19th birthday or the family acquired credible health insurance coverage for the child or a child no longer resides in the household. Any subsequent eligibility period will continue for 12 calendar months.

4.1.9 ☒ Other standards (identify and describe):

Household Composition:

1. The following individuals who reside together are included in a household when determining the size of a household and the income to be counted whether or not a household member is actually eligible to receive Healthy steps benefit coverage.

    a. A natural child, adopted child, or step-child age 0 through 20 years of age, and the family size is increased for each unborn when determining the appropriate household size;

    b. Parents of any child identified in "a" above;

    c. Children of any child identified in "a" above.

2. Any individual identified in paragraph 1 who is temporarily absent from the household by reason of employment, school, training, or medical treatment will be considered as a member of the household.

3. If an adult is providing care to an unrelated child of a divorced, separated, or deceased spouse, the household may include the child if the child is expected to continue to reside in the household, and meets age requirements outlined in paragraph "a".

4. Children who are inmates of public institutions or children who are residing in Institutions for Mental Diseases will be denied coverage under the Healthy Steps program, at application and redetermination.

Parents are allowed to opt any child out of the household if that child's income causes other children in the household to fail eligibility. 4.4 Describe the procedures that assure that:

4.4.1 Through the screening procedures used at intake and follow-up eligibility determination, including any periodic predetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health insurance assistance under the state child health plan. **(Section 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1) (42CFR 457.80(c)(3))**

When an application is received, verified income and deduction information is entered into the eligibility computer system, which first determines whether the children are Medicaid eligible. If the results indicate that any of the children are eligible for Medicaid, Healthy Steps eligibility is not pursued for those children unless the children are Medicaid eligible with a recipient liability, in which case the family is given a choice as to which program they want coverage under. Healthy Steps eligibility is pursued for all other children.

The joint application requests information regarding any current health care coverage a family may have available to them. If the applicant indicates that the children have creditable health care coverage, they are denied coverage under the Healthy Steps Program.

If an application is received from a family who has a family member employed with the State of North Dakota, the application will be denied for Healthy Steps unless it can be documented that the family is not eligible to participate in the coverage offered to state employees. In those instances where benefits are not offered to temporary or other similar employees, families will be allowed to participate in the Healthy Steps Program if they otherwise meet all other eligibility criteria.

Approximately 35 days before the end of the eligibility period, each eligible family is mailed a renewal asking for income information and any other changes that could affect continued eligibility. Information received is entered into the eligibility computer system, which follows the same eligibility determination process as at application.

4.4.2 The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102(b)(3)(B)) (42 CFR 457.350(a)(2))**

As noted in 4.4.1 above, eligibility for Medicaid is determined without the need for a separate application process.

Joint applications may be submitted to either the county social service offices or the Department of Human Services for a Medicaid eligibility determination in the eligibility computer system to determine eligibility for Medicaid.

This process ensures that all joint applications where potential Medicaid eligibility is indicated go through an official eligibility determination process.

4.4.3 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))**

As noted in 4.4.1, any children who are ineligible for Medicaid, or who are eligible for Medicaid with a recipient liability, are automatically processed to determine whether they are eligible for Healthy Steps.

This process assures that joint applications where potential Healthy Steps eligibility exists will receive an eligibility determination.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102(b)(3)(C))) (42 CFR 457.810(a)-(c))**

4.4.4.1 ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The joint application utilized by the Healthy Steps Program asks applicants if anyone in the family is covered by creditable health insurance within the last six months. The applicant provides the information through a self-declaration. If any children were covered by creditable health insurance within the last six months, the child is determined not to be eligible for Healthy Steps. Families are informed to reapply after the six-month period has expired.

The Department allows exceptions to this rule that permits this requirement to be waived if loss of health care coverage occurred because of no fault of the family. Examples include loss of job, accepting another job where coverage is not available and in the case of farm families, residing in a county where a federal disaster has been declared and is currently in affect.

4.4.4.2 ☐ Coverage provided to children in families over 200% and up to 250% of FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3 ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4 ☐ If the state provides coverage under a premium assistance program, describe:

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Children who are also eligible to receive services through the Indian Health Service (IHS) or through Section 638 Tribal contracts will be eligible to enroll in Healthy Steps. Through various outreach processes including the Robert Wood Johnson covering kids grant, a TANF outreach grant and a community access program grant we have encouraged eligible families to enroll in the program.

In addition, we have worked directly with Tribal and Indian Health Service staff to provide information and conduct on-site training sessions to ensure that American Indians are aware of the availability of Healthy Steps and the Medicaid Program. It is important that American Indian children have the opportunity to obtain appropriate and necessary health care and we are committed to inform them about the availability of Healthy Steps and encourage them to apply for the program.

American Indian children, as defined in section 4(c) of the Indian Health Care Improvement Act, 25 USC 1603 c and who are members of federally recognized tribes as determined by the Bureau of Indian Affairs, will be exempt from any cost sharing obligations.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Outreach efforts for the CHIP plan is designed to be a collaborative effort between families and both the state and federal governments to assure children receive health care.

North Dakota uses established relationships with a variety of entities to help identify potentially eligible children and invite them to help put together an outreach system. North Dakota has developed new relationships with a variety of entities to help identify and enroll potentially eligible children into the North Dakota Medicaid CHIP programs.

Certain assumptions about the target population for the expanded Medicaid group of children are based on experiences of the North Dakota Medicaid program, The Caring Program for Children, County Social Service Agencies, public and private health care agencies. The plan must invite families who have regular contact with social service agencies, and to other families who have traditionally avoided government programs.

Identification of Target Populations of Potential CHIP Enrollees

> The Department of Human Services will work with existing Economic Assistance programs, such as TANF and Food Stamps, to identify children in families who are not eligible for Medicaid, but may be eligible for CHIP.

Outreach Strategies for Potential Enrollees

Outreach through Maternal Child Health Programs

Maternal and Child Health Programs coordinates outreach activities with the Department of Human Services through their programs, such as Family Planning, OPOP, WIC, local Public Health Agencies, and Children with Special Health Services. Activities include distribution of written materials such as posters, brochures, and flyers, distribution and assistance in completion of applications. MCH programs that participate in health fairs include CHIP and Medicaid materials onsite. MCH programs will use their intake processes to include information on public insurance programs.

Outreach Through Private Providers

Healthy Steps coordinates outreach activities with Primary Care Providers and Medicaid recipients. A new recipient newsletter has been developed for all Medicaid Primary Care Physician enrollees. The North Dakota Medicaid Program publishes a quarterly newsletter sent to over 20,000 Medicaid providers statewide. Healthy Steps information has been and will continue to be included in these publications on a routine basis.

The North Dakota Medical Association, Academy of Pediatrics, Dental Association, and Primary Care Association received Healthy Steps program information and has shared this information with their members. The information describes program benefits and how to access services.

Providers, such as clinics, hospitals, and dental offices, received Healthy Steps and Medicaid program information, such as flyers, brochures, and applications, to identify and refer potential eligible children to these programs.

Outreach Through Native American Health Programs

The Department will continue to work with Tribal leaders to develop outreach strategies for North Dakota's Native American population. IHS facilities use their benefits or business office procedures for determining third party payment sources including Medicaid and Healthy Steps. Native American MCH programs use their connections with other providers and programs to facilitate referral to Medicaid and Healthy Steps. The Healthy Start program uses their broad-based network as case managers to access coverage for Healthy Steps and Medicaid for their clients.

The Medical Assistance Division collaborated with the North Dakota TANF program to provide funding for two reservation outreach workers. The two sites are located on reservations that were not included in the North Dakota Covering Kids pilot projects. Training and technical assistance will be provided on an ongoing basis to the TANF funded outreach workers.

Outreach Through Schools

The Department coordinates outreach activities with the Department of Public Instruction and local school districts using the following methods:

1. The State Department of Public Instruction includes information on healthcare coverage on the Free and Reduced Price Meals Application each school year that explains the Healthy Steps program. Each school has a supply of applications for Healthy Steps and the schools give each family an application for Healthy Steps if they have indicated interest or families can call 1-877-KIDSNOW.

2. The North Dakota Principals, Teachers, and School Counselors Association will include Healthy Steps information in newsletters and gatherings through their activities.

3. The North Dakota PTA (Parent and Teacher Associations) will distribute information to their local schools. Public health nurses who provide services in local schools will have Healthy Steps information and applications available on site.

Outreach Through Business

The Healthy Steps and Medicaid programs will use a variety of outreach strategies targeted through state and local business, including the printing Healthy Steps information on milk cartons, educational forums to human resource managers, flyers and printed information on store receipts through retail businesses, information included in utility bills and presentations at small business owners State Tax Department seminars.

Outreach Through Head Start Programs

The North Dakota Head Start Collaboration Coordinator has been a part of the Healthy Steps and Medicaid outreach group from its inception. Local Head Start programs will use the following strategies to conduct outreach and assist in enrollment for both programs including:

1. Healthy Steps and Medicaid brochures and applications are provided to Head Start families during Head Start enrollment and to new Head Start families throughout the year

2. Assist families in completing the Healthy Steps and Medicaid applications by making copies of social security and income verifications and helping families locate required verification information.

3. Training parent volunteers to assist families during the enrollment process, and sharing Healthy Steps and Medicaid program information with local Head Start Health Advisory Committees.

Outreach Through State and Local Advocacy Groups

The following advocacy groups and associations have been involved and will continue their involvement with outreach planning for the North Dakota Healthy Steps and Medicaid programs, North Dakota Board of Social Welfare, Family Voices, Federation of Families, North Dakota Mental Health Association, and Department of Human Services Tribal Liaison offices.

Outreach strategies will include the following: Assistance to families in completion of applications, distribution of Healthy Steps and Medicaid written materials at state and local gatherings, including eligibility information in newsletters, and technical assistance in writing more family friendly, culturally relevant and simple program information.

Outreach Through Child Care Programs

Updated Information on public insurance programs will be distributed to all 3,082 licensed, registered, and self-certified centers, preschool, family child care, group child care, multi-licensed, and reservation based childcare programs throughout North Dakota. The Department will also work through the three health nurse consultants contracted with the North Dakota Resource and Referral Centers to provide health information to licensed childcare providers. The nurses will help providers distribute written materials about public insurance programs.

Outreach Through Religious Groups

The North Dakota Catholic Conference has been an active participant in development of public insurance programs. They distribute written material to their local communities and churches through articles in church bulletins, newsletters, and group gatherings.

Outreach Through Other Methods

Pediatrician outreach through an AAP (American Academy of Pediatrics) Grant. A North Dakota AAP affiliated pediatrician was awarded a grant to conduct one on one outreach to each of the state's 77 pediatricians. The outreach includes two visits to each of the pediatric offices throughout North Dakota. The first visit was to assess the physician's awareness of coverage programs, provide education about the programs, determine the type and amount of printed outreach materials in each office, and provide them with additional materials. The second visit is to assess the physician's awareness of coverage programs and look at the outreach materials in each office in order to determine if the initial contacts were effective.

Outreach will be coordinated through North Dakota Extension Programs, Community Action Programs, and North Dakota Rural Survivors Task Force

members. The outreach will be through distribution of written information including the Healthy Steps and Medicaid brochures and applications.

Outreach Through Written and Network Media

The North Dakota Department of Human Services will coordinate with the public information director to develop timely press releases through weekly and daily newspapers, newsletters of professional associations, advocacy groups, and Chambers of Commerce. All written outreach materials, such as brochures, flyers, and posters, will display the 1-800 number to call and receive the information necessary to apply for public insurance programs. A communication plan to address short and long term media outreach is in place.

The North Dakota Department of Human Services has a website for Healthy Steps that allows the user to print an application that can be competed and mailed in for processing.

Coordination of outreach efforts between the North Dakota Healthy Steps Program, Medicaid, other children's public/private health insurance programs and services will be ongoing. The Medical Services Division (Medicaid, and Healthy Steps), and Children and Family Services Division are within the Department of Human Services. The Title V and Title X programs are within the same physical building as Human Services. The Title V, Medicaid, and Children's Special Health Services programs meet on a quarterly basis to discuss mutual program issues.

Children can enroll or receive assistance in enrolling at our single FQHC in Fargo and Rural Health Clinics throughout the state.

Local county social service agencies will inform families who have been denied Medicaid eligibility of the Health Steps program and share information collected in the eligibility determination process with Healthy Steps if the county and family agree to do so.

Healthy Steps will refer applicants who appear to be Medicaid eligible to local county social service agencies and conduct follow up of these children. Coordination and enrollment activities for Medicaid and Healthy Steps have been enhanced since the joint application was implemented in May 2002.

The Department conducts training for county social services and gives these offices Healthy Steps flyers, brochures and applications for children who are not eligible for Medicaid but may be eligible for Healthy Steps.

Education sessions for all outreach partners were held August through November 2001. The purpose of the sessions were to provide information that allows the partners to identify families who may be eligible for Healthy Steps or Medicaid, assist families in completing applications for Healthy Steps and Medicaid, explain the benefits of both programs, enabling families to make informed choices and introduction of the new joint application for the Medicaid and Healthy Steps programs.

Coordination efforts have also been described in Section 2.3.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **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 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☒ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

North Dakota uses the Public Employees Retirement System Health Care Plan (PERS) as the benchmark coverage for Healthy Steps. Most state employees have the option to obtain coverage through this plan that provides comprehensive family health care coverage with no required premium payment. All services in the current plan will be available to enrolled children except for the cost of delivery of newborns.

In addition to the standard PERS coverage, Healthy Steps enrolled children will receive a package of preventive dental services and vision care. Also, an extensive number of deductibles and coinsurance amounts required in the PERS plan were replaced with a modest package of cost-sharing for eligible families.

The signed actuarial report has previously been provided to CMS.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If an existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by An existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

Inpatient services include all bed, board, general nursing, special care units when medically appropriate and necessary, ancillary services when appropriate and necessary, anesthesia and all medical and surgical services provided by a physician except that no payment will be made for the costs associated with the delivery of a child for either the hospital or the attending physician. These services also include appropriate services provided by hospitals operated by the Indian Health Service or Tribal Section 638 facilities.

Reconstructive surgery to restore bodily function or correct deformity resulting from diseases, trauma, congenital or developmental anomalies or previous therapeutic processes are covered.

Coverage for organ transplants include kidney, heart, heart-lung, single or double lung, liver, cornea and pancreas if medically appropriate. Requires prior authorization and must be provided at an approved transplant center.

Bone marrow transplants or other forms of stem cell rescue with related services and supplies are limited to certain diseases and conditions as follows:

1. Autologous bone marrow transplants are only allowed for the following diagnoses: non-Hodgkin's lymphoma, stage III or IV; Hodgkin's disease (lymphoma) stage III or IV; neuroblastoma, stage III or IV; acute lymphocytic or non-lymphocytic leukemia in first or subsequent remission; germ cell tumors and breast cancer.

2. Allogeneic bone marrow transplants are only allowed for the following diagnoses: non-Hodgkin's lymphoma, stage III or IV; Hodgkin's disease (lymphoma) stage III or IV; neuroblastoma, stage III or IV; chronic myelogenous leukemia in blast crisis or chronic phase; and acute lymphocytic or non-lymphocytic leukemia (acute myelocytic leukemia) in first or subsequent remission, but at high risk for relapse.

3. Allogeneic bone marrow transplants for non-malignancies are only allowed for the following diagnoses: severe aplastic anemia; homozygous beta-thalassanemia; Wiskott-Aldrich syndrome; severe combined immunodeficiencies; infantile malignant osteopetrosis; mucopolysaccharidoses; mucolipidoses; and myelodysplastic syndromes.

All other forms of bone marrow transplants or peripheral stem cell transplants are not covered including related services and supplies. Related services and supplies include all services and supplies that are not medically appropriate and necessary for a child's receipt of chemotherapy or radiation therapy requiring stem cell support, and includes specifically and without limitation, chemotherapy and radiation therapy when supported by transplant or other stem cell rescue procedures.

Coverage is not available for chemotherapy or radiation therapy together with all related services and supplies when the dose or manner of administration is expected to result in damage to or suppression of the bone marrow, the blood or blood forming systems, warranting or requiring receipt by the patient of autologous, allogeneic or syngeneic stem cells, or that are derived from the bone marrow or the peripheral blood, unless the procedure is specifically allowed as a covered service detailed above.

Prior approval is required for all bone marrow transplants and must be performed at an approved transplant center.

Coverage is not available for donor organs or tissue other than human donor organs or tissue.

Coverage is available for routine circumcision.

Limitations:

Cosmetic surgery will not qualify as reconstructive surgery when performed for the treatment of a psychological or psychiatric condition. Surgery and related services primarily intended to improve appearance and not to restore bodily function or correct deformities resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes are not considered a covered service.

Sterilization procedures or procedures to evaluate and reverse sterilization are not covered.

Surgery for morbid obesity is limited to one lifetime operative procedure per enrollee. No benefits are available for repair or modification of any or all types of surgical morbid obesity procedures unless there are special circumstances.

Coverage is not available for services that are primarily for diagnostic examinations, physical therapy, rest care, convalescent care, custodial care, maintenance care and sanitaria care or inpatient services performed primarily for the purpose of administering allergy, sensitivity, food challenge or related testing, clinical ecology, and vitamins or dietary nutritional supplements.

Each family will be responsible for a $50 deductible for the first day for each individual inpatient hospital stay. American Indian children are exempt from this requirement.

Preauthorization is required for all inpatient hospital admissions unless the admission is the result of a medical emergency. An emergency is defined as a medical condition which most non-medical people think is life-threatening or could cause death or severe permanent damage to a person or unborn baby if not treated immediately.

Exclusions

No coverage is available when a child is admitted to an inpatient facility prior to the effective date of the child's eligibility for the Healthy Steps Program.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

Outpatient services including outpatient surgery services are covered including emergency care. These services also include services provided through hospitals operated by the Indian Health Services or Section 638 Tribal operations.

Families are responsible to pay a $5 co-payment for each visit to an outpatient hospital emergency room. American Indian children are exempt from this requirement.

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

Physician services include medical office and home visits, consultations and similar services that are medically necessary and appropriate at no cost to the family of enrolled children.

Coverage is available for second surgical opinions, radiation and chemotherapy services except where otherwise prohibited, dialysis treatment and home infusion therapy services. Services covered include the provision of nutrients, antibiotics and other drugs and fluids intravenously, through a feeding tube, or by inhalation, necessary supplies and therapeutic drugs or other substances.

Allergy services are available including direct skin testing and patch testing when ordered by a physician and are performed in accordance with guidelines and criteria for specific IgE testing (RAST), Rinkel Immunotherapy (Serial Endpoint Dilution Titration), the fluorescent allergosorbent test (FAST), total

serum IgE concentration, bronchial challenge testing, conjunctival challenge testing and food challenge testing when specific indications are present.

Coverage is not available for nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgE level testing for food allergies, general volatile organic screening test and mauve urine test.

Coverage is not available for desensitization treatment, provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, urine autoinjections, repository emulsion therapy, candidiasis hypersensitivity syndrome treatment or IV vitamin C therapy.

Coverage is not available for clinical ecology, orthomolecular therapy, vitamins, dietary nutritional supplements, food challenge, or related testing rendered on an outpatient basis.

Preventive care that includes all appropriate immunizations and wellness services are covered. This includes all recommended immunizations by the Advisory Committee on Immunization Practices (ACIP) and the North Dakota Department of Health. Wellness visits shall be based on Bright Futures, which includes up to seven physician visits in the first eleven months of life, newborn hearing screening, no more than two home nursing visits for newborns if requested by physicians and the family, developmental screening, mental health screening and coverage of nutrition services for diabetes, hyperlipidemia, eating disorders, chronic renal failure, and phenylketonuria. Coverage for nutritional care is limited to no more than two office visits per year for hyperlipidemia and four office visits for the other covered conditions. Other wellness services include up to six well care and immunization visits for enrolled children 12 through 36 months of age and one visit per year for enrolled children four years of age through 18 years of age. Children six through 18 years of age are also allowed one preventive screening service per year that can include a sports or school physical.

Wellness services shall include diabetic education services. These services are limited to 10 hours for initial education and an additional two hours per benefit period.

Coverage is not available for any other annual, periodic or routine examinations except those specified above or for immunizations required because of a child's employment, occupation or immunizations required for foreign travel.

Coverage is not available for any other annual, periodic or routine examinations except those specified above or for immunizations required because of a child's employment, occupation or immunizations required for foreign travel.

Costs associated with the delivery of a child are not included in this health benefit package.

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 $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.

Coverage is not available for the insertion and routine removal of intrauterine devices, contraceptive delivery systems, evaluations and procedures to evaluate sterilization reversals, reversal of sterilization procedures or any other procedures or supplies designed to prevent pregnancy including oral and other forms of contraceptive drugs, contraceptive devices and appliances.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

As of January 1, 2019, Prior authorization is not required for all admissions. A $50 co-payment applies.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

As of January 1, 2019, Preauthorization is not required.

Group psychotherapy is also available.

Coverage is also available for the intensive outpatient program. This service is a formal program for a child who requires more than one visit per week for mental health services but does not require the intensity of inpatient hospital or partial hospitalization. Generally more than one treatment modality is used and a plan must identify a treatment goal that is related to the child's diagnosis.

Exclusions:

Coverage is not available for services provided by a social worker who does not meet the qualifications required by state law or a psychologist who is not eligible for listing in the National Register of Health Service Providers.

Special education, counseling or care of learning disorders or behavioral problems whether or not associated with a manifest mental disorder or other disturbance.

Sex therapy services.

Bereavement, codependency, marital, family, sex or interpersonal relationship, gambling addiction or nicotine addiction counseling services or services provided by a vocational residential rehabilitation center or a community reentry program.

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

Rental or purchase of home medical equipment is covered when prescribed by a physician and required for therapeutic use. No benefits are allowed for motorized equipment except wheelchairs with prior approval. No coverage is available for batteries required for home equipment.

Covered services include replacement and repairs when medically appropriate and necessary.

Coverage is available for the purchase, fitting and necessary adjustments of prosthetic appliances and supplies that replace all or part of a body part. Benefits are available only for standard appliances. Covered services

include replacement and repairs when medically appropriate and necessary.

Coverage is not available for any testicular prostheses regardless of the cause of the absence of the testicle.

The rental of medically appropriate and necessary oxygen equipment and the administration of the oxygen is a covered service.

Orthotic devices that are medically appropriate and necessary when ordered by a physician or podiatrist are covered. Benefits are not available for leisure or recreational activities or to allow a child to participate in a sports activity.

Coverage is not available for personal hygiene and convenience items including air conditioners, humidifiers or physical fitness equipment.

Hearing Aids are covered when medically necessary and appropriate. Benefits are limited to $4,000 per enrolled child every three years.

Coverage is not available for electronic speech aids, robotization devices, robotic prosthetics, myoelectronic prosthetics, customized cutaneal dermal protective covers, and endolite prosthetic systems or artificial organs.

Coverage is available for one set of eyeglass frames and one set of lenses every 12 months for each child. The amount allowed for each frame is $100. Any amount over that cost is the responsibility of the family.

If desired, contact lenses may be substituted for eyeglass frames and lenses. Payment allowances are limited to the allowance for frames and prescribed lenses that are considered appropriate and medically necessary.

Medically appropriate and necessary medical equipment and supplies are subject to a maximum benefit allowance of $8,000 per member per year for all covered services received.

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

Coverage is provided for medically and necessary supplies for the administration of prescription medications or drugs such as hypodermic needles and syringes and ostomy supplies

Medically appropriate and necessary medical equipment and supplies are subject to a maximum benefit allowance of $8,000 per member per year for all covered services received.

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

Coverage is provided for a homebound child in the child's place of residence. The service must be on a part-time visiting basis in accordance with a physician's prescribed plan of treatment that is approved prior to admission into home health care.

Services are available only if, in the absence of home health care, a child would require inpatient hospital or skilled nursing facility services.

Covered services include registered nurse, licensed vocational nurse or licensed practical nurse; physical, occupational or speech therapy; medical and surgical supplies; administration of prescribed drugs; oxygen, including administration; and home health aide services when a child is receiving daily covered skilled nursing services or therapy services.

Coverage is not available for dietitian services, homemaker services, maintenance care, custodial care, food or home delivered meals, respite care or home health care or supplies for children who are ventilator dependent unless a skilled nursing facility bed is not available. In the event a skilled nursing facility bed is not available, the maximum benefit allowance will be the average semi-private room rate for a skilled nursing facility bed.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

PRIVATE DUTY NURSING SERVICES

Coverage is available for services provided by a registered nurse or licensed practical nurse when ordered by a physician,

Payment is not available to a nurse who lives in the child's home or is a member of the child's immediate family.

Coverage is not available for maintenance care.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

Coverage is limited to abortions that are necessary to prevent the death of a woman.

Coverage is not available for other abortions including abortions for removal of all or part of a multiple gestation.

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

Coverage is provided for emergency, diagnostic and well child dental care including preventive and restorative services. These services include emergency palliative treatment, simple extractions, pulpotomies on deciduous teeth, routine oral examinations, dental x-rays that include bitewing, full-mouth and panoramic, routine prophylaxis, sealants, topical fluoride applications, space maintainers, amalgam and resin restorations, stainless steel crowns and administration of anesthesia.

Routine oral examinations and topical fluoride applications are limited to no more than twice per year. Prophylaxis is limited to no more than four per year. Bitewing x-rays are limited to no more than once during a year. Full mouth and panoramic x-rays are limited to once every three years.

Coverage is available for medically appropriate and necessary orthodontic services. Interceptive Orthodontic treatment is aimed at preventing dental/facial development problems before they occur. Treatment is performed while the patient has only primary teeth. Service is limited to once per lifetime. Comprehensive Orthodontic treatment is for patients who only have permanent teeth and their jaw/facial bones are completely developed. Treatment is comprehensive in nature, meaning a variety of problems have been identified and are being corrected. Orthodontic correction is done to establish correct tooth and jaw positional relationships; proper chewing function; evenly distributed chewing forces; esthetic facial proportions, and an esthetic smile. Service is limited to once per lifetime. Orthodontic services do not apply to the benefit period maximum. Prior authorization is required. Additional requests for orthodontic treatment above the limit, will be reviewed on a case by case basis, in instances of accidental injury or if the child's teeth have moved significantly following orthodontic treatment.

Coverage is also available for appropriate and necessary treatment of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face that occurs after the date a child is enrolled in Healthy Steps. Treatment must occur within 12 months of the date of injury. Injury is defined as an external force that causes a specific impairment to the areas described above. Injury that is a result of chewing or biting is not considered an accidental injury.

Coverage for medically appropriate and necessary dental services is limited to $1,000 per benefit period. In case of medically necessary care in excess of the $1,000, prior approval will be needed and exceeding the $1,000 limit may be granted.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services. **(Section 2110(a)(18))**

As of January 1, 2019 Prior authorization is not required for all admissions. A $50 co-payment applies.

6.2.19. ☒ Outpatient substance abuse treatment services. **(Section 2110(a)(19))**

Coverage for partial hospitalization for mental illness and substance abuse is available. As of January 1, 2019, Preauthorization is not required.

Coverage is provided for outpatient substance abuse services.

Coverage for group psychotherapy services is available. As of January 1, 2019, Preauthorization is not required.

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(22))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. **(Section 2110(a)(22))**

PHYSICAL THERAPY

Coverage is available for physical therapy services performed by or under the direct supervision of a physical therapist to restore maximum function following disease, injury or loss of body part. Services will be limited based on a predetermined number of visits based on the presenting condition.

Coverage is available for treatment of chronic conditions such as a multiple sclerosis, progressive rheumatoid arthritis or cerebral palsy when medically appropriate and necessary.

Coverage is not available for maintenance care including such care related to the treatment of chronic conditions.

Coverage is not available for massage therapy provided by a masseuse or masseur.

OCCUPATIONAL THERAPY

Coverage is available for occupational services performed by or under the direct supervision of a licensed occupational therapist for the treatment of a physically disabled child by means of constructive activities designed and adapted to promote the restoration of a child's ability to satisfactorily accomplish the ordinary tasks of daily living.

Coverage is limited to a maximum of 90 consecutive days per condition beginning on the day the first service was provided. After 90 days,

services will be reviewed to determine if additional services should be available based on medical appropriateness and need.

Coverage is not available for maintenance care.

SPEECH THERAPY

Coverage is available for speech therapy services performed by or under the direct supervision of a certified speech therapist for the correction of a speech impairment resulting from disease, surgery, injury, congenital anomaly or previous therapeutic process. Prior authorization is required and services must be provided in accordance with prescribed plan of treatment ordered by a physician

Coverage is not available for maintenance care or for group speech therapy services.

Care must be delivered based on a prescribed treatment plan ordered by a physician.

Preauthorization is required and service must be delivered in accordance with a prescribed plan of treatment.

Coverage is not available for physical, occupational or speech therapy associated with work hardening programs, prevocational evaluations or functional capacity evaluations.

6.2.23. ☒ Hospice Care **(Section 2110(a)(23))**

Coverage is available for hospice benefits when provided through an organized and approved hospice program. Preauthorization is required.

Services are limited to treatment of children who have been diagnosed with a condition where there is a life expectancy of 6 months or less.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

PROFESSIONAL VISION SERVICES PROVIDED BY AN OPTOMETRIST

Coverage is available for emergency and well child services that include treatment of sore eyes, foreign body removal and sudden impairment of vision, annual routine complete examinations and visits to supervise patching progress and orthoptics for children with amblyopia. Benefits are limited to a lifetime maximum of 16 visits per child.

Examinations are limited to no more than one per year.

Coverage is not available for any other service or material that may be provided through an optometrist

CHIROPRACTIC SERVICES

Coverage is available for medically appropriate and necessary services provided within the scope of licensure and practice of a chiropractor to the extent services would be covered if provided by a physician.

Benefits are not available for maintenance care.

BIOFEEDBACK

Coverage is available for chronic headaches, gastrointestinal disorders, neuromuscular disorders and panic disorders.

Coverage is limited to no more than four sessions per child per year.

TEMPOROMANDIBULAR (TMJ) OR CRANIOMANDIBULAR JOINT TREATMENT (CMJ)

Coverage is available for TMJ and CMJ that includes surgical and Nonsurgical services when treatment is medically appropriate and necessary.

Coverage for surgical services are subject to a lifetime maximum of $10,000 per child. Coverage for nonsurgical services including diagnostic and biofeedback services, supplies and outpatient treatments are subject to a lifetime maximum of $2,500 per child. Coverage for splints are limited to no more than $275 and are subject to the nonsurgical service lifetime maximum.

Coverage is not available for orthodontic services or osseointegrated implant surgery or related services performed for the treatment of temporomandibular or craniomandibular joint disorder(s).

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

Coverage is available for medically appropriate and necessary ambulance services to the nearest facility equipped to provide the required level of care. Coverage is provided from the home or site of accident or emergency, between hospitals, or between a hospital and a skilled nursing facility.

Coverage for air ambulance is available only if it is not medically appropriate and necessary to transport by ground ambulance. Preauthorization is required.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services) (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

Skilled nursing facility services that are medically appropriate and necessary that include skilled nursing services and supplies generally provided in a skilled nursing facility are covered. Preauthorization is required.

Coverage is not available for maintenance or custodial care.

The following is a general list of exclusions not associated with a particular service.

1. Services not prescribed or performed by or under the direct supervision of a professional health care provider consistent with the professional health care provider's licensure and scope of practice.

2. Services provided and billed by a registered nurse (other than an advanced practice registered nurse), physician extender, intern, licensed athletic trainer or other paramedical personnel.

3. Any drug, device, medical treatment or procedure that is experimental or investigative.

4. Services, treatment or supplies that the contractor determines are not medically appropriate or necessary.

5. Standby services provided or billed by a health care provider.

6. Services when benefits are provided by any governmental unit or social agency. Medicare Part A and B will be considered the primary payor with respect to benefit payments unless otherwise required by federal law.

7. Illness or injury caused directly or indirectly by war or an act of war or sustained while performing military services, if benefits for such illness or injury are available under the laws of the United States or any political subdivision thereof.

8. Illness or bodily injury that arises out of and in the course of child's employment if benefits are compensation for such illness or injury are available under the provisions of a state workers' compensation act, the laws of the United States or any state or political subdivision thereof.

9. Loss caused or contributed by a child's commission or attempted commission of a felony or a child's involvement in an illegal occupation.

10. Any services when benefits are provided by a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

11. Services provided by a health care provider who is a member of the child's immediate family.

12. Telephone consultations or charges for failure to keep a scheduled visit or charges for completing of any forms required by the contractor.

13. Health screening assessment programs or health education services, including services provided through the rental or purchase of TV, audiovisual tapes or pamphlets.

14. Health and athletic club membership or facility use, and all services provided by the facility, including physical therapy, sports medicine therapy and physical exercise.

15. Complications resulting from noncovered services received by a child.

16. Services prescribed by, performed by or under the direct supervision of a nonpayable health care provider.

17. Services that a child has no legal obligation to pay in the absence of this or any similar coverage.

18. Cost sharing amounts.

19. Services, treatments, or supplies not specified as a covered service in this coverage plan.

6.2-D The state will provide dental coverage to children through one of the following:

6.2.1-D ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

Diagnostic (CDT codes: D0100-D0999) (must follow periodicity schedule).

Preventive (CDT codes: D1110-D1206) (must follow periodicity schedule).

Restorative (CDT codes: D2000-D2999).

Endodontic (CDT codes: D3000-D3999).

Periodontic (CDT codes: D4000-D4999).

Prosthodontic (CDT codes: D5000-5899 and D5900-D5999 and D6200-6999).

Oral and Maxillofacial Surgery (CDT codes: D7000-D7999).

Orthodontics (CDT codes: D8000-D8999).

Emergency Dental Services.

Please note: this form has not been approved by OMB pursuant to the PRA and States are not obligated to use it.

6.2.1.1-D ☐ Periodicity Schedule. Please Select and include a description.

☐ Medicaid

☒ American Academy of Pediatric Dentistry

☐ Other Nationally recognized periodicity schedule: (Please Specify)

6.2.2-D ☐ Benchmark Coverage; **(Section 2103(c)(5), 42 CFR 457.410 and 42 CFR 457.420)** States must, in accordance with 42 CFR 457.410, provide coverage for dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions if these services are not provided in the chosen benchmark package.

6.2.3-D ☐ FEHBP-equivalent coverage; **(Section 2103(c)(5)(C)(i))** (if checked, attach a copy of the dental supplemental plan benefits description and the applicable CDT codes. If the necessary dental services are not provided, please include a description of, and the CDT code(s) for, the required service(s).)

6.2.4-D ☐ State employee coverage; **(Section 2103(c)(5)(C)(ii))** (if checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If necessary dental services are not provided, please also include a description of, and the CDT code(s) for, the required service(s).)

6.2.5-D ☐ HMO with largest insured commercial enrollment **(Section 2103(c)(5)(C)(iii))** (if checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If necessary dental services are not provided, please also include a description of, and the CDT code(s) for, the required service(s).)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in

the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☐ Yes

☒ No

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of

section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☐ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☐ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☐ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☐ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☐ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5)) ☐ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☐ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☐ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

6.2.3.1.1 MHPAEA The State assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

Inpatient: a person confined as a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

Outpatient: a person treated as a registered Outpatient at a Hospital, clinic or in a Professional Health Care Provider's office, who is not, at the time of treatment, a registered patient in a Hospital, Skilled Nursing Facility, Substance Abuse Facility, Psychiatric Care Facility or other Institutional Health Care Provider.

Prescription Drugs: any legend drug, Payable Over-the-Counter Drug, biologic or insulin that is lawfully dispensed according to federal laws, upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for the treatment of the disease or illness for which the Member Child is receiving care.

Emergency Care: health care services, supplies or treatments furnished or required to screen, evaluate and treat an Emergency Medical Condition.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☒ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☐ No

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount

expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☐ No

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

BCBS ND has historically been a strong advocate of behavioral health services in North Dakota. Because of BCBS ND's long-standing predilection for robust behavioral health coverage, implementation of the federal mental health parity laws has not been a challenge. BCBS ND's certificates of insurance identify consistent financial and quantitative treatment limit application across the board for medical/surgical benefits and behavioral health benefits. Services that require prior approval or preauthorization are identified the same for medical/surgical benefits and behavioral health benefits based on the following strategies, processes, evidentiary standards and other factors including: practice variation/variability, significant drivers of cost trend, outlier performance against established benchmarks, disproportionate utilization, preference/system driven care, gaps in care that negatively affect cost, quality and or utilization and outcome yield from the utilization activity/administrate cost analysis.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☒ No

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☐ State

☒ Managed Care entities

☐ Both

☐ Other

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☒ Managed Care entities

☐ Both

☐ Other

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii)); OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2 of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f)).** Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **Section 2105(c)(s) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a));**

6.4.1.1 Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery**

system. The state may cross reference section 6.2.1 – 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3 The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3))A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3 The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **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 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories unutilized.)

7.1.1. ☒ Quality standards

The Department of Human Services contracts with Noridian Mutual Health Insurance to provide medical, dental and vision services to eligible children. The contractor has a current Certificate of Authority from the Insurance Department. The contractor is also required to maintain a Quality Assurance/Quality Improvement Plan that summarized the contractor's quality assurance system including but not limited to the following standards for the entire range of clinical care and services provided:

- Detailed quality objectives and timetables for accomplishing these objectives. Section 9 contains many of the quality indicators the Department will be using to measure the quality of services provided to children eligible for Healthy Steps.
- Description of the quality assurance committee structure.
- Identification of contractor staff responsible for quality assessment and improvement.
- Description of the manner in which providers participate in quality assurance and improvement activities. The contractor uses provider profiling on a statewide basis to identify quality issues and bring them to the attention of practitioners.
- Credentialing procedures.
- Standards of clinical care that address preventive services and are based on reasonable scientific evidence and are regularly reviewed by clinicians and distributed to providers. The contractor periodically sends information to providers relating to standards based on the Academy of Immunization Practices and educational materials relating to specific disease states such as asthma, diabetes, and lipid lowering agents.
- Standards of service accessibility. The contractor has an extensive provider network that includes 100% of hospitals, 99.6% of all physicians actively practicing in North Dakota, 99.1% of optometrists and 64.1% of dentist participate in the provider network that provides services to eligible children.
- Medical records standards, including medical records confidentially provisions.

- Utilization review standards and processes. The contractor has developed this requirement and it is on file with the Department of Insurance.
- Quality indicator measures and clinical study designs. Quality measures and clinical study have been designed and incorporated into the quality objectives covered in Section 9 of the plan. HEDIS standards will be utilized where appropriate

  CHIPRA initial core set technical specifications manual 2011 will be utilized where appropriate, and are designed to improve the delivery for enrolled children.

The Department is especially aware of the need to encourage the use of preventive services for eligible children. As such, we have established goals that are designed to track and improve the delivery of preventive services that include immunizations, well baby and well childcare. A Healthy Steps report card has been developed that will be used to track the progress made to improve the delivery of preventive care services to enrolled children. Goals have been established that will encourage the contractor to educate families and providers about the importance of preventive care and encourage families to seek appropriate immunization and well baby, well child visits in order to ensure that children remain healthy during their formative years.

In addition, the contractor will also have goals for other preventive service improvement including dental and vision visits and hospital emergency service usage. The contractor will also be monitoring with the plan of reducing the rate of institutional psychiatric and chemical dependency services, improving the management of asthma and diabetes, thus reducing the need for expensive hospital interventions.

- Quality Assurance and Quality improvement plan documentation methods. This information is included in the Healthy Steps Report Card process.
- Description of how quality improvement activities are integrated with other plan or management functions. The contractor and the Department have periodic discussions regarding quality measures in order to improve or change the quality improvement process. In many instances the Department is using similar measures when establishing quality indicators for the Medicaid program. We are then able to draw comparisons between the programs to assist in identifying issues and improving performance.
- Monitoring the effectiveness of the client grievance process, including identification of contractor staff with specific

responsibility to resolve problems. The contractor maintains a quarterly grievance report. The Medical Director for the contractor is responsible for resolving any grievances received from the families of enrolled children.

7.1.2. ☒ Performance measurement

The contractor for the Healthy Steps program will assure that high quality and appropriate services are provided to enrolled children. The contractor is required to collect and report data for the following areas that are similar to that required by the Department from our capitated service providers. Modified HEDIS measures will be acceptable, if available.

- Childhood Immunizations
- Adolescent Immunizations
- Well Baby Visits
- Well Child Visits
- Treatment Dental Services
- Preventive Dental Services
- Optometric Services
- Preventive Health Promotion Activities
- Membership Surveys
- Indicators of contractor financial stability
- Pharyngitis
- Otitis Media with Effusion
- Emergency Department Utilization
- Asthma related ER visits
- Follow-up care for children prescribed attention-deficit/hyperactivity disorder medication
- Follow-up after hospitalization for mental illness
- Children and adolescents' access to primary care practitioners (PCP)

Most of the measurements noted above are included in the Healthy Steps Report Card, a required reporting tool by the contractor used to track progress in meeting specific goals for quality improvement. The contractor has encouraged preventive health promotion activities such as sending out annual birthday cards for enrolled children reminding them to make appointments for preventive dental and vision services. The contractor has completed annual membership surveys that are used to evaluate the quality of services being provided to enrolled children.

7.1.3. ☒ Information strategies

The contractor has developed Healthy Steps enrollee education materials to ensure those children and their families are informed of their benefits, their rights and their responsibilities. The educational material includes information regarding covered services, limitations, grievance procedures, toll-free numbers available to answer questions about covered services and grievance procedures and policies on referrals and after hours care.

7.1.4. ☒ Quality improvement strategies

The contractor has developed an internal measurement and monitoring system that is used to inform providers with emphasis on preventive and coordinated care according to clinical standards and guidelines that includes annual HEDIS information that is shared with providers.

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

The Department is committed to ensure that enrolled children have access to preventive services. Several of the objectives outlined in Section 9 of this plan are designed to monitor the provision of these services and to devise ways of improving the number of preventive services if targets are not being met including educational efforts for families and providers.

The contractor also conducts yearly surveys that assists in identifying preventive service usage and needs and will be used to correct any issues raised by families concerning access to important preventive services that include preventive physician visits and appropriate immunizations for enrolled children.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

The contractor survey of families seeks information regarding the availability and use of services including hospital emergency room services. The surveys are monitored to determine if any deficiencies exist and action is then taken to correct any apparent problems with access to services.

Emergency room services must be available to all enrollees and are not subject to any prior approval requirements.

The contractor has an extensive provider network that includes all licensed hospitals in the state and more than 99% of practicing physicians. This network

allows enrolled children the opportunity to receive needed care throughout the state including rural areas.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, and serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Children with chronic, complex or serious medical conditions may seek the services of any specialist participating in the contractor's provider network without the need to seek prior approval. Since more than 99% of all physicians participate in that network, access to specialty care is excellent.

While most conditions can be treated by specialists within the contractor's network, there are certain instances when out of network specialty services are indicated. These services are available from providers located in Minneapolis or Rochester, Minnesota. Participating physicians in North Dakota may make appropriate referrals to these specialists if the services are not available in North Dakota.

The yearly survey conducted by the contractor has a section dedicated to availability of specialty care. Responses are monitored to ensure that specialty services are readily available to enrolled children.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The contractor follows the Utilization Review Accrediting Council of Facilities regarding prior authorization of services and adheres to the 14-day time frame.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **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 the Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES

8.1.2. ☐ NO, **skip to question 8.8**8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) & (c), 457.515(a) & (c))

8.2.1. Premiums: No premiums are imposed on covered children.

8.2.2. Deductibles: No deductibles are imposed on covered children.

8.2.3. Coinsurance or copayments: A $5 co-payment will be applied for each emergency room visit to a hospital. 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.

A $50 copayment is applied for the first day of each inpatient hospital admission in a general hospital, an inpatient psychiatric facility or a substance abuse inpatient facility.

8.2.4. Other: There are no other cost-sharing requirements in the Healthy Steps Program.

8.3. Describe how the public will be notified, including the public schedule, of the cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

All eligible families of enrolled children will receive a handbook from the insurance carrier that includes information regarding their cost sharing responsibilities. The information is distributed during the first month the children are enrolled in the program. Each family receives notice of the amount of their cumulative maximum at the time they are determined eligible for the Healthy Steps Program.

Cost sharing information is available for the general public through brochures that are distributed throughout the state to various advocacy groups, government agencies, providers and others interested in promoting health care coverage,. Information regarding cost sharing is also posted on the Department's Website.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3. ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☒ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☒ Yes (Specify: $50 per inpatient hospitalization, $5 co-payment will be applied for each emergency room visit to a hospital. 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).

☐ No

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☒ Yes

☐ No

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☒ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within

which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☒ Yes

☐ No

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☒ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☒ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the state. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Cost sharing is limited to no more than 5% of gross income for each eligible family. Each family receives a notice that lists the children who are eligible for Healthy Steps. The notice also informs families of the maximum amount of cost-sharing each family is responsible to pay each year. The contractors are required to track the cost sharing. If a child reaches the cost sharing limit, copayments are no longer charged. The insurance carrier issues new cards indicating that the family is no longer subject to any cost sharing.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

North Dakota uses a self-declaration process to ensure that American Indian children are excluded from cost-sharing. The application requests race information for each applicant. If the applicant indicates that the child is American Indian, it is assumed that they meet the definition as described in the Indian Health Care Improvement Act of 1976.

North Dakota has four recognized Reservations and one Indian Service Area. Nearly all Indians in the state either reside on these reservations or have moved to other areas from the reservations. They originate from tribes that are recognized under the Indian Health Care Improvement Act. Therefore, the department concluded that self-declaration of race is appropriate.

If a child is identified as American Indian, the insurance carrier is notified. The Department makes a premium payment to the carrier that is slightly higher in order to cover the extra costs of not applying co-payments for services provided to enrolled children. The insurance cards issued by the insurance carrier, informs providers that the child is not subject to any of the co-payments that apply to other enrolled children.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c)**

Enrolled children in the Healthy Steps Program are not subject to disenrollment if they fail to pay cost-sharing to providers. It is the responsibility of the parents of an enrolled child to pay the cost-sharing amount directly to the provider of service. The provider may take any ordinary means available to collect the amount due. Program enrollment will continue as long as a child is eligible for the Healthy Steps whether or not the family pays the cost sharing amounts to the appropriate providers.

8.7.1. Please provide an assurance that the following disenrollment protections are being applied:

- ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☐ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- ☐ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFS 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** *(Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Strategic Objective 1: Reduce the number of North Dakota children, from birth to age 19 who are uninsured.

Strategic Objective 2: Improve access to health care services for North Dakota children enrolled in SCHIP.

Strategic Objective 3: Ensure that children enrolled in SCHIP receive timely and comprehensive preventive health care services.

Strategic Objective 4: Ensure that children enrolled in SCHIP receive high-quality health care services.

Strategic Objective 5: Improve the health status among children enrolled in SCHIP.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

The Department is acutely aware that outcome measurements are an integral part of SCHIP. We realize that merely making services available does not ensure that children are receiving necessary services or that they are receiving quality health care services. The performance measures outlined below are designed to ensure that enrolled children receive appropriate and necessary health care services.

In order to meet yearly federal reporting requirements we intend to gather information based on services provided between July 1 and June 30 of each year, our state fiscal year. This will permit us to ensure that data provided to CMS is accurate and meaningful.

Performance Measures for strategic Objective 1: Reduce the number of North Dakota children from birth to age 19 who are uninsured.

1.1 Annually at least 600 previously uninsured low-income children will be enrolled in Medicaid and Healthy Steps Programs.

1.2 By December 31, 2011 the percentage of children from birth to 19 years of age without health insurance will decrease-by about .5% using the rate based on the current population survey (CPS).

Performance Measures for Strategic Objective 2: Improve access to health care services for North Dakota children enrolled in CHIP.

2.1 Annually at least 90% of children surveyed in CHIP will have an identified primary care provider.

2.2 Annually there will be a 2% decrease in the proportion of enrolled children in CHIP who were unable to obtain needed medical care during the previous year as measured through a survey of enrolled families.

2.3 Annually at least 85% of children enrolled in CHIP will have received a preventive dental service before age 8.

2.4 Annually there will be a 2% increase in the number of enrolled children that received a preventative dental service.

Performance Measures for Strategic Objective 3: Ensure that children enrolled in CHIP receive timely and comprehensive preventive health care services.

3.1 Annually there will be a 5% increase in the number of children who turned two years of age during the preceding year and were continuously enrolled in CHIP will have received at least four well-child visits during the first 24 months of life.

3.2 Annually there will be a 2% increase in the number of children ages three through six-year-old children who were continuously enrolled in CHIP during the

preceding year that will have received one or more well care visits with a primary care provider.

3.3 Annually there will be a 2% increase in the number of children enrolled in CHIP that have received all age appropriate immunizations using the HEDIS measure definition.

3.4 Annually there will be a 2% increase in the number of 13-year-old children enrolled in CHIP that have received a Meningoccal, , TdaplTD or combination vaccine.

3.5 Annually at least 45% of eight-year-old children enrolled in CHIP will have received a vision screening examination.

Performance Measures for Strategic Objective 4: Ensure the children enrolled in this Medicaid Expansion receive high quality health care services.

4.1 The annual readmission rate for asthma hospitalizations among children enrolled in CHIP will be compared and monitored to the rate during the previous year.

4.2 Annually thereafter, the average number of emergency room hospital visits will be monitored for children enrolled in CHIP.

4.3 Annually at least 80% of families with children enrolled in CHIP who are surveyed will report overall satisfaction with their health care.

Performance Measures for Strategic Objective 5: Improve health status among children enrolled in CHIP.

5.1 Vacated.

5.2 For children enrolled in Healthy Steps with a diagnosis of diabetes will annually be tracked to ensure that the health status of these children improve over time.

5.3 In order to track improvements in the delivery of mental health services in the least restrictive setting, annually the rate of admissions for inpatient hospitalizations and the number of admissions and length of stay residential treatment services for enrolled children with mental illness will be monitored.

5.4 Vacated.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: **(Section 2107(a)(4)(A),(B) (42CFR 457.710(d))**

Strategic Objective 1: Reduce the number of North Dakota children from birth to 19 years of age who are uninsured.

The Department will compare the number of children enrolled on January 1st of each year in the Medicaid and Healthy Steps Programs with the number of children enrolled as of January 1 of the previous year.

The Department will show that the percentage of uninsured children has decreased by about .5% based on the current population survey.

Strategic Objective 2: Improve access to health care services for North Dakota children enrolled in CHIP.

The Department working with the MCO will conduct a survey on an annual basis of families with children enrolled in the program to determine how many eligible children have selected a primary care provider.

The Department working with the MCO will conduct a survey on an annual basis of families with children enrolled in the program to determine if families have access to needed care.

The Department working with the MCO through evaluation of paid provider claims will identify those children who have received preventive dental care compared to those who have not received this service.

Strategic Objective 3: Ensure the children enrolled in CHIP receive timely and comprehensive preventive health care services.

The Department working with the MCO will use information from our claims data and the immunization registry to track the age appropriate services and report how well the children are receiving the identified preventive services.

Strategic Objective 4: Ensure the children enrolled in CHIP receive high quality health care services.

The Department working with the MCO will track and report the rate of readmissions for asthma hospitalization for enrolled children.

The Department working with the MCO will track and report using claims data information on the trends in the use of emergency room services by enrolled children.

The Department working with the MCO through the use of a family survey will determine the satisfaction level of medical services received by children enrolled in the Medicaid Expansion Program.

Strategic Objective 5: Improve health status among children enrolled in ~~S~~CHIP

The Department working with the MCO through analysis of claims data will track children with a diagnosis of diabetes and obesity to determine if improvement in selected quality indicators have improved over time.

The Department working with the MCO will track the number of dental fillings received by enrolled children and report results with the anticipation that regular dental care and proper oral hygiene will reduce the number of cavities in children over time.

The Department working with the MCO will track children with mental illness diagnosis and report progress in the reduction of hospitalizations and residential treatment service admissions and length of stay over time.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. ☒ Immunizations
- 9.3.7.2. ☒ Well child care
- 9.3.7.3 ☐ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6 ☒ Dental care
- 9.3.7.7 ☒ Other, please list: Other areas of performance measurement include access to primary care, vision care, asthma inpatient hospital reductions, reduction in emergency room visits, and quality improvement for children with diabetes.

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

The state assures that it will comply with the annual assessment and evaluation required under Section 10.1 and 10.2.

The state will on an annual basis assess and evaluate the operation and effectiveness of this plan and report all findings to CMS by January 1 of each year. The data sources will include but are not limited to, claims data available through the decision support system obtained from Noridian Mutual Health

Insurance Company, other reports provided by Noridian, and other information available through the North Dakota Department of Human Services, the North Dakota Department of Health, the Indian Health Service, the Census Bureau and other entities who might have accurate data concerning the number of uninsured children residing in North Dakota.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.135)**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(A0 and (b))**

During the last legislative session, the Healthy Steps program was thoroughly discussed including the use of a joint application for Medicaid and CHIP. Any major changes

concerning the operation of the Healthy Steps Program will require legislative approval. In North Dakota, the legislative process is open to anyone who wishes to testify on any bill and all bills must be voted on by the legislature. This process provides the citizens of North Dakota with ample opportunity to provide input before final action is taken by the legislature.

In addition, the Department will provide an opportunity for public input whenever major changes in the state plan are finalized and before the plan is submitted for approval. Comments from all interested parties will be solicited either in writing or orally. These comments will be reviewed and considered prior to the submission of any substantial change to the state plan.

Ongoing input from the public will continue. For example, a legislative interim committee is monitoring the Children's Health Insurance Program in North Dakota to determine if any changes need to be made in the future. Interim committee meetings are open to any interested party who wishes to provide input bout this program.

The Department will also utilize the Medical Care Advisory Committee which is made up of providers, advocates and recipients to provide input and advice regarding the ongoing operation of the Medicaid Expansion and the separate Healthy Steps Program.

9.9.1. Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **(Section 2107(c)) (42CFR 457.120(c))**

Whenever a major change in the state plan is anticipated, the Department will send a letter to the tribal chairman in each of the four Indian Reservations and one Indian Service Area. They will receive information about the proposed changes in the title XXI Program and will be requested to provide any written comments about the propose changes.

In addition, if requested, we will schedule informational meetings regarding the proposed changes at any Reservation or Service Area requesting a meeting. We will accept both written and oral comments from any interested party concerning the proposed changes. All comments received will be analyzed and considered prior to the submittal of any substantial change in the state plan.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided and required in 457.65(b) through (d).

Prior to any change in eligibility or benefits procedures are implemented, the Department will schedule a series of public meetings throughout the state. All interested parties will be invited to provide comments regarding the proposed changes. Written and oral comments will be accepted. The Department will analyze and consider all comments before implementing any changes that could adversely affect the eligibility or benefits of children currently enrolled in the program.9.10. Provide a one year projected budget.

A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including –
  -Projected amount to be spent on health services;
  -Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation, and
  -Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable federal laws and regulations, including but not limited to federal grant requirements and federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ **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 to Section 12.

11.1. ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6 – 9.8.9)*

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6 ☒ Section 1128E (relating to the national health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120. Requirements for the processing of CHIP applications in contained in North Dakota Administrative Code, Chapter 75-02-02.2. The state operates a program specific review process. The Department is required to promptly make an eligibility determination. In almost all cases the review is completed before the end of the month in which the Department receives the application.

The Department provides a written notice to each applicant whenever the department denies, suspends or terminates eligibility. The notice includes the effective date of the action taken, the reason for the action taken and the appeal rights available to the applicant. The appeal rights information includes information on filing a written appeal with the appeals supervisor within thirty days after the date of the notice of decision.

If a timely filed appeal is received, the department must conduct an administrative hearing in accordance with requirements outlined in 42 CFR 457.985.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

North Dakota operates a statewide standard review process that is contained in Chapter 26.1-36-42 of the North Dakota Century Code that meets the requirements prescribed in 42 CFR 427.1120. This chapter requires all health insurance companies to establish and maintain a procedure for resolving complaints by covered persons regarding any aspect of the plan.

In addition to the above statewide standard review, the department also permits enrollees that are dissatisfied with the final decision of the insurance carrier to appeal that decision to the department.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable in North Dakota.