

John Hoeven, Governor  
Carol K. Olson, Executive Director

## MEMORANDUM

**Date:** June 1, 2010

**To:** ND Medicaid Providers with a current or past Contract Health Service contract number with Indian Health Services (IHS)

**From:** Maggie Anderson, Medical Services Director *Maggie*

**Subject:** Contract Health Services – Medicaid Copayments

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The American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5 provides protections for Indians [enrolled] in Medicaid. Section 5006(a) of the Recovery Act amends sections 1916 and 1916A of the Act, to preclude states from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers and to assure that Indian health providers, and providers of contract health services (CHS) under a referral from an Indian health provider, will receive full [Medicaid] payment. (State Medicaid Director's Letter 1/22/2010, SMDL# 10-001)

This memo is specifically directed at the copayments. If your agency is providing services to American Indians enrolled in Medicaid and receiving services at your facility under a referral from CHS, then you are not allowed to assess the Medicaid copayments for the services delivered through a CHS referral. This exemption is retroactive to July 1, 2009. If you assessed and collected copayments from American Indians enrolled in Medicaid for services rendered through a CHS referral, you must repay copayments to the client. See **Attachment A** for a list of services that have copayments under the ND Medicaid program.

Please note that none of the provisions in the American Recovery and Reinvestment Act pertain to recipient liability. Also, the Recovery Act does not bypass Primary Care Provider program (PCP) and Coordinated Services Program (CSP) rules.

We understand from information received from Indian Health Services that CHS pays only through a referral. Possible forms of notification of a referral include:

1. Copy of referral received directly from CHS,
2. Copy of CHS referral sent with the client, or
3. Copy of the attached sample letter sent with the client (**Attachment B**).

In order to receive reimbursement for the Medicaid copayments, providers will need to keep track of CHS referrals and associated services for reconciliation and submission to Medicaid quarterly. Please submit all the following:

- Certification Memo (**Attachment C**)
- Copy of each CHS referral
- Corresponding remittance advice or ICN/date paid for each CHS referral claim paid during the calendar quarter

The above items must be submitted within 45 days after the end of the calendar quarter. For copayments prior to July 1, 2010 submit all information identified above by August 15, 2010. If you have questions on the reimbursement process please contact LeeAnn Thiel at (701) 328-4893.

The ND Medicaid claims system is currently not able to exempt the application of copayments when processing CHS referral claims. Providers are not required to bill ND Medicaid for the copayments but cannot charge the client.

The certification memo and documentation should be submitted to:

ND Department of Human Services  
Medical Services Division  
Attn: LeeAnn Thiel  
600 E Boulevard Ave. Dept. 325  
Bismarck, ND 58505-0250

cc: Cindy Gillaspie, Centers for Medicare and Medicaid Services  
Karla Hall, Aberdeen Area Indian Health Services  
Contract Health Offices  
Tribal Offices  
Eligibility Supervisors, County Social Service Boards

NORTH DAKOTA  
DEPARTMENT OF HUMAN SERVICES  
Medical Services Division

### **COPAYMENT INFORMATION**

#### *SERVICES THAT HAVE COPYAMENTS UNDER THE ND MEDICAID PROGRAM*

All medical doctors, nurse practitioners, certified nurse midwives, or certified physician assistants	\$2.00
Brand name prescription drugs	\$3.00
Dental clinic appointment	\$2.00
Optometry or Ophthalmology appointment	\$2.00
Spinal manipulation received during a chiropractic appointment	\$1.00
Outpatient speech therapy	\$1.00
Outpatient physical therapy	\$2.00
Outpatient occupational therapy	\$2.00
Outpatient psychological or psychiatric appointment	\$2.00
Outpatient hearing test	\$2.00
Hearing aid supplied	\$3.00
Rural Health Clinic or Federally Qualified Health Center	\$3.00
Podiatry office appointment	\$3.00
Inpatient hospital stay	\$75.00
Emergency room visit that is not an emergency (eff. 5/25/2010) (For services prior to 5/25/2010 copay is \$6.00)	\$3.00

<Provider Full Name>  
<Address>  
<City, State Zip Code>

Dear <Provider Full Name>,

On July 1, 2009 the American Recovery and Reinvestment Act (ARRA) of 2009, Public Law 111-5 became law. Section 5006(a) of ARRA amends SSA Section 1916 by providing exemptions for certain American Indians and Alaska Native applicants and participants from cost sharing requirements and assures Indian health providers and those providing services under a Contract Health Services referral from an Indian health provider will receive full payment. Section 5006a states:

- Exempts Indians from enrollment fees, premiums, or similar charges if they are furnished an item or service by an Indian health care provider (Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under CHS.
- Exempts Indians from payment of a deductible, coinsurance, co payment, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian Health provider – I/T/U – or through CHS.
- Prohibits any reduction of payment that is due under the full Medicaid payment rate for furnishing the item or service. The payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

In summary the Indian patient can not be billed for any enrollment fee, premium, deductibles,, copayment, or similar charge that otherwise would be due from the Indian and you should be paid by Medicaid at the full Medicaid payment rate for furnishing the item or service. Further information on this notice can be obtained by contacting our office at [insert phone number].

Date: [Insert MM/DD/YYYY]  
Name of Entity/Sender: [Insert Name of I/T/U Site]  
Contact--Position/Office: [Insert Position/Office]  
Address: [Insert Street Address, City, State & Zip Code of Entity]  
Phone Number: [Insert Entity Phone Number]

NORTH DAKOTA  
DEPARTMENT OF HUMAN SERVICES  
Medical Services Division

**CERTIFICATION MEMO**

**CONTRACT HEALTH SERVICES COPAYMENTS**

**Quarter Requesting Reimbursement:** \_\_\_\_\_

**Number of Referrals Attached:** \_\_\_\_\_

**Reimbursement Request:** \_\_\_\_\_

I hereby certify that \_\_\_\_\_ has not billed or  
(Provider)  
received payment from the client(s) for the copayment portion for services provided  
under the CHS referral(s) attached.

\_\_\_\_\_  
(Authorized Signature)

\_\_\_\_\_  
(Date)