State: North Dakota

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of North Dakota enrolls Medicaid beneficiaries on a mandatory basis into managed care entities and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__X_ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;
____ ii. capitation;
__X_ iii. a case management fee;
____ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

Citation	Condition or Requirement
	____ii. Incentives will be based upon specific activities and targets.
	____iii. Incentives will be based upon a fixed period of time.
	____iv. Incentives will not be renewed automatically.
	____v. Incentives will be made available to both public and private PCCMs.
	____vi. Incentives will not be conditioned on intergovernmental transfer agreements.
	__X__vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The design of the program is to allow Medicaid enrollees to select a Primary Care Provider (PCP) to provide, through an ongoing patient/provider relationship, primary care services and referral for all necessary services. The State will consult with the Medicaid Medical Advisory Committee or an advisory committee with similar membership to ensure on-going public involvement. The North Dakota Medicaid Medical Advisory Committee meets on a quarterly basis. Program updates and recommendations are presented at the meetings. The Medicaid Medical Advisory Committee includes physicians, representative of provider groups, representatives of advocacy groups, recipients, the State Health Officer, representatives of the Department's Executive Office, and other Divisions, and North Dakota Legislators. The State reports to the Medicaid Medical Advisory Committee on program changes. In addition, the state seeks the input of the committee on program changes and implementation options.
1932(a)(1)(A)	5. The state plan program will _X_/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____ ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____

Citation	Condition or Requirement

iv. area/areas (voluntary)_____.

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. __X__The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. ___X_The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. __X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. ____The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
for 42 CFR 447.362
42 CFR 438.50(c)(6)

7. __X__The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.

45 CFR 74.40

8. __X__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.
The following eligible groups will be enrolled on a mandatory basis:
1. Categorically needy

Citation	Condition or Requirement

a. Family Coverage Group 1931
b. Transitional Extended Medicaid.

2. Optionally Categorically Needy
3. Medically Needy nonexempt
4. Poverty Level
   a. Pregnant Women
   b. Children to age 6
   c. Children ages 6 to 19

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. ____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. ____Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

IHS service facilities serve as Primary Care Providers within the PCCM Program.

1932(a)(2)(A)(i)
Supplemental
42 CFR 438.50(d)(3)(i)

iii. ____Children under the age of 19 years, who are eligible for Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii)
42 CFR 438.50(d)(3)(ii)

iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

1932(a)(2)(A)(v)
out-of-
42 CFR 438.50(3)(iii)

v. ____Children under the age of 19 years who are in foster care or other the-home placement.

1932(a)(2)(A)(iv)
42 CFR 438.50(3)(iv)

vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

1932(a)(2)(A)(ii)

vii. ____Children under the age of 19 years who are receiving services through a 42 CFR 438.50(3)(v) family-centered, community based,

Citation	Condition or Requirement

coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children under 19 years of age whom are enrolled with Children Special Health Services and/or receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

_X_ i. program participation,
____ ii. special health care needs, or
____ iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_X_ i. yes
____ ii. no

1932(a)(2)
exempt 42 CFR 438.50 (d)
identification)

4. Describe how the state identifies the following groups of children who are from mandatory enrollment: *(Examples: eligibility database, self-*

i. Children under 19 years of age who are eligible for SSI under title XVI;

There is an indicator within our Eligibility Database.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

There is an indicator within our Eligibility Database System.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

Within the Eligibility Database, we identify living arrangements which include foster care and other out of home placements.

Citation	Condition or Requirement

iv. Children under 19 years of age who are receiving foster care or adoption assistance.
Within the Eligibility Database, we identify living arrangements which include foster care and other out of home placements and income types.

1932(a)(2)5.
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

The state receives a report from the Department of Health, Children's Special Health Services Unit. This report is received on a monthly basis. The recipients are then provided an "exempt" status under managed care.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Within the Eligibility Database we have specific identifiers for Medicare.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

IHS service facilities serve as Primary Care Providers within the PCCM Program.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

- Aged, Blind and Disabled Enrollees
- Women's Way Program Enrollees
- Enrollees receiving refugee assistance
- Enrollees having a retroactive eligibility period (the retro-active eligibility period is exempt)
- Individuals residing in: a Nursing Home/Long Term Care Facility; Swing Bed; Psychiatric Residential Treatment Facility; the State

Citation	Condition or Requirement

Hospital (Individuals under 21 and 65 and over); Intermediate Care Facility/MR.

- Enrollees receiving Home and Community Based Services

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

None

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. The existing provider-recipient relationship (as defined in H.1.i).

The default enrollment process takes into account the previous provider assigned within the past 12 months. If there is no provider assigned, the system will then indicate a past history of medical claims in which a provider assignment is generated from that information.

ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

The default enrollment process takes into account the previous provider assigned within the past 12 months. If there is no provider assigned, the system will then indicate a past history of medical claims in which a provider assignment is generated.

iii. The equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56

Citation	Condition or Requirement
	(d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)* The process takes the bottom 50% of Primary Care Providers that have recipients assigned to them, determines the county each PCP is located in, takes the recipients that have not had a PCP assigned and determines which county they are in, then randomly auto-assigns a PCP to a recipient in that county. Each time the report is run, the bottom 50% is recalculated.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will __X__ /will not____ use a lock-in for managed care managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be within14 Days. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* A State generated letter is sent to the recipient notifying them of the need to choose a PCP and the time frame which is required to contact the State or designated agent. The letter also contains information regarding the auto-assignment process should a provider not be chosen within the allotted timeframe. Once a provider has been auto-assigned another State generated letter is sent to the recipient notifying them of the provider. iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* A State generated letter is sent to the recipient upon auto-assignment of a provider and describes the right to disenroll without cause during the first 90 days of their enrollment with the Provider. v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* For those recipients who have not had a PCP previously assigned or claims history within the past 12 months, the system will take the bottom 50% of PCP's that have recipients assigned to them, determine the county each PCP is located in, take the recipients that have not had a PCP assigned and determine which county they are in,

Citation	Condition or Requirement

create subsets for the recipients for each county along with the PCP's located in that county, randomly auto-assign a PCP to the recipient in that county. The bottom 50% of PCP's is recalculated upon generation of the auto-assignment report.

Those recipients who have been identified as American Indians will be assigned to an IHS facility.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State will develop a report regarding the number of managed care members auto-assigned compared to the total managed care population per month.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. _X_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

___This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

Citation	Condition or Requirement

_X_ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _X_ /will not___ use lock-in for managed care.

2. The lock-in will apply for _6_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

PCP relocates, PCP disenrolls as a Medicaid provider, PCP disenrolls as a PCP provider, and recipient's lack of access to a PCP.

The State will review disenrollments for medical reasons on an individual basis.

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Medicaid recipients enrolled in PCCM's have access to all Medicaid services with appropriate referrals.

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not__X_ intentionally limit the number of entities it contracts under a 1932 state plan option.

Citation	Condition or Requirement

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ____ The selective contracting provision in not applicable to this state plan.