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Jack Dalrymple, Governor
Carol K. Olson, Executive Director

MEMORANDUM

Date: November 29, 2011

To: Tribal Chairman
Tribal Health Directors
Indian Health Services Representative

From: Maggie D. Anderson, Director, Medical Services Division *Maggie*

Re: Tribal Consultation on North Dakota Medicaid State Plan Amendments

This letter is regarding the Tribal Consultation between the North Dakota Department of Human Services (Department) and the North Dakota Indian Tribes and Indian Health Services (IHS). This consultation process was established to ensure Tribal governments are included in the decision making processes when changes in the Medicaid or Children's Health Insurance Program(s) will affect items such as cost sharing, IHS Encounter rates or service reductions and additions. The Department engages Tribal consultation when a State Plan Amendment, waiver proposal or amendment, or demonstration project proposal directly impacts the North Dakota Tribes and/or their Tribal members, or Indian Health Services.

The following DRAFT Medicaid State Plan Amendments are enclosed for your review:

1. Health Management Program
2. Targeted Case Management for Children in Alternative Care
3. Targeted Case Management for Children in Protective Services
4. Targeted Case Management for Individuals with a Serious Mental Illness or Serious Emotional Disturbance

Effective January 1, 2012, North Dakota Medicaid will be implementing hospital acquired conditions (HAC) and provider-preventable procedures standards. The HACs will require prospective payment system (IPPS) hospitals to submit claims with the present on admission indicator. When a hospital acquired condition is not present on admission, but is reported as a diagnosis associated with the hospitalization, the Medicaid payment under the IPPS to the hospital may be reduced to reflect that the condition was hospital acquired. A copy of the draft State Plan Amendment is enclosed.

If you have any comments, questions or concerns about the REVISED proposed State Plan Amendment, please contact me by **December 28, 2011** at manderson@nd.gov or by mailing a written response to 600 East Boulevard Avenue, Department 325, Bismarck, ND 58505 or by calling 701-328-1603.

The Department appreciates the continuing opportunity to work collaboratively with you to achieve the Department's mission, which is: "To provide quality, efficient, and effective human services, which improve the lives of people."

MDA/mlt

Enclosures

26. For diagnostic, screening, preventive and rehabilitative services... (continued)

- a. The Contractor(s) (i.e., Disease Management Organization [DMO], providers and or clinics) for the preventative services – Health Management Program – will be reimbursed through a payment methodology as follows:

The DMO/Health Care Teams will be reimbursed utilizing a blended rate which included costs associated with nursing contracts (assessments, monitoring, face to face visits, telephonic, development of care plans) and education and program information mailings to participants and providers.

Providers and Clinics will be reimbursed through a payment methodology that is compliant with 42 CFR 438.6(c).

Capitation payments will be made monthly.

The program will operate under the authority of the State Plan.

The current fee schedule(s) for health management services and any annual/period adjustments to the fee schedule are published on <http://nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html>.

The agency's fee schedule rate was set as of July 1, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website.

- b. Effective for services provided on or after January 1, 2010:

The current fee schedule(s) for rehabilitative services are published on the North Dakota Department of Human Services web-site. The fee schedules were set on July 1, 2009 and are effective for services provided on and after that date.

For rehabilitative services, each qualified Medicaid service practitioner will be reimbursed a rate from the Medicaid fee schedule for defined units of service. For the private providers, the fee schedule was historically established by a comparison of codes to other, relative codes and to what other regional (private, Medicare and Medicaid) payers allowed. For the governmental providers, the fee schedule is established based on the cost of delivering the services, which is used to set a fee for each service provided.

For private providers enrolling the following provider-types, reimbursement is the lower of billed charges or a maximum of 75% of the professional fee schedule for the following provider types: Licensed Social Worker (LSW), Licensed Independent Clinical Social Worker (LICSW), Licensed Certified Social Worker (LCSW), Licensed Addiction Counselor (LAC), Licensed Associate Professional Counselor (LAPC), Licensed Professional Counselor (LPC), and Licensed Professional Clinical Counselor (LPCC).

For Crisis Stabilization, Transitional Living, and Day Treatment reimbursement will be at a daily rate; not to exceed cost.

The State Medicaid agency will have a contract with each entity receiving payment under provisions of services (Crisis Stabilization, Transitional Living, and Day Treatment) as defined in Attachment 3.1-A and Attachment 3.1-B that will require that the entity furnish to the State Medicaid agency on an annual basis the following:

- a. Data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
- b. Cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers.

DRAFT

State:

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 (managed care organization (MCOs) 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) 1. The State will contract with an

1932(a)(1)(B)(ii)

42 CFR 438.50(b)(1)

- i. MCO
- 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;
- iii. a case management fee;
- iv. a bonus/incentive payment;
- v. a supplemental payment, or
- vi. other. (Please provide a description below).

North Dakota operates a statewide PCCM program. This program was initiated in 1994 with the primary goal of increasing access to primary care; provide care

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coordination, and lowering costs. The State contracts with primary care providers to provide care coordination for their enrolled recipients.

North Dakota continues to operate its original PCCM program; however, on October 1, 2011, the State expanded the PCCM program to providers and clinics whom now have the option of providing additional care coordination services in the form of a health management program for recipients with certain chronic diseases.

Please see an extensive description of the Health Management program at the end of this filing in section(s) N.1, N.2, and N.3.

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.
- 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.
- 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.*)

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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 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 /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) _____
- 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)

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

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42 CFR 438.50(c)(2) 1902(a)(23)(A)	
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> 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. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> 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) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 92.40	8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
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: <ol style="list-style-type: none">1. Categorically needy<ol style="list-style-type: none">a. Family coverage Group 1931b. Transitional Extended Medicaid2. Optionally Categorically Needy3. Medically Needy nonexempt4. Poverty Level<ol style="list-style-type: none">a. Pregnant Womenb. Children to age 6c. Children ages 6 to 19

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	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. <input type="checkbox"/> Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i>
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. <input type="checkbox"/> 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.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. <input type="checkbox"/> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. <input type="checkbox"/> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. <input type="checkbox"/> Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <input type="checkbox"/> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <input type="checkbox"/> Children under the age of 19 years who are receiving services through a family-centered, community based, 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.

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1932(a)(2) 42 CFR 438.50(d)	<p data-bbox="695 485 1382 541">Within the Eligibility Database, we identify living arrangements which include foster care and other out of home placements.</p> <p data-bbox="578 606 1349 663">iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p data-bbox="695 699 1382 785">Within the Eligibility Database, we identify living arrangements which include foster care and other out of home placements and income types.</p> <p data-bbox="521 884 1425 972">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. <i>(Example: self-identification)</i></p>
1932(a)(2) 42 CFR 438.50(d)	<p data-bbox="695 1003 1425 1121">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.</p> <p data-bbox="521 1220 1425 1306">6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i></p> <p data-bbox="578 1341 1425 1425">i. Recipients who are also eligible for Medicare. Within the Eligibility Database we have specific identifiers for Medicare.</p> <p data-bbox="578 1493 1425 1701">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.</p>

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	IHS service facilities serve as Primary Care Providers within the PCCM program.
42 CFR 438.50	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u></p> <ul style="list-style-type: none">• Aged, Blind and Disabled Enrollees• Women's Way Program Enrollees• Enrollee's 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 Hospital (Individuals under 21 and 65 and over); Intermediate Care Facility/MR.• Enrollees receiving Home and Community Based Services
42 CFR 438.50	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p>Enrollment into the Health Management program is voluntary therefore eligible groups does not apply. However, recipients with the following classifications are excluded from participating in the Health Management program:</p> <ul style="list-style-type: none">• Enrolled in a Medicaid managed care organization (MCO)• In a nursing facility or intermediate care facility for the mentally retarded (ICF/MR)• Receiving Medicare Benefits (Dual Eligibles)• Identified as having Recipient Liability;• With other major medical health insurance
1932(a)(4) 42 CFR 438.50	<p>H. <u>Enrollment process.</u></p> <p>1. Definitions</p> <p>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</p>

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1932(a)(4) 42 CFR 438.50	<p>records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.</p> <p>ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.</p> <p>2. State process for enrollment by default.</p> <p>Describe how the state's default enrollment process will preserve:</p> <p>i. the existing provider-recipient relationship (as defined in H.1.i).</p> <p>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.</p> <p>ii. The relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</p> <p>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.</p> <p>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 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</p> <p>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.</p>

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1932(a)(4) 42 CFR 438.50	<p data-bbox="519 472 1433 546">3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p data-bbox="568 567 1433 640">i. The state will <u>X</u> /will not use a lock-in for managed care managed care.</p> <p data-bbox="568 661 1433 735">ii. The time frame for recipients to choose a health plan before being auto-assigned will be <u>within 14 days</u>.</p> <p data-bbox="568 777 1433 850">iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p data-bbox="665 871 1433 1092">A State generated letter is sent to the r 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-assigned 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.</p> <p data-bbox="568 1144 1433 1270">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. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i></p> <p data-bbox="665 1302 1433 1396">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.</p> <p data-bbox="568 1449 1433 1554">v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i></p> <p data-bbox="665 1575 1433 1761">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, create subsets for the recipients for each county along with the PCP's located in that</p>

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	<p>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.</p> <p>vi. Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p> <p>The State will develop a report regarding the number of managed care members auto-assigned compared to the total managed care population per month.</p>
1932(a)(4) 42 CFR 438.50	<p>I. <u>State assurances on the enrollment process</u></p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p>1. <input checked="" type="checkbox"/> 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.</p> <p>2. <input checked="" type="checkbox"/> 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).</p> <p>3. <input checked="" type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p><input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>4. <input type="checkbox"/> 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.)</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p>

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	5. <input type="checkbox"/> 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. <input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. <u>Disenrollment</u> 1. The state will <input checked="" type="checkbox"/> /will not <input type="checkbox"/> use lock-in for managed care. 2. The lock-in will apply for <u>6</u> months (up to 12 months). 3. Place a check mark to affirm state compliance. <input checked="" type="checkbox"/> 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.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	K. <u>Information requirements for beneficiaries</u> Place a check mark to affirm state compliance. <input checked="" type="checkbox"/> The state assures that its state plan program is in compliance with 42 CFR 438.10(t) 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. <u>List all services that are excluded for each model (MCO & PCCM)</u> Medicaid recipients enrolled in PCCM's have access to all Medicaid services with appropriate referrals.

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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 intentionally limit the number of entities it contracts under a 1932 state plan option:
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.

N. Additional Health Management Program Design:

1. Providers/Clinics (including FQHC's, RHC's and Indian Health Services) will receive a PMPM for subsets of populations that have the following chronic conditions: Asthma, Diabetes, Congestive Heart Failure (CHF) and/or Chronic Obstructive Pulmonary Disease (COPD) so that enhanced care management services can be provided (the PMPM capitated rate is excluded from; the encounter rate for Indian Health Services on Attachment 4.19B Page 3b, the established rate for Rural Health Clinics on Attachment 4.19B Page 4 and Federally Qualified Health Centers on Attachment 4.19B Page 5).
2. All Health Management contracts shall set forth all payments (other than fee-for service reimbursements) to the provider, clinic, health team or disease management organization including health management services descriptions, and reimbursements. The current fee schedule(s) for health management services is posted on the North Dakota Department of Human Services web site. All Health Management contracts shall be submitted to CMS for review and approval.

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3. Providers, Clinics, and Health Teams provide additional health management services by:
- a. A systematic screening process to identify qualified eligible Medicaid recipients for outreach, intervention and education
 - b. A medical home for care coordination of treatment and services.
 - c. Ensure that recipients receive evidence based care.
 - d. Individualized care planning based on need and level of intensity.
 - e. Educate recipients about disease states and self-management skills.
 - f. Availability of advance access of appointments and/or triage services to minimize urgent and emergency department utilization.
 - g. Involvement from a "team" of ancillary medical professionals from the recipient's "medical home" (this may include dietitians, respiratory therapists, pharmacists, etc. as appropriate considering the recipient's condition.
 - h. An integrated package that includes but are not limited to a high risk screening and assessment, triage, referral system which includes tracking referrals and results, recall system for appointments, pharmacy review, inpatient and discharge transitions, education, and emergency department diversion.
 - i. Culturally and linguistically appropriate care.
 - j. Dedicated staff to perform care coordination and care management functions.
 - k. Use of population and disease registries.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. 3/31/2014)

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LIMITATIONS ON AMOUNT, DURATION AND SCOPE

Services

13c. Preventive Services (continued)

Health Management

The North Dakota Medicaid Program will provide a statewide Health Management Program to certain eligible Medicaid recipients with one or more of the following conditions:

- a. Asthma
- b. Diabetes
- c. Chronic Obstructive Pulmonary Disease (COPD)
- d. Congestive Heart Failure (CHF)

The health management services will be provided to individuals who are eligible under the authority of the state plan amendment

1. Excluded Populations

- a. Recipients excluded from enrollment in the Health Management Program are those receiving health management through other means including those:
 - i. Enrolled in a Medicaid managed care organization (MCO)
 - ii. In a nursing facility or intermediate care facility for the mentally retarded (ICF/MR)
 - iii. Receiving Medicare benefits
 - iv. With other major medical health insurance
 - v. With recipient liability (spend down)

2. Components of the Health Management Program

The Health Management Program vendor(s) (i.e., Disease Management Organizations [DMO], Health Teams) provides services to enrolled participants utilizing a nurse care manager model.

The health management program consists of the following:

- a. The Health team is staffed by licensed nurses within the State to provide health management services.
- b. A systematic screening process to identify qualified, eligible

Medicaid recipients for outreach, intervention and education.

- c. The health team's licensed nurses' conduct an initial health assessment in the form of a questionnaire. Based on the responses, along with additional data (i.e. medical records, if available), the nurse care managers develop and implement an individual plan of care, guided by the results of the initial assessment, to address the enrollee's multiple health, behavioral and social needs, and assure continuity, quality and effectiveness of care in consultation with the enrollee's primary care physician (PCP) and other appropriate ancillary staff (i.e., pharmacists, certified educators, nutritionists, etc.).
- d. The DMO/Health Team will also:
 - i. Provide the participant (as well as family and provider) with health information and education to improve the participant's self-management skills related to their specific chronic condition(s); improve adherence to the PCP's treatment plan; improve self-administration of medications, as well as minimize urgent care and emergency department utilization.
 - ii. Establish a local presence and building collaborative relationships with providers.
 - iii. Plan for coordination, communication and integration of local service systems and supports by building collaborative relations with local social, community, and State service agencies.
 - iv. Individualized care planning based on need and level of intensity.
 - v. Conducts face to face, telephonic and/or other means of communication based on participant preference, level of need and intensity.
 - vi. Collaboration with the participant's personal primary care provider and other health team members as needed, along with supporting the primary care provider's plan of care through consistency and continuity of care.
 - vii. Advocate for recipients with complex chronic conditions to ensure that recipients receive appropriate evidence based care.
- e. A telephone call center in which participants or providers may speak to a nurse care manager. The DMO will accomplish these activities through maintenance of a telephone health information line (THIL) through which the licensed nurses may initiate monitoring and follow-up calls to enrollees in the program and provide enrollees with twenty-four hour seven days per week (24/7)

toll-free access to nurse consultation to answer questions or address concerns about their treatment plan, self-management, and other inquiries.

3. Enrollment/Disenrollment Process

Participation in the Health Management Program is voluntary. Participants may request to enroll or their provider may recommend enrollment. However, the participant must agree to enroll. The participants are notified that they may disenroll from the program at any time.

Procedures for enrollment and disenrollment must be consistent with the Code of Federal Regulations (CFR), Part 42, Section 438, *Managed Care*, paragraphs 438.56(a) through (g).

4. Choice of Providers

The Health Management Program is a voluntary program. Potential enrollees have free choice to receive or not receive Health Management Program services through the DMO, Health Team or other provider or clinic that is enrolled as a Health Management provider with ND Medicaid, or by choosing not to participate. Enrollees may opt out of the program at any time, for any reason.

5. Qualifications for Care Manager Nurses

The nurses staffed by the DMO or Health Team must be licensed with the North Dakota Board of Nursing as either licensed practical nurses (LPNs) or registered nurses (RNs). The nurses must satisfactorily complete the training requirements and preceptorship defined by the DMO including training or certification specific to the chronic conditions the nurses will manage in the program.

The nurses must complete annual continuing education credits as required by the North Dakota Board of Nursing.

6. Health Management Provider Criteria

- a. The DMO and/or Health Team must meet the following conditions.
 - i. Comply with applicable federal and state laws and regulations governing the participation of providers and recipients in the Medicaid program including:

1. Title XIX of the Social Security Act and any final regulations promulgated pursuant to that title.
 2. Title 42, *Public Health*, of the Code of Federal Regulations (CFR), Part 438, *Managed Care*. The Health Management Program is a Prepaid Ambulatory Health Plan (PAHP) and is subject to federal regulations pertaining to PAHPs.
 3. North Dakota Administrative Code, Chapter 75-02-02, *Medical Services*.
 4. Any other pertinent provisions of Federal or State law.
- ii. Hire licensed nurses employed by the DMO or Health Team who reside and are licensed to practice in North Dakota.
 - iii. Provide 24/7 access to a THIL staffed by licensed nurses. The THIL must be equipped with appropriate technology to accept calls from all enrollees in the Health Management Program and to provide services for those with limited English proficiency.
 - iv. Stratify participants based on their risk and provide a level of service consistent with the participants needs, including face-to-face intervention by licensed nurses as necessary.
 - v. Assure all program activities are conducted consistent with evidence-based clinical practice guidelines for each chronic condition being managed.
 - vi. Assure frequent communication through nurse case managers with participant's PCPs using phone calls and face-to-face interactions as necessary. The DMO or Health Team will also provide the PCP with periodic reports on each participant's health status including information on the PCP's success in providing care consistent with established clinical guidelines.
 - vii. Implement internal quality assurance/quality improvement, outcomes measurement, and evaluation and information management systems.
 - viii. Provide participant with self-care education materials and education methods (telephonic, face-to-face, group education with peer support, etc.) appropriate to each chronic condition

being managed.

- ix. Establish a collaborative healthcare practice model to include North Dakota providers and community-based partners in program administration in a consultative capacity.
- x. Maintain a computer information system sufficient to carry out all the required components of the Health Management Program.

7. Comparability of Services

All enrollees will receive comparable services based on their risk stratification level (high, moderate, low).

8. Confidentiality Requirements

To ensure the enrollee's confidentiality, the must comply with applicable local, state and federal laws, regulations and policies regarding confidentiality. Any forms or documents developed by the DMO or Health Team must be revised to reflect North Dakota law. The computer information systems and policies and procedures utilized by the DMO or Health Team must be HIPAA compliant.

9. Documentation Requirements

The DMO or Health Team must submit monthly, quarterly and/or annual reports as specified by the State and documented in the contract.

10. Payment Methodology for the Health Management Program

See Attachment 4.19B, page 3a-1, item #26, sub-item (a).

**TARGETED CASE MANAGEMENT SERVICES FOR
CHILDREN IN ALTERNATIVE CARE**

Target Group:

The person for whom Medicaid participates in the cost of Case Management Services for Children in Alternative Care must be Medicaid eligible; be a foster child age 0-21 who is in the care, custody or control of the North Dakota Department of Human Services, a North Dakota County Social Service Board, North Dakota Division of Juvenile Services, a North Dakota Tribal organization, or a similar agency in another state and placed in North Dakota; or be a child who has been in foster care and has been appointed a legal guardian by a court having jurisdiction; or be a child placed in North Dakota pursuant to the Interstate Compact for children who are placed by an agency from another state.

Areas of state in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount duration and scope.

Definition of Services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation; and

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with
 - Medical, social, educational providers or
 - Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of Providers:

1. In order to ensure that care is properly coordinated, targeted case management services need to be provided by agencies who have or have had legal custody of the child or by agencies who are part of a care team that includes the legal custodian. Also the services must be delivered in a culturally appropriate manner.
2. Individual Case Managers must, at a minimum, hold a Bachelor of Social Work degree and successfully completed the Child Welfare Certification Training or be in "candidate" status of completing the Child Welfare Certification Training within six months, or hold a Bachelors Degree in Social Work, Psychology, Counseling or closely related field, or Individual Case Managers from a North Dakota Tribal Organization serving this population must, at a minimum, been certified by the Native American Children and Family Services Training Institute as a Child Welfare Practitioner or be in "candidate" status of being certified within six months.

Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42CFR 431.10(e)]

Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; [DRA]The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.(2001 SMD)
- Activities integral to the administration of foster care programs; or (2001 SMD) and
- Activities for which third parties are liable to pay. (2001 SMD)

**TARGETED CASE MANAGEMENT SERVICES FOR
CHILDREN IN PROTECTIVE SERVICES**

Target Group:

The person for whom Medicaid participates in the cost of Case Management Services for Children in Protective Services must be Medicaid eligible; be a child who has been the subject of a child abuse or neglect report or believed to be at risk thereof as defined by North Dakota Century Code 50-24.1; and be under age 18 and determined to be (1) services recommended; or (2) services required as defined by the North Dakota Department of Human Services in accordance with North Dakota Century Code 50-25.1.

Areas of state in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount duration and scope.

Definition of Services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment of an individual to determine the need for any medical, educational, social or other services. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development of a Specific Care Plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and Related Activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
 - Medical, social, educational providers or
 - Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and Follow-up Activities:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of Providers:

1. In order to ensure that care is properly coordinated, targeted case management services need to be provided by providers who have experience in conducting child abuse and neglect assessment investigations.
2. Individual Case Managers must, at a minimum, hold a Bachelor of Social Work degree and have completed Child Welfare Certification Training or be in candidate status of completing Child Welfare Certification Training and anticipate completing such training within six months.

Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services,

or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42CFR 431.10(e)]

Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; [DRA]The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.(2001 SMD)
- Activities integral to the administration of foster care programs; or (2001 SMD) and
- Activities for which third parties are liable to pay. (2001 SMD)

TARGETED CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH A SERIOUSLY MENTAL ILLNESS OR SERIOUSLY EMOTIONAL DISTURBANCE

Target Group:

The person for who Medicaid participates in the cost of case management services must:

1. Be Medicaid eligible; and
2. For an adult – be chronically mentally ill in accordance with NDCC 57-38-01, which states:

“Chronically mentally ill” means a person who, as a result of a mental disorder, exhibits emotional or behavioral functioning which is so impaired as to interfere substantially with the person’s capacity to remain in the community without verified supportive treatment or services of a long-term or indefinite duration. This mental disability must be severe and persistent, resulting in a long-term limitation of the person’s functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

This does not include persons with the infirmities of aging, or a primary diagnosis of mental retardation or chemical dependence, or

“Children with serious emotional disturbance” are persons:

- Up to age 21,
- Who currently have a diagnosable mental, behavioral, emotional disorder of sufficient duration to meet diagnostic criteria specified with DSM-IV,
- That resulted in functional impairment of 50 or less on the GAF scale of the DSM-IV which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

These disorders include any mental disorders (including those of biological etiology) listed in DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV “V” codes, substance use, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

Children must meet the GAF score criteria of 50 or less to initiate this service. Children who would have met functional impairment criteria during the prior year without the benefit of treatment or other support services are included in this definition.

Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

3. Be determined:

- To be having a psychiatric crisis or emergency which requires emergency intervention to prevent institutional placement; or
- To be in need of long-term mental health services.

For case management services provided to individuals in medical institutions:

Target group is comprised of individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount duration and scope.

Definition of Services:

Case Management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, education and other services.

Case Management includes the following assistance:

- Assessment of an individual to determine the need for any medical, education, social or other services. These assessment activities include:
 - Taking client history;
 - Identifying the individual's needs and completing related documentation; and
 - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development of a Specific Care Plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible Individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and Related Activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
 - Medical, social, educational providers; or
 - Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and Follow-up Activities:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - Services are being furnished in accordance with the individual's care plan;
 - Services in the care plan are adequate; and
 - If there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of Providers:

Bachelor's degree in Social Work, psychology, counseling, nursing, occupational therapy, vocational rehabilitation, therapeutic recreation, or human resources with required addiction studies, and two years of experience working with the targeted population groups in a direct care setting; or a master's degree in one of the fields listed above.

Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

- Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Regional Human Service Centers (HSC) have oversight by a psychiatrist, and all cases are staffed by a Ph.D Clinical Psychologist and two other professional disciplines such as psychiatry, social work, nursing, or advance clinical specialist. Training of staff is targeted to mental health diagnosis, functioning, and evidence-based interventions. Seriously Mental Illness (SED) Case Management is anchored in the wraparound process, a promising practice for children with SED. Case Managers have access to a multidisciplinary resources (psychiatry, psychology, substance abuse, vocational rehabilitation), all of which are accessible within the same HSC. The North Dakota Department of Human Services is given legislative authority through NDAC 25-10-01.1 which defines a unified delivery system. In NDCC 50-06-05.2, it requires human services must be delivered through Regional Human Service Centers in the areas designated by the Governor's Executive Order 1978-12 dated October 5, 1978. This service can also be provided by qualified providers who are employed by the Federally recognized North Dakota Indian Tribes.

Access to Services:

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42CFR 431.10(e)]

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Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; [DRA]The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.(2001 SMD)
- Activities integral to the administration of foster care programs; or (2001 SMD) and
- Activities for which third parties are liable to pay. (2001 SMD)

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Prospective Payment (PPS) Hospitals-For claims with dates of payment on or after January 3, 2012, when a health care-acquired condition occurs during hospitalization and the condition was not present on admission, claims shall be paid as though the diagnosis is not present. Reimbursement for PPS hospitals regarding health care-acquired conditions is identified on page _____ of Attachment 4.19A.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 A and B.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

North Dakota Medicaid will adopt the baseline for other provider preventable conditions as identified by Medicare. The following reimbursement changes will apply:

Payment will be denied for these conditions in any health care setting as identified in Attachments 4.19A and 4.19B and any other settings where these events may occur. For any North Dakota Medicaid claim with dates of payment on or after January 3, 2011, that contains one of these diagnosis codes, these claims will be denied and will not be reimbursed.

TN No. _____

Supersedes _____

TN No. _____

Approval Date _____

Effective Date _____

CMS ID: 7982E

Reimbursement for PPS hospitals regarding other provider preventable conditions is identified on _____, of Attachment 4.19A.

____ Additional Other Provider-Preventable Conditions identified below (*please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services*) of the plan:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1136. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No. _____
Supersedes _____
TN No. _____

Approval Date _____

Effective Date _____

CMS ID: 7982E