north dakota department of human services

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Jack Dalrymple, Governor
Carol K. Olson, Executive Director

February 10, 2012

Ms. Dori Junker, Health System Specialist
IHS Resource Mgmt Bus Office
Aberdeen Area I.H.S. Office
115 4th Ave SE Rm 309
Aberdeen SD 57401

RE: State Plan Amendments Approved and Medicaid Medical Advisory Committee

Dear Ms. Junker:

Medicaid State Plans Approved
The following Medicaid State Plan Amendments have received approval from the Centers for Medicare and Medicaid Services. Copies of each, approved State Plan Amendment is enclosed for your reference.

Indian Health Services Encounter Rate - was approved January 25, 2012. In addition, we have enclosed a copy of the policy guidance that corresponds to this Amendment. If you have any questions, please contact Erik Elkins or me at 701-328-2321.

Tribal Consultation – was approved February 7, 2012. Please contact me if you have questions.

Targeted Case Management for Long Term Care Services – was approved February 8, 2012. This amendment authorizes qualified Community Health Representatives to provide Targeted Case Management for Medicaid-eligible individuals who are in need of Long Term Care Services. Please contact Karen Tescher at 701-328-2324 if you have questions or would like additional information about enrollment.

Medicaid Medical Advisory Committee
The next meeting of the Medicaid Medical Advisory Committee has been scheduled for **Thursday, February 23, 2012 from 1:30pm to 4:30pm in the Pioneer Room of the Judicial Wing, in the State Capitol, Bismarck.**

You, or your designee, are invited to participate as a member of the Medicaid Medical Advisory Committee. A draft agenda is enclosed for your reference. Thank you for your consideration to participate in this committee. Please RSVP regarding your participation to Mary Lou Thompson at 701-328-2321 or mlthompson@nd.gov. We hope to see you on February 23, 2012.

If you have any questions, please contact me at manderson@nd.gov or 701-328-1603.

Sincerely,

Maggie D. Anderson, Director
Medical Services Division

MDA/mlt

Enclosures

29 Health Services Payments to Indian Health Service (IHS) will be per encounter per day and based on the approved all-inclusive rates published each year in the Federal Register by the Department of Health and Human Services

An encounter for a 638 or IHS facility means an encounter between a recipient eligible for Medicaid and a health professional at or through an IHS or 638 service location

Multiple visits for different services on the same day with different diagnosis
IHS facilities are eligible for multiple encounter rates for multiple **general covered service categories** on the same day for the same recipient with a different diagnosis For example, IHS may bill a mental health service, an outpatient service and a pharmacy service for a single recipient on the same day

Multiple visits for different services on the same day with the same diagnosis
IHS facilities are eligible for multiple encounter rates for multiple **general covered service categories** on the same day for the same recipient with the same diagnosis provided they are for different **general covered service categories** The diagnosis code may be the same for each of the claims, but the services provided must be distinctly different and occur within different units of the facility For example, IHS may bill a mental health service, an outpatient service, and a pharmacy service for a single recipient on the same day

Multiple visits for the same type of service on the same day with different diagnoses
IHS facilities are eligible for multiple encounter rates for multiple same day visits for the same type of **general covered service category** if the **diagnoses are different.** For example, consider a recipient who goes to an outpatient emergency room for the flu in the morning and returns later in the day as a result of an automobile accident While these visits are both outpatient emergency room visits they are meeting distinctly different health needs and have different diagnosis codes

The general covered service categories are Inpatient, Outpatient, Pharmacy, Vision, Dental, Mental Health, and EPSDT

NORTH DAKOTA MEDICAID INDIAN HEALTH SERVICES AND TRIBALLY-OPERATED 638 PROGRAMS

GENERAL INFORMATION

This section provides covered services information that applies specifically to Indian Health Service (IHS) and tribally-operated 638 programs that provide services to recipients who are eligible for both Medicaid and IHS.

Members of federally recognized Indian Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS) and tribally-operated 638 programs. The IHS is an agency of the U.S. Public Health Service, Department of Health and Human Services.

Indian Health Care claims for Medicaid eligible recipients are processed through the North Dakota Medicaid Management Information System (MMIS).

Like all health care services received by Medicaid recipients, these services must also meet the general requirements listed in the Provider Requirements chapter of the General Information For Providers manual. The North Dakota Medicaid state plan provides that an Indian Health Service facility meeting State requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider in accordance with 42 CFR 431.110(b). However, when State licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, a Medicaid agency or State licensing authority may not take into account an absence of licensure of any staff member of the facility.

SERVICES

North Dakota Medicaid covers the same services for recipients who are enrolled in Medicaid and IHS as those recipients who are enrolled in Medicaid only. Requirements for specific services are covered in the Medicaid 'General Information for Providers' manual as well as other specific manuals (e.g. Dental, Durable Medical Equipment, etc.) available on the North Dakota Department of Human Services website. Coverage and reimbursement of services provided through telemedicine is on the same basis as those provided through face-to-face contact. General covered service categories include:

- **Inpatient Services**
- **Outpatient Services**
- **Pharmacy Services**
- **Vision Services**
- **Dental Services**
- **Mental Health Services**
- **Early Periodic Screening and Diagnostic Treatment (EPSDT) Services**

REIMBURSMENT METHODOLOGY

Services provided by Indian Health Services and/or tribal 638 facilities are paid with federal funds. IHS and tribally operated 638 programs are reimbursed an All Inclusive Rate (AIR) for inpatient and outpatient covered services. The AIR is negotiated annually between CMS and the IHS providers and then published in the Federal Register or Federal Register Notices by the Office of Management and Budget (OMB). The AIR is the same for all IHS providers. The North Dakota Medicaid Program acts as the "pass-through" agency for these services, which are funded with 100 percent federal funds. The IHS encounter rate is paid for any North Dakota Medicaid covered service when provided in an IHS clinic or hospital, with the exception of Ambulatory Surgical Center (ASC) and Physician Inpatient services. These services are reimbursed on the Medicaid fee schedule.

Billing Encounters (Multiple)

Multiple visits for different services on the same day with different diagnosis:

IHS facilities are eligible for multiple encounter rates for multiple **general covered service categories** on the same day for the same recipient with a different diagnosis. For example, IHS may bill a mental health service, an outpatient service, and a pharmacy service for a single recipient on the same day, all with a different diagnosis for each general covered service category.

Multiple visits for different services on the same day with the same diagnosis:

IHS facilities can be reimbursed for multiple **general covered service categories** on the same day for the same recipient with the same diagnosis provided they are for *different* **general covered service categories**. The diagnosis code may be the same for each of the claims, but the services provided must be *distinctly different* and occur within different units of the facility. For example, IHS may bill a mental health service, an outpatient service, and a pharmacy service for a single recipient on the same day, all with the same diagnosis for each general covered service category.

Multiple visits for the same type of service on the same day with different diagnoses:

IHS facilities are eligible for multiple encounter rates for multiple same day visits for the same type of **general covered service category** if the **diagnoses are different**. For example, consider a recipient who goes to an outpatient emergency room for the flu in the morning and returns later in the day as a result of an automobile accident. While these visits are both outpatient emergency room visits they are meeting distinctly different health needs and have different diagnosis codes.

Billing Encounters (Multiple) cont.

Multiple visits for the same type of service on a different day with the same diagnoses:

IHS facilities are eligible for multiple encounter rates for different day visits for the same type of **general covered service category**. For example, consider a recipient who has an outpatient service for a certain diagnosis, but requires a follow-up MRI for the same diagnosis, but scheduled on a different date of service. While both these visits may be billed as outpatient services for same diagnosis, they are provided on different dates of service.

*Multiple same day encounters that will **not** be reimbursed:*

Multiple visits of the same **general covered service categories** with the same diagnosis are not reimbursed separately. For example, a recipient who goes to the clinic in the morning with flu symptoms and then returns to the clinic with symptoms relating to the initial diagnosis will not be paid for multiple visits. The primary diagnosis is the same and only one encounter rate will be paid.

CLAIMS SUBMISSION AND BILLING INFORMATION

Below are billable IHS and tribally-operated 638 program services:

Indian Health Services and tribally-operated 638 program services are billed on a paper UB-04 form or electronically using a HIPAA-compliant 837 Institutional transaction using the following Revenue Codes (with CPT codes when appropriate). All Pharmacy claims need to be billed electronically through the pharmacy point-of-sale (POS) system.

	Bill Types	Revenue Codes	CPT Code Required
Inpatient	111	100	
Outpatient	131	500	
Vision	131	510	
ASC	831	490	Yes*
Dental	131	512	
Mental Health (Psychiatrist/Psychologist)	131	513	
EPSDT	131	519	
Telemedicine (clinic/physician)	131	509	
Telemedicine (mental health)	131	961	
Physician Inpatient Services	131	987	Yes*

** Revenue codes 490 and 987 require CPT codes in Form Locator 44. Payment is based on Medicaid fee schedule. We will only accept the following CPT codes for revenue code 987: 99221-99239; 99251-99263; 99291-99297; and 99431-99440.*

It is important to remember timely filing requirements are applicable to these claims. The timely filing requirement is defined as billing within **one year of the date of service** in accordance with 42 CFR 447.45(d)(1).

31 For Targeted Case Management Services for Individuals needing Long Term Care services, payment will be based on the lower of the provider's actual billed charge or the fee schedule established in monthly increments Except as otherwise noted in the plan, the state developed fee schedule rates are the same for both governmental and private providers of case management for individuals needing Long Term Care The fee schedule and any annual/periodic 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

State Plan under Title XIX of the Social Security Act

State/Territory North Dakota

TARGETED CASE MANAGEMENT FOR INDIVIDUALS IN NEED OF LONG TERM CARE SERVICES

Target Group (42 Code of Federal Regulations 442 18(a)(8)(i) and 441 18(a)(9))

Targeted Case Management for individuals in need of long term care – In order to receive targeted case management services an individual must (1) Be Medicaid Eligible, (2) Not currently be covered under any other targeted case management system, (3) Be considered, as defined by the North Dakota Department of Human Services to have a need for Long Term Care services, (4) Not receiving case management services through an HCBS 1915(c) Waiver Lives in the community and desires to remain there Be ready for discharge from a hospital within 7 days Resides in a basic care facility Not reside in a nursing facility unless it is anticipated that a discharge to alternative care within 6 month

For case management services provided to individuals in medical institutions

X 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 The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided

X 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
X Services are not comparable in amount duration and scope

Definition of Services (42 CFR 440 169)

Targeted 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
- At a minimum includes an initial assessment and six month face-to-face reassessments

- 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
    - At a minimum this includes an initial assessment to determine need, and if there is a need, ongoing six month face-to-face reassessments

___ 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 (42 CFR 441 18(a)(8)(v) and 42 CFR 41 18(b))

In order to ensure that care is properly coordinated, TCM services must be delivered by an individual or an agency that have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled persons

Individual case managers must at a minimum must hold a ND social work license or must be a Developmental Disabilities program manager The DD Program manager must be a Qualified Mental Retardation Professional (QMRP) or must have one year experience as a Developmental Disabilities Case Manager in the North Dakota Department of Human Services

Indian Tribes or Indian Tribal Organization Provider Qualifications

Qualifications for staff of federally recognized Indian Tribes or Indian Tribal Organizations performing case management must be able to deliver needed services in a culturally appropriate and relevant manner to enrolled tribal members

Staff must have successfully completed either a) the 120 hour basic Community Health Representative (CHR) Certification Training (provided through Indian Health Service), supplemented by 20 hours of training in Case Management Process *and* 20 hours of training in Gerontology topics, *or b) an approved Tribal College Community Health Curriculum, which* includes coursework in Case Management principles and Gerontology

The Case Management Implementer (the individual providing the direct service) must provide services under the supervision of a licensed health professional (Licensed Practical Nurse, Social Worker, Registered Nurse, Physical Therapist, Occupational Therapist, or Medical Doctor)

Medicaid will reimburse a CHR Program for case management services provided by CHR Program staff that have not yet completed the necessary certification requirements so long as case management services are provided under the supervision of a licensed professional (Licensed Practical Nurse, Social Worker, Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, or Medical Doctor) and the CHR Program staff are actively in the process of completing the necessary certification requirements within two years

Freedom of Choice (42 CFR 441 18(a)(1))

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, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441 169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302 F)

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441 169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, making placement arrangements (42 CFR 441 18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act (§§1902(a)(25) and 1905(c))

Payment (42 CFR 441 18(a)(4))

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose

Case Records (42 CFR 441 18(a)(7))

Providers maintain case records that document for all individuals receiving case management as follows (i)The name of the individual, (ii) The dates of the case management services, (iii)The name of the provider agency (if relevant) and the person providing the case management service, (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved, (v) Whether the individual has declined services in the care plan, (vi) The need for, and occurrences of, coordination with other case managers, (vii) A timeline for obtaining needed services, (viii) A timeline for reevaluation of the plan

State Plan under Title XIX of the Social Security Act

State/Territory North Dakota

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- At a minimum includes an initial assessment and six month face-to-face reassessments

- Development (and periodic revision) of a Specific Care Plan that
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    - 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
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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

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FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act (§§1902(a)(25) and 1905(c))

Payment (42 CFR 441 18(a)(4))

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose

Case Records (42 CFR 441 18(a)(7))

Providers maintain case records that document for all individuals receiving case management as follows (i)The name of the individual, (ii) The dates of the case management services, (iii)The name of the provider agency (if relevant) and the person providing the case management service, (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved, (v) Whether the individual has declined services in the care plan, (vi) The need for, and occurrences of, coordination with other case managers, (vii) A timeline for obtaining needed services, (viii) A timeline for reevaluation of the plan

State North Dakota

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Section 1.4 State Medical Care Advisory Committee (42 CFR 431.12(b))

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431 12

The Department of Human Services has invited each tribe to identify designees to attend the Medicaid Medical Advisory Committee. Individuals who have been designated are *added to the distribution lists for information about the meetings.*
If a Tribe has not identified a designee, the Department notifies the Tribal Chairperson and the Health Care Lead of the upcoming meeting(s).

Tribal Consultation Requirements:

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA) Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP) Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS Please include information about the frequency, inclusiveness and process for seeking such advice

Background and purpose:

The American Recovery and Reinvestment Act (ARRA) of 2009 contains provisions for Medicaid that "In the case of any State in which one or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for the process under

which they seek advice on a regular, ongoing basis from the designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Health Organization and that a) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and b) may include appointment of an advisory committee and of a designee advising the State on its State plan under this title "

The North Dakota Department of Human Services acknowledges that there are legal and stakeholder partnerships with the Indian Tribes in North Dakota. These partnerships have grown throughout the years and will continue to be an integral part of implementing the revisions set forth by the American Recovery & Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (ACA).

It is the intent of the North Dakota Department of Human Services to consult on a regular basis with the Indian Tribes established in North Dakota on matters relating to Medicaid and Children's Health Insurance Program (CHIP) eligibility and services, which are likely to have a direct impact on the Indian population. This consultation process will ensure that Tribal governments are included in the decision making process when changes in the Medicaid and CHIP programs will affect items such as cost or reductions and additions to the program. The North Dakota Department of Human Services shall engage Tribal consultation with a State Plan Amendment, waiver proposal or amendment, or demonstration project proposal when any of these items will likely have a direct impact on the North Dakota Tribes and/or their Tribal members.

Direct Impact

Direct impact is defined as a proposed change that is expected to affect Indian Tribes, Indian Health Services (IHS) and/or Native Americans through: a decrease or increase in services; a change in provider qualifications; a change in service eligibility requirements; a change in the compliance cost for IHS or Tribal health programs; or a change in reimbursement rate or methodology.

Consultation:

When it is determined that a proposal or change would have a direct impact on North Dakota Tribes, Indian Health Services or Tribal members, the North Dakota Department of Human Services will issue written correspondence to Tribal Chairs, Tribal Healthcare Directors, the Executive Director of the Indian Affairs Commission, Indian Health Services

Representatives and the Executive Director of the Great Plains Tribal Chairmen's Health Board. In addition to the written correspondence, the Department may use one or more of the following methods to provide notice or request input from the North Dakota Indian Tribes and IHS.

a. **Indian Affairs Commission Meetings**
b. **Interim Tribal and State Relations Committee Meetings**
c. **Medicaid Medical Advisory Committee Meetings**
d. **Independent Tribal Council Meetings**

Ongoing Correspondence:

- **A web link will be located on the North Dakota Department of Human Services website specific to the North Dakota Tribes. Information contained on this link will include: notices described below, proposed and final State Plan amendments, frequently asked questions and other applicable documents.**
- **A specific contact at the North Dakota Department of Human Services Medical Services Division, in addition to the Medicaid Director, will be assigned for all ongoing Tribal needs. This contact information will be disseminated in the continuing correspondence with the North Dakota Tribes.**

Content of the written correspondence will include:

- **Purpose of the proposal/change**
- **Effective date of change**
- **Anticipated impact on Tribal population and programs**
- **Location, Date and Time of Face to Face Consultation OR If Consultation is by Written Correspondence, the Method for providing comments and a timeframe for responses. Responses to written correspondence are due to the Department 30 days after receipt of the written notice.**

Meeting Requests:

In the event that written correspondence is not sufficient due to the extent of discussion needed by either party, The North Dakota Department of Human Services, the North Dakota Tribes, or Indian Health Services can request a face to face meeting within 30 days of the written correspondence, by written notice, to the other parties

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved

September 2009, the Medicaid Director attended the "Tribal-State Medicare and Medicaid meeting" sponsored by the Office for Elimination of Health Disparities (ND Department of Health). Input was received from those attending regarding the implementation of changes from the American Recovery and Reinvestment Act; including Tribal Consultation.

October 2009, The Department of Human Services hosted a Tribal Consultation/Collaboration meeting. Letters of Invitation were sent to all Tribal Chairpersons, Tribal Substance Abuse Administrators, Tribal Health Administrators. and the Executive Director of the Aberdeen Area Tribal Chairman's Health Board.

July 2010 – The Department of Human Services met with Tribal staff members for a Tribal Stakeholder meeting. The Draft Tribal Consultation Policy was discussed.

August 2010 – The Department invited each Tribe, the Indian Affairs Commission, and Indian Health Services to the Medicaid Medical Advisory Committee meeting on October 21, 2010.

September 2010 – Tribal leaders were invited to a Collaboration meeting with staff from the Indian Affairs Commission, the Department of Human Services and County Social Services staff. The Draft Tribal Consultation policy was distributed and discussed and comments were requested.

December 2010 – The Department mailed the Draft Tribal Consultation Policy to Tribal Chairpersons, Tribal Health Administrators, Indian Health Services Offices, and the Aberdeen Area IHS office and Tribal Chairman's Health Board. Comments were requested.

August 2011 - The Department invited each Tribe, the Indian Affairs Commission, and Indian Health Services to the Medicaid Medical Advisory Meeting on September 14, 2011.

September 2011 – The Medicaid Director provided testimony to the Interim Tribal and State Relations Committee. The testimony included a review of the revised Tribal Consultation Policy. The day after the committee meeting, the Tribal Consultation Policy was sent to the Executive Director of the Indian Affairs Commission, and he forwarded the policy to the Tribal Chairs.

November 2011 – The Department worked with the Great Plains Tribal Chairman's Health Board to schedule a meeting with Tribal and IHS representatives. The CMS changes to the consultation amendment were discussed. Representatives suggested including an expedited process. This was added and another consultation letter was sent to Tribes and IHS on November 17, 2011. No additional input has been received.

An expedited consultation will be used in situations that do not allow for advanced consultation It is expected that an expedited consultation would be used when there are changes in either Federal or state law that require immediate implementation or in cases where a natural disaster warrants immediate action Under an expedited review, written notice will be provided to all individuals/entities identified in the "Consultation" section of this amendment, however, the response time may be truncated or implementation may need to occur prior to the issuance of the written notice

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 ***0938-1098*** *The time required to complete this information collection is estimated to average 1 hour 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*

Department of Human Services
Medicaid Medical Advisory Committee
February 23, 2012

DRAFT

Introductions
State Plan and Administrative Rule Updates

Program Discussion
Thomson Reuters – ND Medicaid – Cost and Use Analysis
Ronald McDonald Care Mobile Update - Kathy Keiser and Kathy Mangskau
Inpatient Hospital – APR/DRGs
LCD/NCD – Correct Coding Initiative Changes
Out of State Policy Change
Developmental Disability Rate Setting Project
Developmental Disability Waiver Changes
HCBS
- Waiver Changes/Updates
- Realistic Job Preview Video
- Money Follows the Person Update

Health Management Program Update
Medical Home Update
PACE - Review Update
CHIP
- Outreach Grant
- Performance Bonus

Program Integrity Discussion
Recovery Audit Contract (RAC)
Payment Error Rate Measurement (PERM)
Provider Enrollment
- Enrolling Residents/Prescribers

Healthcare Acquired Conditions/Provider Preventable Conditions

Information Systems
5010
ICD-10
Electronic Health Records

Health Care Reform
Updates

north dakota department of human services