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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-12-004

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

January 30, 2013

Maggie Anderson, Medicaid Director
Medical Services Division
North Dakota Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota #12-004

Dear Ms. Anderson:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 12-004. This SPA amends the State Plan to revise the Health Management program for limitations on amount, duration, and scope and 4.19-B payment amendments.

Please be informed that this State Plan Amendment was approved January 29, 2013 with effective date of October 1, 2011. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Ann Clemens at (303) 844-2125.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

CC: Mary Lou Thompson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 12-004	2. STATE: North Dakota
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: October 1, 2011	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ **NEW STATE PLAN** ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
1932(a)(1)(A) and 42 CFR 438	a. FFY 2012 $ 728,530 b. FFY 2013 $ 760,164
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment 2.1-A, Pages 1-14~~ (WITHDRAWN) Attachment to Page 6 of Attachment 3.1-A Attachment to Page 5 of Attachment 3.1-B Attachment 4.19-B, Page 3b-2 (NEW) Attachment 4.19-B, Page 3b-1	~~Attachment 2.1-A, Pages 1-11~~ (WITHDRAWN) Attachment to Page 6 of Attachment 3.1-A Attachment to Page 5 of Attachment 3.1-B Attachment 4.19-B, Page 3b-1

10. SUBJECT OF AMENDMENT:

Amends the State Plan to ~~add enhanced PCCM option for certain chronic diseases as per 1932(a)(1)(A) and~~ revises the Health Management program for limitations on amount, duration and scope. Payment methodology in 4.19-B is also amended.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Maggie D. Anderson, Director, Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: Maggie D. Anderson	Maggie D. Anderson, Director Division of Medical Services ND Department of Human Services 600 East Boulevard Avenue Dept 325 Bismarck ND 58505-0250
14. TITLE: Director, Division of Medical Services	
15. DATE SUBMITTED: ~~12-28-2011~~ REVISED 12-21-2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/28/11	18. DATE APPROVED: 1/29/12
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/11	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: RICHARD C. ALLEN	22. TITLE: ARA DMCHO

23. REMARKS:

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

a. 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.

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

b. Health Management Program provider(s) (i.e . Disease Management Organizations (DMO) and Disease Management Providers (DMP), for the preventative services provided as part of the Health Management Program will be reimbursed through a payment methodology as follows:

DMO and DMP for Health Management services as described in Attachment to Page 6 of Attachment 3.1-A,13c, and Attachment to Page 5 of Attachment 3.1-B, 13c. Non-DMO and non-DMP services will be reimbursed on a fee-for-service basis. DMO and DMP rates will be established on a contractual basis and meet all of the Federal Requirements of non-risk contracts (42 CFR 447.362).

The current rates for DMO and DMP services, as well as any annual/period adjustments to the fee schedule are published on the agency's website at:

http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html.

The agency's fee schedule rates were set as of October 1, 2011 and are effective for services provided on or after that date.

LIMITATIONS ON AMOUNT, DURATION AND SCOPE

Services

13c. Preventive Services (continued)

Health Management

The North Dakota Medicaid Program will provide a voluntary statewide Health Management Program to eligible Medicaid participants 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 certain Medicaid individuals who are eligible under the authority of the state plan amendment through qualified Disease Management Organizations (DMO) and Disease Management Providers (DMP). DMP consists of medical providers, clinics, and health teams.

1. Excluded Participants

Participants excluded from enrollment in the Health Management Program are those receiving health management services 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 Intellectually Disabled (ICF/ID)

iii. Receiving Medicare benefits (Dual Eligible)

iv. Additional Major Medical coverage

v. Identified as having Recipient Liability

2. Components of the Health Management Program

A. Components of the program that apply to both DMOs and DMPs:

i. A systematic screening process to identify qualified, eligible Medicaid participants for outreach, intervention and education.

ii. Provide the participant (as well as family members and providers if appropriate) 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. The education may be, but no limited to, written materials, telephonic, face-to-face, group education with peer support.

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. Conducts face to face, telephonic and/or other means of communication based on participant preference, level of need and intensity.

v. Emphasis will be placed on the need for collaboration with the participant's personal primary care provider and other health team members on a routine basis. Feedback from the participant's personal primary care provider and other health tem members is to be received regularly to assure changes made to the care plans are being followed. This collaboration will insure the DMO is supporting the primary care provider's plan of care through consistency and continuity of care.

vi. Assure all program activities are conducted consistent with evidence-based clinical practice guidelines for each chronic condition being managed.

vii. Implement internal quality assurance/quality improvement, outcomes measurement, and evaluation and information management systems.

viii. Maintain a computer information system sufficient to carry out all the required components of the Health Management Program.

ix. Individualized care planning as needed based on need and level of intensity.

x. Culturally and linguistically appropriate care.

xi. Dedicated staff to perform care coordination and care management functions.

xii. Establish a collaborative healthcare practice model to include North Dakota providers and community-based partners in program administration in a consultative capacity.

xiii. Advocate for participants with complex chronic conditions to ensure that participants receive appropriate evidence based care.

xiv. 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 participants in the program and provide participants 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. The THIL must be equipped with appropriate technology to accept calls from all participants in the Health Management Program and to provide services for those with limited English proficiency.

xv. There are several variables within the health management program distinguishing the delivery method and services between DMOs and DMPs. This is a result of the availability of resources and data each health management program provider may have access too, such as medical records, subjective data and triage capabilities. The outcomes, however, should be the same, such as: improvement in self- management skills, minimize utilization of urgent care and emergency departments, and decrease inpatient stays relating to chronic disease.

The result offers two options for clients who seek the services of a health management program. One option will utilize DMPs throughout the State. The second will utilize DMOs. All entities must meet the health management criteria set forth by the Department.

B. Additional components that apply only to DMOs:

i. The DMO is staffed by nurses who reside within the state and hold an active North Dakota nursing license.

ii. The DMO 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 participant's multiple health, behavioral and social needs, and assure continuity, quality and effectiveness of care in consultation with the participant's primary care provider (PCP) and other appropriate ancillary staff (i.e., pharmacists, certified educators, nutritionists, etc.)

iii. Establish a local presence and building collaborative relationships with providers.

iv. Assure frequent communication through nurse case managers with participant's PCPs using phone calls and face-to-face interactions as necessary. The DMO 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.

C. Additional components that apply only to DMPs:

i. A medical home for care coordination of treatment and services.

ii. Ensure that participants receive evidence based care.

iii. Availability of advance access of appointments and/or triage services to minimize urgent and emergency department utilization.

iv. Involvement from a "team" of ancillary medical professionals from the participants "medical home" (this may include dieticians, respiratory therapists, pharmacists, etc. as appropriate considering the participants condition.

v. An integrated package that may include but is 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.

3. Enrollment and 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 participants have free choice to receive or not receive Health Management Program services. They have the opportunity to choose either a single DMO or DMP to provide services from any of the ND Medicaid enrolled DMPs or DMO's. They also have the option not to participate. Participants may disenroll from the program at any time, for any reason.

5. Confidentiality Requirements

To ensure the participant's confidentiality, adequate consents, authorizations, information, privacy, and security measures must be established to comply with HIPAA requirements and other federal and state laws.

6. Documentation Requirements

Monthly, quarterly or annual reports as specified by the State must be submitted as documented in the contract(s).

7. Payment Methodology for the Health Management Program

DMO and DMP contracts shall set forth all payments (other than fee-for-service reimbursements) for health management services as described in *"Section 2 – Components of the Health Management Program."*

Payment for DMOs and DMPs who meet the criteria set for by the

Department to provide Medicaid health management services is outlined in Attachment 4.19B, page 3b-2, item #26, sub-item (b).

DMPs (including FQHC's, RHC's and Indian Health Services), who meet the criteria set ~~for~~ by the Department to provide Medicaid health management services will receive a health management fee for subsets of populations that have the following chronic conditions: Asthma, Diabetes, Congestive Heart Failure (CHF) and/or Chronic Obstructive Pulmonary Disease (COPD). The health management fee is excluded from the encounter rate paid for Indian Health Services on Attachment 4.19-B Page ~~3b~~ 3c, the established rate for Rural Health Clinics on Attachment 4.19-B Page 4, and Federally Qualified Health Centers on Attachment 4.19-B Pages 5, 6 and 6a.

8. Other Requirements

a. DMOs and DMPs that enroll as health management providers must meet the following conditions.

i. Comply with applicable federal and state laws and regulations governing the participation of providers and participants in the Medicaid program including:

a. Title XIX of the Social Security Act and any final regulations promulgated pursuant to that title.

b. 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.

c. North Dakota Administrative Code, Chapter 75-02-02, *Medical Services*.

d. Any other pertinent provisions of Federal or State law.

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