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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 22-0024

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS Form 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

March 6, 2023

Krista Fremming, Director
Medical Services Division
ND Department of Human Services
600 East Boulevard Avenue Dept. 325
Bismarck, ND 58505-0250

Re: North Dakota State Plan Amendment (SPA) 22-0024

Dear Ms. Fremming:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) ND-22-0024. This amendment proposes to amend the State Plan to update the minimum requirements for an assessment for personal care services.

We conducted our review of your submittal according to statutory requirements in 42 CFR 430.12(b). This letter is to inform you that North Dakota Medicaid SPA 22-0024 was approved on March 2, 2023, with an effective date of October 1, 2022.

If you have any questions, please contact Tyson Christensen at (816) 426-6440 or via email at tyson.christensen@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: LeeAnn Thiel

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0024

2. STATE: ND

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 430.12(b)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment to Page 10 of Attachment 3.1-A
Attachment to Page 9 of Attachment 3.1-B
Supplement 7 to Attachment 3.1-A
Supplement 7 to Attachment 3.1-B

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment to Page 10 of Attachment 3.1-A (TN 11-021)
Attachment to Page 9 of Attachment 3.1-B (TN 11-021)
Supplement 7 to Attachment 3.1-A (TN 08-011)
Supplement 7 to Attachment 3.1-B (TN 08-011)

9. SUBJECT OF AMENDMENT

Amends the State Plan to update the minimum requirements for an assessment for personal care services.

10. 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:
Krista Fremming, Interim Director
Medical Services Division

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Krista Fremming

13. TITLE
Interim Medical Services Director

14. DATE SUBMITTED
~~December 7, 2022~~ December 8, 2022*

15. RETURN TO
Krista Fremming, Interim Director
Medical Services Division
ND Department of Health and Human Services
600 East Boulevard Avenue Dept 325
Bismarck ND 58505-0250

FOR CMS USE ONLY

16. DATE RECEIVED
December 8, 2022

17. DATE APPROVED
March 2, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS

*CMS was granted permission from the state, via email, to correct the information in Box 14 on March 3, 2023.

Instructions on Back

26. Personal Care Services (continued)

The comprehensive assessment identifies the individual's needs and the personal care services that must be provided to address the individual's needs.

A comprehensive assessment must be completed by Aging Services case manager, or by a regional human service center developmental disabilities, or mental health case manager, or an individual home and community-based services case manager, initially before any personal care services can be authorized, and annually thereafter. The case manager also completes a comprehensive review of the individual's needs at least annually or when there is a significant change in the individual's needs. Personal care services must be provided in accordance with a care plan developed from the assessment of the individual's needs. The care plan authorized by the State Medicaid Agency approves the maximum number of hours of personal care services that an individual may receive during a month.

The State does not allow a physician to authorize, but can refer an individual to the State.

PROVIDER QUALIFICATIONS

Agencies must verify that they have procedures in place to accurately document the provision of furnished services and that they have trained the individuals furnishing services in their responsibility to report the furnished services properly and accurately.

Personal care service must be provided by an individual who is at least 18 years of age and who has provided evidence that he or she meets the standards established by the Department of Human Services for providing personal care services. Competency of meeting the standards can be verified by a health care professional and must be reestablished every two years or can be by virtue of licensure or certification as a registered nurse, licensed practical nurse, physical therapist, occupational therapist, or certified nursing assistant.

The providers are not required to have a degree or a specific educational level. They are required to meet the standards of tasks commonly performed in the provision of personal care and the ability to perform tasks as verified by the health care professional or by virtue of licensure in North Dakota Administrative Code.

26. Personal Care Services (continued)

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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 annual 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, ongoing annual face-to-face reassessments, and if there is a need, monitoring to occur as frequently as needed to address the individual's needs.

___ 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.

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