NORTH Dakota | Health & Human Services
Be Legendary.

ND DHHS Medicaid & Tribal Government Care Coordination Guidance (last updated August 4, 2023)

Contents

100% FMAP and Tribal Care Coordination

Services for ND Medicaid-covered beneficiaries "received through" an Indian Health Service facility whether operated by the IHS service or by a Tribe or Tribal organization (per section 4 of the IHCIA) are eligible for 100% Federal Medical Assistance Percentage (FMAP). See State Health Official (SHO) Letter 2/26/16.

"Received Through" services

Include:

- Any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the North Dakota approved Medicaid state plan; and

- Services furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of their patient and the patient remains in the Tribal facility practitioner's care **in accordance with a written care coordination agreement**.

Care Coordination Agreement

Care coordination services are provided under a Care Coordination Agreement which is between the Tribe and the provider. A template can be found here.

The Agreement describes the Tribe and the Provider responsibilities and defines terms.

The Agreement's intent is:

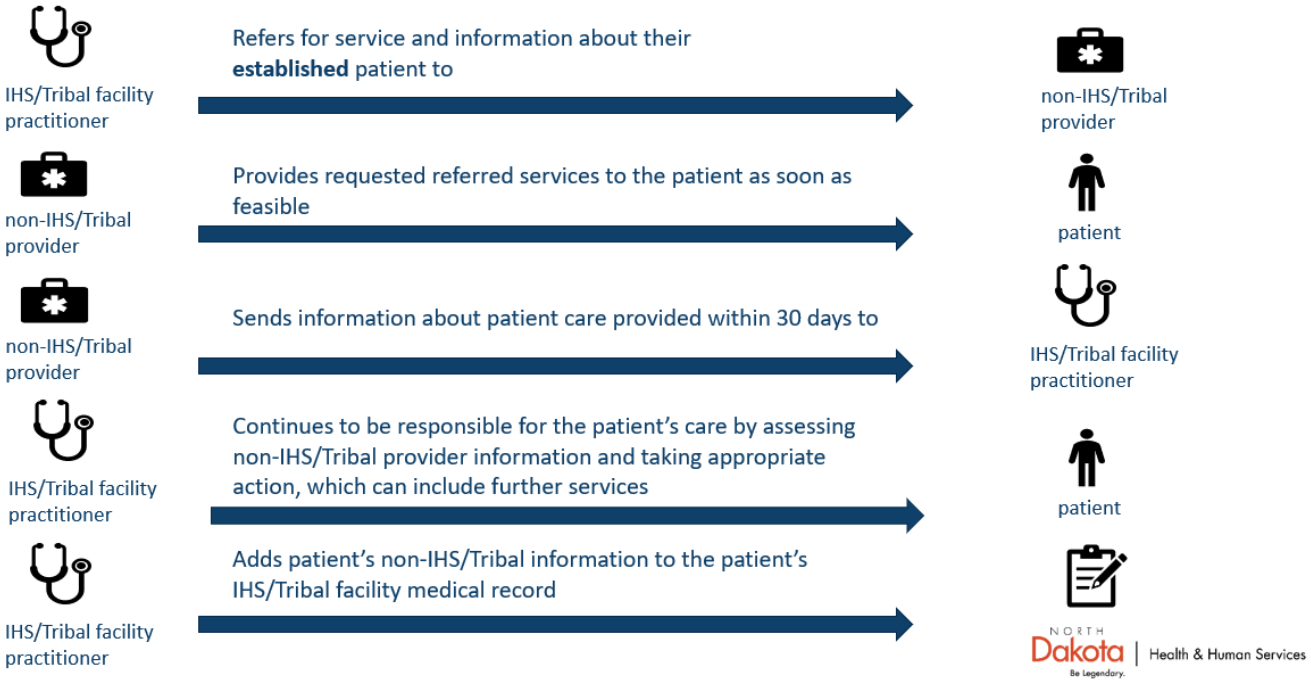
- to ensure Tribal 638/IHS practitioners will remain responsible for a patient who is a Medicaid-enrolled IHS beneficiary and be able to coordinate and manage the care furnished to a patient of the 638/IHS facility upon a Request for Services.

This is so the patient receives appropriate care regardless of whether the rendering provider is an IHS/Tribal facility employee.

Minimum Care Coordination requirements

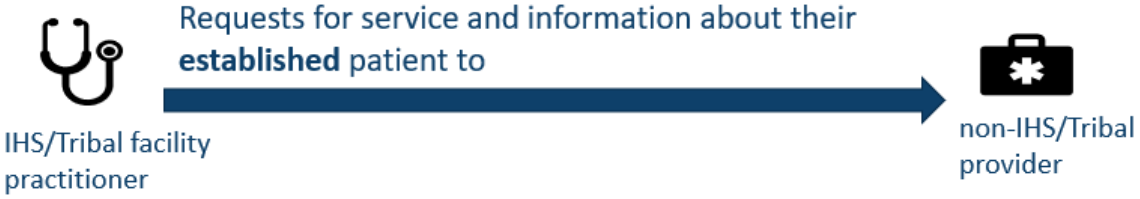
The IHS/Tribal facility practitioner and the non-IHS/Tribal provider must be enrolled with ND State Medicaid as rendering providers.

Care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider.



Service Requests/Referrals

Care coordination services are provided through service requests/referrals.



Requests should include:

- A clear description of the identity of the patient
- Specific requested service or services to diagnose or treat a patient for an identified episode of care
- The date of the request
- Any additional medical information necessary for provision of the requested service in accordance with the IHS Practitioner's determination of the patient needs and course of care

The covered IHS facility must maintain documentation of the request.

Services not eligible for 100% FMAP

- Self-request for services by beneficiary
- Request from a non-IHS/Tribal provider, **requests for services MUST come from an IHS/Tribal facility practitioner**
- Services provided that are not pursuant to the service request
- Services furnished prior to the request
- Services outside the provider's scope of practice
- Services not covered by the North Dakota-approved Medicaid plan
- Services requested without an established patient-practitioner relationship (relationship may be established using telehealth)
- Services provided to an IHS beneficiary not enrolled in Medicaid

Claims

"Received through" services billed by non-Tribal 638/IHS providers eligible for 100% FMAP must:

- Include the appropriate care coordination referral number
- Be submitted by the non-Tribal 638/IHS provider to ND Medicaid

Claim Filing

North Dakota Medicaid follows the timely filing requirements found at 42 Code of Federal Regulations (CFR) 447.45(d).

ND Medicaid must receive a provider's original Medicaid primary claim submission within 180 days from the date of service.

Final submission of claims that will be considered for adjudication (including resubmitted claims) must occur within 365 days from the date of service. The complete policy is located here - https://www.hhs.nd.gov/sites/www/files/documents/DHS Legacy/timely-filing-policy.pdf.

Detailed claim guidance found here.

ND Medicaid-assigned Tribal 638/IHS unit identifier numbers

Each Tribal 638/IHS unit will use their own identification number in the data element of each Tribal Care Coordination referral.

These numbers are the only way ND Medicaid can identify Tribal Care Coordination claims.

THREE AFFILIATED TRIBES	200CC
SPIRIT LAKE	300CC
UNITED TRIBES TECH COLLEGE	400CC
TRENTON	600CC
SISSETON WAHPETON	700CC
STANDING ROCK	800CC
TURTLE MOUNTAIN	900CC

Tribal Health Fund Agreement

The Care Coordination Agreement is in place to allow for care coordination claims billing to happen. Next, an agreement needs to be signed between the Tribe and ND Health and Human Services (HHS). This is the agreement that allows HHS to make distributions from the Tribal Health Care Fund to a Tribe. Distributions are conditioned on a Tribe's ability to meet the North Dakota's legal requirements for fund distribution.

The Tribal Health Fund Agreement is between the Tribe and ND Health and Human Services (HHS). A template can be found here.

The Agreement:

- Describes responsibilities and mirrors the requirements from North Dakota law at N.D.C.C. section 50-24.1-40.

The Agreement's intent:

- Is to put into writing the parties' responsibilities in compliance with the requirements of North Dakota law.

Agreements must be in place

Prior to care coordination claim billing

Care Coordination Agreement (& resolution of agreement, if applicable)

Prior to fund distributions

Tribal Health Fund Agreement

Things to send to ND Medicaid as they happen

- ✓ A copy of each fully signed and executed Care Coordination Agreement
- ✓ Any changes to a Care Coordination Agreement
- ✓ Resolutions of Agreement, if applicable

ND Medicaid keeps this documentation to support the 100% FMAP claiming.

Process

Agreements signed

- Care coordination agreement between Tribe & Provider
- Agreement between Tribe & HHS

Care Coordination billing

- Billing by non-Tribal provider
- Funds distributed 80% to Tribal health care coordination fund and 20% to State general fund

Reporting

- Annual report submitted by Tribe
- Reviewed by State
- Biannual Tribe audit report submitted from independent CPA

Distribution

- Funds spent per agreed purposes are distributed annually by HHS
- Inappropriately spent funds withheld

Overview of HHS/Tribe Tribal Health Fund Agreement

This is the agreement between an individual Tribe and HHS for purposes of getting Tribes their appropriate share of the excess FMAP funding resulting from care coordination claims.

HHS and the Tribe must follow the terms of the contract and N.D.C.C. § 50-24.1-40.

Of any federal funding HHS receives in excess of the state's regular share of federal medical assistance funding which results from care coordination agreements, HHS must

deposit 80% in the Tribal health Care Coordination Fund and 20% in the general fund. Monies in the fund are appropriated to HHS on a continuing basis for distribution to a Tribal government in accordance with respective care coordination agreements.

Example showing 100% Federal Medical Assistance Percentage (FMAP) distribution

In this example, we'll look at a $100 Medicaid paymentfor a claim filed by a non-IHS/Tribal provider through a Care Coordination Agreement.

$100
payment

	"Regular" FMAP – approx. 52%	Care Coordination "received through" Service – 100% FMAP
Federal Share	$52	$100
State Share	$48	
Distribution amount		$48
		80% to Tribal Care Coordination Fund 20% to State general fund

$38.40

$11.60

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HHS will keep track of each Tribe's Care Coordination claims qualifying for 100% FMAP. Eighty percent of the amount of these claims exceeding the state's regular FMAP funding will be transferred on a quarterly basis to a special fund established by the Office of Management and Budget (OMB) – the Tribal Care Coordination Fund ND Special Fund 585. This fund will be viewable on the OMB funds dashboard page here.

HHS has agreed to:

Distribute money annually from the Tribal health care coordination fund in proportion to the federal funding received from care coordination agreement requests for services originating within that Tribal nation.

Distribution of Tribal health care coordination funds is dependent on

1) Submission of a timely annual report by the Tribe;
2) Submission of a timely audit report by the Tribe, at least every 2 years; and
3) Completion of annual and audit report reviews by HHS.
    - If an audit or review finds a Tribal government used fund distributions for a purpose inconsistent with law and the agreement, HHS must withhold future distributions to that Tribal government in an amount equal to the improperly used funds.

- If an audit or review finds fund distributions have been used consistent with law and the agreement, HHS must distribute funds appropriately.
-

The Tribe has agreed to:

1) Use funding for purposes related to:
   - The ten essential services of public health (Centers for Disease Control and Prevention (CDC); and
   - The development or enhancement of community health representative programs or services.

   No more than 50% of funds may be used for capital construction thru June 30, 2025. Beginning July 1, 2025, no more than 35% of these funds may be used for capital construction.
2) Send HHS annual reports detailing the use of distributed funds
3) Conduct an audit and send HHS an audit report detailing the use of distributed funds every 2 years. The audit must be done by an independent licensed Certified Public Accountant (CPA). The Tribe may conduct audits more often than every 2 years. **Distributed funding may be used to pay for the audit report.**

Timeframes

Fund Distribution

There will be an initial fund distribution per each Tribal care coordination agreement. Distribution of funds will be in proportion to the federal funding received from the Care Coordination Agreement requests for services originating from within that Tribal nation.

Once an initial fund distribution has occurred, the Tribe's duty to submit an annual report detailing its use of the funds begins. Reports are due by **August 30th** of each year.

Annual Report & Review

Annual reports detailing the Tribe's use of distributed funds must contain the following information:

- Total amount of funds received since the last annual distribution
- Total amount of above received funding spent on the following items, including the dates of expenditures, and an explanation of how the funding was spent for that purpose:
  - Monitor health status to identify and solve community health problems
  - Diagnose and investigate health problems and health hazards in the community
  - Inform, educate, and empower people about health issues

- Mobilize community partnerships and action to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure competent public and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems
- Development or enhancement of community health representative programs or services
- Capitol construction costs (must be less than 50% through June 30, 2025, and less than 35% beginning July 1, 2025).

Deadlines

Reports must be sent by to the Medicaid Tribal Liaison by **August 30th** of each year. The Department will review annual reports within **30 days** and respond in writing. The written response will either:

- confirm the funds have been used for purposes consistent with the law and agreement, or
- confirm the funds were used for purposes inconsistent with the law and agreement. HHS will detail the amount of any funds used inconsistently that will be withhold from future distributions.

Appropriate distributions will be made after HHS issues a written response.

If a Tribe fails to file an annual report or audit report with HHS by **August 30th**, HHS shall withhold fund distribution to the Tribe until the report is filed and reviewed.

Audit Report & Review

Tribes must submit an audit report every 2 years to the Medicaid Tribal Liaison by **August 30th**. The audit must be conducted by an independent Certified Public Accountant (CPA).

Distributed Health Fund dollars may be used to fund this CPA audit. There is a section on the Annual Reporting form to report this.