NORTH Dakota | Health & Human Services
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Meeting Minutes

ND HHS Tribal Consultation

December 4, 2025
8:30-10:30am CT

Topic and Speaker	Meeting Notes
Welcome & Introductions	
Public Health Division Updates Krissie Mayer, *Community Engagement Director*	The Public Health Conference will take place on May 5-7 in Bismarck at Bismarck State College. Abstracts for speaking are due on December 12. More information can be found at https://conferencesatbsc.com/
Q&A no questions	
Rural Health Transformation Program Updates Sarah Aker, *Medical Services Director*	The Rural Health Transformation (RHT) Program was authorized by the One Big Beautiful Bill Act (OBBBA - Section 71401 of Public Law 119-21) and empowers states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. • OBBBA appropriates $50 billion to a Rural Health Transformation Program from Federal Fiscal Year 2026 – 2030. • One time application for all 5 years. Applications must be approved by CMS before December 31, 2025. RHTP Submission: • ND HHS submitted the RHTP application on November 3. ○ SNAP Waiver submitted by HHS. Awaiting approval from USDA Food Nutrition Service (FNS). • Application, budget narrative and supporting information available online: hhs.nd.gov/rural-health-transformation. Rural Health Transformation Governance and Project Management Structure • HHS will use an internal Steering Committee to provide project management and oversight to meet federal grant requirements. • Each initiative will have a lead area of HHS that will provide subject matter expertise related for specific projects and awards. • HHS will collaborate with other state entities, external partners, and stakeholders on award processes.

	Anticipated Award Processes
	• HHS anticipates using several mechanisms to award funds:
	  ○ Direct Contracts
	  ○ Grants
	  ○ Requests for Information
	  ○ Requests for proposals
	• All awards will require an agreement between HHS and the entity awarded funds.
	• Award process will include a mechanism to ensure funding is prioritized relative to impacts to communities in need and/or rural/frontier communities.
	  ○ Awards will be guided by subject matter experts in relevant HHS divisions.
	• HHS intends to limit administrative burden as much as possible within the award process. All awards will require reporting and monitoring in compliance with federal guidance and state law or any waivers of state law.
	• HHS is prioritizing stakeholder, provider, and community engagement in the award process to ensure that awards meet rural provider and community needs.
	• Note: Funding awards must be made in compliance with any federal award guidance and requirements. CMS has indicated that all sub-awards will be approved by CMS.
	Award and Implementation Timeline
	• Deadline for state submissions – November 5
	• ND HHS submitted November 3
	• States expect to receive awardee decisions by December 31, 2025
	• ND HHS anticipates release of subaward opportunities in a couple of target areas in January 2026.
	• All awards will require an agreement between HHS and the entity awarded funds.
	• Award process will include a mechanism to ensure funding is prioritized relative to impact to communities in need and/or tribal and rural/frontier communities.
	• HHS intends to limit administrative burden on applying for awards. All awards will require reporting and monitoring in compliance with federal guidance.
	• Subawards will be released on a rolling basis.
	Submitted Funding Allocations by Initiative:
	• **Strengthen and Stabilize Rural Health Workforce (16.2% of budget)**
	  ○ TA and Training for Existing Workforce
	  ○ Technology as an Extender
	  ○ Improve Retention
	  ○ Expand Rural Training Pipelines
	• **Make North Dakota Healthy Again (8.6% of Budget)**
	  ○ Investing in Value

	○ Building Connection & Resiliency ○ ND Moves Together ○ Eat Well ND • **Bring High-Quality Health Care Closer to Home (58.4% of budget)** ○ Coordinating & Connecting Care ○ Ensuring Transportation ○ Ensuring Safety Net Service Delivery ○ Clinics Without Walls ○ Sustaining Revenue ○ Rightsizing Rural Health Care • **Connect Tech, Data, and Providers for Stronger ND (16.8% of budget)** ○ Support Consumer Focused Apps ○ Harnessing AI and New Tech ○ Cooperative Purchasing for Tech and Other Infrastructure ○ Breaking Data Barriers Note: Budget is not final; allocation percentages may change. Final funding amounts dependent on CMS scoring and award. • HHS will communicate subaward opportunities through the following channels: ○ RHTP webpage ○ Email listservs ○ RHTP listserv ○ Tribal Consultation listserv ○ HHS committees and councils ○ Tribal Consultation meetings ○ Listening sessions ○ RHTP Legislative Committee
Tribal Consultation Question: Is there a priority listing for Tribes, and will a specific funding amount be designated? Response: Tribes are identified as a priority; however, no set funding amount has been designated. Funding is intended for entities able and willing to provide services within the scope of the grant. Question: May Tribal behavioral health programs, mobile health units, and EMS providers apply within the same year or timeframe? Response: Yes. Tribes may select initiatives and apply on a rolling basis, and multiple initiatives may be pursued concurrently. Comment: Participants shared positive experiences with mobile dental units and bulk purchasing models and expressed support for Tribe-led approaches as an exercise of Tribal sovereignty.	

Comment: HHS noted that grant opportunities focused on prevention and resiliency align well with traditional healing and daily wellness practices. Autonomy and the inclusion of elders and individuals with lived experience were highlighted as important components of healthcare and innovation efforts. Question: How will HHS engage with Tribes going forward? Response: HHS plans to engage in frequent and ongoing communication with Tribes, including visits and discussions focused on successes, challenges, and reducing administrative burden. Monthly meetings have been discussed, and HHS will coordinate with Tribes to align with existing meetings where possible. Question: Will a timeline outlining the State's goals for this grant be shared? Response: Yes. A timeline will be shared once funding amounts and parameters are finalized. All funds must be obligated by October 30, 2026. The first grant year will have tighter timelines because it isn't a full year. HHS is awaiting federal guidance and will schedule a special session once award amounts are known. The first grant year is anticipated to begin in Jan. 1, 2026, and a consistent allocation process will be used annually. Question: Will information on grant fund spending be shared with Tribes? Response: Yes. Information on grant awardees, funding amounts, plans, and related details will be publicly available.	
Client Share/Medically Needy • Overview of recent meeting • Discussion of CMS "ask," including potential request for formal clarification Monique Runnels, *Tribal Medicaid Liaison*	Overview of Client Share: • The monthly amount an individual must pay in medical bills before the Medicaid program will pay for care received. • Works like a monthly deductible. Examples of income deductions that can be used to reduce client share: • Medicare • Private health insurance premiums • Certain other costs How Client Share is calculated: • The household's countable gross monthly income minus allowable deductions (health care premiums, payroll taxes, etc.) minus FPL income limit based on household size equals Client Share. • Example: $2750 (gross income) - $185 (Medicare) - $210 (BCBS) - $1174 (FPL income limit for 1) = $1,181 Client Share Key Points for Tribal members: • Individuals who are in a coverage group that has client share must meet their client share before coverage begins. • Services provided by or through IHS or Tribal Health Programs (THPs) do not count toward meeting the Client Share. • This can create challenges for Tribal members and providers.

	• Example: A Tribal clinic provides care but cannot bill Medicaid until the Client Share is met, often leaving tribes paying the entire cost. Background: • Federal law treats IHS and THPs as federal trust responsibility services, not "private" providers. • CMS does not allow care provided through IHS/THP to count toward Client Share to avoid what it considers "double payment." • What CMS Means by "Double Payment": o IHS and THPs already receive federal funding under the Indian Health Care Improvement Act to provide care. o Medicaid is also a federal program, and when it pays for IHS/THP care, it uses 100% federal funds (FMAP = 100%). o CMS believes counting IHS/THP care toward the Client Share would mean using one source of federal funding (IHS) to trigger payment from another source of federal funding (Medicaid) or what CMS calls "duplicate" or "double payment." ND Medicaid is reviewing Tribal feedback and identifying areas that may need further clarification or discussion with CMS. • Possible areas for exploration include: o Clarifying federal guidance related to IHS and PRC services. o Reviewing data on financial impact on Tribal health systems • ND Medicaid values Tribal input to help inform future review and consultation. • What steps can we take together to address this issue?

Tribal Consultation

Question: Have Tribes received any additional information from CMS following earlier discussions?
Response: No.
Comment: Tribes are not provided the full amount of funding. IHS funding typically covers approximately 40% of what is needed.
Cost-of-living factors should be considered in client share calculations (e.g., rent, vehicle payments, groceries, travel for care)?
Cost-of-living increases and travel distances are often higher for Tribal members.
Comment: Participants noted that IHS does not cover all healthcare needs and does not "double pay," but rather reallocates remaining funds across patients. Specialty medications not covered by Medicaid are often paid for by Tribes and do not count toward a member's client share.
Question: Are the client share deductions something the State can change?
Response: No. Client share deductions are governed by federal regulation and cannot be changed at the state level. The State can, however, advocate to CMS regarding the impact of these calculations. It was acknowledged that current deduction allowances may not leave families with sufficient funds for daily living.
Question: What medical costs can be deducted when calculating client share?

Response: This question will be taken back to Eligibility staff for further clarification, including whether certain medication costs may be considered.
Question: Can CMS provide clearer guidance or examples on client share calculations?
Response: The State has requested additional clarification from CMS and will continue to request further guidance and illustrative examples.
Question: How can individuals who are unable to work due to health barriers pay their client share?
Response: Individuals should update their income information to reflect their current financial situation, so eligibility and client share are calculated accurately.
Question: Does Medicaid consider prior months of income?
Response: Eligibility is based on the month of application. Prior months are reviewed only to determine retroactive coverage. Seasonal income is considered on a case-by-case basis.
Question: Was there a public announcement regarding changes to retroactive coverage?
Response: Yes. A webpage is available with current information. Additional public communication will occur closer to implementation deadlines. This change is more than a year away, and further details will be shared once available.
Comment: Participants noted that retroactive coverage has helped with delayed billing and expressed concern about future impacts.
Response: The change does not affect billing deadlines but affects whether retroactive services can be paid. Emphasis was placed on assisting individuals with applying as early as possible. An offer was made to support Tribes through outreach and enrollment assistance.
Question: What support would be helpful from the State to assist with Medicaid enrollment?
Response: Suggestions included outreach to individuals without phones, email, or stable housing; additional benefits coordinators; and meeting people where they are through community events.
Question: Could enrollment support activities be addressed through RHTP?
Response: Yes. Ideas included on-site application support at clinics and pharmacies, use of mobile devices, and reducing denials related to follow-through barriers.
Question: Will the State revisit presumptive eligibility?
Response: The goal is full Medicaid coverage through a complete application.
Question: How does presumptive eligibility work for emergency room patients?
Response: Presumptive eligibility begins on the date the application is received. Hospitals are encouraged to submit applications on the date of service.
Question: Is there a required standard to be designated as a presumptive eligibility entity?
Response: Presumptive eligibility is currently limited to hospitals in the Medicaid State Plan.
Question: Why are eligibility processing times exceeding the two-week timeframe previously shared?
Response: Human Service Zones oversee eligibility processing and are experiencing increased workloads due to open enrollment, renewals, seasonal assistance programs, holidays, and staffing pressures. The State has acknowledged the need to further explore processing delays.

Commented [FK2]: I think this is what you mean? HHS has a webpage with information on the impacts of HR 1 and when the provisions are effective?

Traditional Healthcare Services Monique Runnels, *Tribal Medicaid Liaison*	Background: • Over the last 17 months, we have worked together with Tribal partners to advance the Traditional Healthcare Services SPA. • SPA submitted to CMS in April 2025. • CMS issued a Request for Additional Information on June 20, 2025. • Worked with the Tribal workgroup to develop a response, which was submitted to CMS on September 10, 2025. Next Steps: • We have not yet received a response from CMS and expect to hear back within the next week. • Once we receive a response, we will regroup with our workgroup to review it and determine next steps together. • Indigenized Behavioral Healing will host a Traditional Healthcare Services discussion for Tribes, Tribal leaders, and community organizations on January 28–29, 2026 at the Skydancer Casino & Resort.
Tribal Consultation Question: Will the response be sent directly to Tribes? Response: Yes. Once the State receives the response, HHS will meet with Tribes to review the information and determine next steps collaboratively.	

State Plan Amendments
• Behavioral Health Rehabilitative Services
• Other Licensed Providers
• School-based Services
Janice Tweet, *Coverage Policy Director*
	For all proposed SPAs listed below please refer to our most current tribal consultation letter on our website.
	• Tribal Consultation Comment period is open until Monday, January 5, 2026.
	Behavioral Health Rehabilitative Services
	• Enhanced guidelines for certain services
	• Addition of annual service limitations
	• Effective January 1, 2026
	• Public comment period open Wednesday, November 19 – Wednesday, December 3
	• Proposed policy will be available on our website
	• Enhanced Guidelines
	  ○ Expand definition of certain services to provide further detail on what services should entail.
	  ○ Example – the review process for behavioral intervention services would change from as needed to monthly. This change will ensure the service is having its intended effects, and if not, allows the opportunity for goals to be adjusted.
	  ○ Ensures members are receiving appropriate and medically necessary care and make progress on care plan goals.

	• Service limitations
	  ○ Ensure services provided are medically necessary.
	  ○ Service authorization is available for any services that exceed the limit and are medically necessary.
	  ○ Estimated to impact less than 200 members.
	• Tribal Impacts:
	  ○ For Tribal members and families: These refinements help ensure members receive the right level of care at the right time, improving access to consistent behavioral health services and reducing delays or gaps in treatment.
	  ○ For Tribal providers and programs: Clearer medical necessity standards and service definitions can support billing consistency, documentation accuracy, and staffing/caseload planning within Tribal behavioral health programs.
	  ○ For Tribal communities: More consistent service delivery may help strengthen community wellness infrastructure.
	Other Licensed Providers: Licensed Master Social Workers (LMSWs) added under Other Licensed Providers (OLPs)
	• *Any person licensed or certified under state law to provide medical or behavioral health services and practicing within the scope of his or her licensure pursuant to the applicable state law for his or her licensure or certification.*
	• Able to bill covered services within their scope of practice
	• Effective January 1, 2026
	• Other Licensed Providers policy
	• Tribal Impacts:
	  ○ For Tribal members and families: This change increases access to assessments, care coordination, and therapy support, which can help reduce wait times and improve continuity of care.
	  ○ For Tribal providers and programs: Expanding provider eligibility creates new billing opportunities and allows Tribal programs to fully utilize LMSW staff, supporting workforce capacity and flexibility.
	  ○ For Tribal communities: Improved access to behavioral health services may strengthen prevention and early-intervention efforts and support community mental health needs.
	School-Based Services
	• Allow LPNs to provide nursing services to children with complex medical needs to support their access to free appropriate public education.
	• Service allowed under supervision of an RN
	• CPT® code T1000 – Private duty/independent nursing services

	• Effective January 1, 2026
	• School-Based Services policy
	• Tribal Impacts
	  ○ For Tribal members and families: Expanding who can provide medical services in schools helps students with complex medical needs remain safely in school and reduces educational disruption.
	  ○ For Tribal providers and programs: Tribal and BIE schools may have increased flexibility in meeting IEP-required medical services and can rely on a broader pool of nursing staff when shortages occur.
	  ○ For Tribal communities: This change supports school stability, improves student access to necessary health supports, and may reduce reliance on out-of-school placements due to medical needs

Tribal Consultation Question: Will these limits affect the number of patients receiving care or require additional paperwork? Response: The changes are not expected to significantly impact paperwork. The intent is to adjust how services are reviewed, not to reduce access to care. Question: What types of limitations are being proposed? Response: The proposal includes soft limits, meaning services may be provided with no prior authorization if they are under the limits. If additional services above the soft limits are medically necessary, a provider may submit a service authorization for additional services to be approved.	
Review of 2025 Accomplishments & Planning for 2026 Priorities Monique Runnels, *Tribal Medicaid Liaison*	**2025 Accomplishments & 2026 Priorities** Strengthening our partnership through consultation and collaboration Tribal Consultation Meeting Goals: • Increase engagement and feedback from tribal partners. • Tailor presentations to you, our tribal stakeholders. • Create purposeful agendas. • Identify learning opportunities. Tribal Consultation Letter Goals: • Increased focus on what the changes mean to tribes and tribal members. Learning and Engagement Goals: • Provide timely information on topics Tribes identify as priorities. • Work together to understand root causes and barriers. • Create space for Tribal partners to share solutions, perspectives, and policy recommendations.

	Review of 2025 Learning Opportunities: • 1915(i) • Traditional Healthcare Services • Tribal Care Coordination • MMAC Tribal Representative • Medicaid 101 • Eligibility • Client Share • Tribal HCBS Meetings • Community Health Workers • Rural Health Transformation Program • Economic Assistance & Medicaid Service Delivery • IHS/Tribal Provider Policy Update Issues we navigated together included: • Billing questions • Traditional Healthcare Services • Tribal Care Coordination • Medicaid denials (payments and eligibility) • Provider enrollment • Tribal disbursement income • Client share (recipient liability) How we responded: • Updated policies • Corrected information when errors were identified • Updated system information • Provided additional clarification when needed • Connected Tribal partners with the right program contacts 2025 Shared Progress: • Increased discussion and potential solutions shared during our meetings. • Increased identification of areas where additional information and collaboration are needed. • Increase in tribal partners reaching out for assistance. • Policy updates based on tribal feedback. • Increase in number of people engaged in our ND Medicaid meetings. • Tribal representation on MMAC and MMEC. • Less requests for assistance for disregarded income.

	• Submitted Traditional Healthcare Services SPA & Request for Additional Information. • Finding more effective ways of addressing issues. • Completed first Tribal Care Coordination disbursements.
Tribal Consultation **Questions posed to the group:** • What has been helpful in our consultation meetings? • What changes or improvements would make them more meaningful for you? • How can we make our consultation letters clearer and more useful? • What topics or learning opportunities do you want us to cover in 2026? • What progress would you like to see in 2026? • What issues would you like to work on together in 2026? Feedback: Provide presentation slides in advance so Tribal members can review materials and share input with leadership prior to meetings. Encourage greater Tribal participation, particularly in RHTP and related initiatives. Increase Tribal member and leadership presence at consultation meetings. Make letters shorter and more direct. Clearly explain how proposed changes impact Tribal communities and individual members. Use plain language to connect policy changes to outcomes. RHTP teams coming to each tribe to address their unique community needs. Express the importance of tribal proactiveness. Work together to get tribal leadership to attend tribal consultation meetings. Some technical improvements and assistance level setting. Using more impactful language in technical assistance. Question asked: Does the state have guidelines that defines tribal consultation? Yes. The State has a Tribal Consultation State Plan Amendment available on its website. The SPA does define who is required to be notified for Tribal Consultation. The State uses GovDelivery to ensure required notifications are distributed, and additional individuals may subscribe through the Tribal Consultation listserv, which reaches over 1,000 recipients.	
Upcoming Engagement Opportunities	Medicaid Medical Advisory Committee (MMAC) • Tuesday, Feb. 17, 3:00-5:00 p.m. CT -Teams Native American Public Input- HCBS • 2nd Wednesday of every month • Contact Monique Runnels for the meeting link. 1915(i) Office Hours • Every Wednesday 9-10am Other Upcoming Meetings: IHS/THP Policy Education: Each Tribe will have a scheduled session during the second week of December

	Reminder: Subscribe to News & Alerts

Date posted: 12/18/2025