
Table of Contents

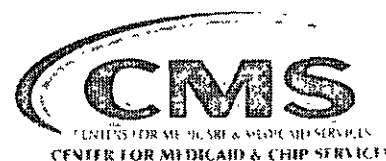
State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-12-001

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-14-26
Baltimore, Maryland 21244-1850.



Disabled & Elderly Health Programs Group

January 14, 2013

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

Dear Ms. Anderson:

We have reviewed North Dakota State Plan Amendment (SPA) 12-001, received in the Regional Office on December 09, 2011. This amendment proposed to change the drug ingredient cost reimbursement from the lesser of Average Wholesale Price (AWP) minus 10% or Wholesale Acquisition Cost (WAC) plus 8% to WAC plus 8%, or if no WAC exists for the product, then the Estimated Acquisition Cost (EAC) will be Direct Price plus 8%. The SPA also adds a \$10 dispensing fee for compounds and for 340B providers using 340B inventory for Medicaid recipients. Providers are to bill Medicaid at their actual cost for the product plus their reasonable dispensing fee as determined by their cost analysis on file in their contract with the 340B qualifying entity. We are pleased to inform you that the amendment is approved, effective October 19, 2011.

A copy of the CMS-179 form, as well as the pages approved for incorporation into the North Dakota state plan, will be forwarded by the Denver Regional Office. If you have any questions regarding this amendment, please contact Terry Simananda at (410) 786-8144.

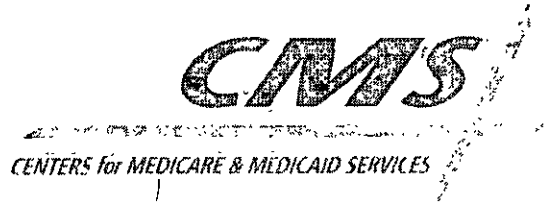
Sincerely,

/s/

Larry Reed
Director
Division of Pharmacy

cc: Richard Allen, ARA, Denver Regional Office
Diane Dunstan-Murphy, Denver Regional Office

Department of Health & Human Services
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967



Region VIII

January 14, 2013

Maggie Anderson
Medicaid Director
North Dakota Department of Human Services
Medical Services Division
State Capitol Judicial Wing
600 East Boulevard Avenue
Bismarck, ND 58505-0250

Dear Ms. Anderson:

This letter is being sent as a companion to our "request for additional information" letter for ND SPA 12-001 that changes the pharmacy reimbursement policy. Our review of this amendment included assessment of the corresponding coverage pages for the amended service in section 4.19B of the North Dakota State Plan. Based on this review, CMS determined that North Dakota needs to address the following additional elements in order to bring the State Plan into compliance with federal law.

Please note that the following questions apply to the services included in page 2 of Attachment 4.19-B including transportation, home health agency services and hospice services.

Transportation:

The state indicates that it claims NEMT as an optional medical benefit. States may only claim NEMT as an optional medical service if the state complies with freedom of choice of provider, comparability, statewideness and direct vendor payment.

1. Does the state register all individual drivers as vendors? If so, what are the requirements for these "vendors"? Only true volunteer drivers may be registered as vendors and the state must have oversight procedures or minimum requirements for volunteer drivers who are registered as vendors.
2. Does the state provide mileage reimbursement to the beneficiary? If so they may not register the beneficiary as a vendor and therefore may only claim admin for the mileage.
3. When the state reimburses family members for mileage does the state register the family member as vendor? If so, they should not be claiming the mileage at the FMAP rate because family members may not be considered vendors.

Home Health:

Attachment 3.1-A, Attachment 3.1-B, item #7 Home Health Services:

1. Please incorporate a sentence under the Home Health section that reads as follows: "Home Health services are provided in accordance with 42 CFR 440.70."
2. Please add language to address any limitations on the mandatory services, as well as, the optional services which the state provides. (NOTE: The state has checked off on the 3.1-A and 3.1-B preprint pages that there are limitations to services. Please define what those limitations are.)
3. 2nd paragraph, 1st sentence: Please define the term "unusual or complex cases".
4. Please be advised that there is a new rule that requires the physician to have a face-to-face encounter with the patient prior to the authorization of home health services. Section 6407 of the Affordable Care Act requires the physician to document the existence of a face-to-face encounter (including the use of telehealth) with the Medicaid eligible individual prior to ordering the provision of home health services. This face-to-face encounter can be conducted by a physician, by a nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law, or by a physician assistant under the supervision of a physician. Additionally, the Affordable Care Act requires that the physician to document the existence of a face-to-face encounter (including telehealth) with the Medicaid eligible individual prior to ordering medical supplies, equipment or appliances. State plan changes may be requested in the future to reflect this requirement.

Hospice:

Attachment 3.1-A, page 7 and Attachment 3.1-B, page 6, item #18:1. The state indicates it furnishes the hospice benefit "without limitations" under Item 18. In accordance with section 2302 of the Affordable Care Act which was effective March 23, 2010, states must furnish curative care concurrently with hospice services for Medicaid and CHIP-eligible children under age 21 who elect the hospice benefit. We previously provided you with a draft template and the State Medicaid Director Letter, #10-018, dated September 9, 2010 and the Informational Bulletin, dated May 27, 2011. Please complete the draft template to reflect that the state provides concurrent care under the hospice benefit in accordance with section 2302 of the Affordable Care Act.

Inpatient psychiatric facility services for individuals under age 21:

Attachment 3.1-A, page 7 and Attachment 3.1-B, page 6, items #16 and 16a:

1. The state has modified its current preprint page by adding item "16a". Since this is supposed to be subsumed under item 16, please delete item 16a. Once the State's revised preprint page is submitted, we will have to review coverage for Psychiatric Residential Treatment Facilities as a same page item.

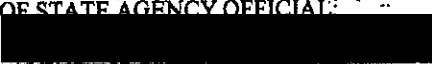
Please respond to this letter within 90 days of receipt with a corrective action plan describing how the State will resolve the issues identified above. During this 90-day period we are happy to provide any technical assistance that you and your staff may need. State Plans that are not in compliance with requirements at 42 CFR 430.10 are grounds for initiating a formal compliance process.

If you have any questions about this letter, please contact Ann Clemens of my staff at either 303-844-2125 or by email at Ann.Clemens@cms.hhs.gov.


Sincerely,



Richard C. Allen
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-001	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 19, 2011	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.331		7. FEDERAL BUDGET IMPACT: a. FFY <u>2011</u> \$ <u>-0-</u> b. FFY <u>2012</u> \$ <u>-0-</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 2 Attachment 4.19-B, Page 2a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Page 2 Attachment 4.19-B, Page 2a	
10. SUBJECT OF AMENDMENT: Amends the State Plan to address the change in the benchmark used for reimbursement algorithm for the pharmacy EAC calculation.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Maggie D. Anderson, Director, <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Medical Services Division			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Maggie D. Anderson, Director Division of Medical Services ND Department of Human Services 600 East Boulevard Avenue Dept 325 Bismarck ND 58505-0250	
13. TYPED NAME: Maggie D. Anderson			
14. TITLE: Director, Division of Medical Services			
15. DATE SUBMITTED: December 9, 2011 December 9, 2011 - REVISED 1-07-2013			

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/9/11	18. DATE APPROVED: 1/14/13
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/19/11	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: RICHARD C. ALLEN	22. TITLE: ARA, DMCHD
23. REMARKS: 1/14/13 Pen & ink changes authorized by State for block 15	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

- 10) Transportation by common carrier will be reimbursed at the going rate or fare established for the general public. Ambulance services will be paid at the lower of actual billed charges or the maximum allowable charge established by the state. Private vehicles when utilized by a third party to provide transportation to a Medicaid recipient will be paid at the lower of billed charges or the mileage rate up to an upper limit periodically established by the state agency, not to exceed the mileage established by the state legislature. The payment for all meals necessary for recipients and attendants cannot exceed the amount allowed for state employees while they are traveling in the state of North Dakota. The payment for necessary lodging for recipients and attendants traveling within North Dakota cannot exceed the amount allowed for state employees. The payment for necessary lodging for recipients and attendants traveling outside of North Dakota will be limited by a maximum established by the single state agency. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for dates of service July 1, 2011, as authorized and appropriated by the 2011 Legislative Assembly.
- 11) Family planning services provided by local health departments under the auspices of the Maternal and Child Health (MCH) Division of the State Department of Health will be paid the lower of billed charge or maximum established by the MCH Division. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for dates of service July 1, 2011, as authorized and appropriated by the 2011 Legislative Assembly.
- 12) Home Health Agency services including nursing care, home health aide services, physical therapy, occupational therapy, speech pathology or audiology services, reimbursement will be at the lowest of the billed charge or maximum allowable charge established by the State. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for dates of service July 1, 2011, as authorized and appropriated by the 2011 Legislative Assembly.
- 13) For hospice services Medicaid will pay the amounts established by HCFA at Sections 4306, 4307, and 4308 Part 4 of the State Medicaid Manual.
- 14) Nurse-Midwife services will be paid at the 85% level of the payment made for covered pre-natal, delivery and postpartum services provided by physicians, i.e., the lower of actual charge or 85% of the allowable amount established by the state agency for payment of physician services. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for dates of service July 1, 2011, as authorized and appropriated by the 2011 Legislative Assembly.

TN No. 12-001
Supersedes
TN No. 11-021

Approval Date 1/14/13

Effective Date 10-19-2011

- 15) For prescribed drugs, including non-legend drugs that are prescribed by an authorized prescriber and legend drugs, Medicaid will reimburse at the lower of 1) the Estimated Acquisition Cost (EAC) for that drug plus a dispensing fee, 2) the Federal Upper Limit (FUL) for that drug plus a dispensing fee, 3) North Dakota Medicaid's established Maximum Allowable Cost (MAC) for that drug plus a dispensing fee, or 4) the provider's usual and customary charges to the general public. The dispensing fee for legend drugs is \$4.60 for brand name drugs and \$5.60 for generic drugs. The dispensing fee for non-legend drugs that are prescribed by a physician is calculated at 1.5 times the allowed amount (EAC, FUL, or MAC) up to a maximum of \$4.60. The dispensing fee for compounds is \$10.

The ingredient cost for multiple source drugs identified and listed by CMS as having Federal Upper Limit (FUL) will not exceed, in the aggregate, the level of payment for those drugs as calculated by the current FUL methodology used by CMS.

Estimated acquisition cost (EAC) will be this agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is defined as Wholesale Acquisition Cost (WAC) plus 8%; if WAC does not exist for a given product, then EAC will be set at Direct Price (DP) plus 8%. WAC and DP are determined by First Data Bank on a weekly basis.

For 340b providers using 340b inventory for Medicaid recipients, the providers are limited to billing Medicaid at their actual cost for the product plus their reasonable dispensing fee as determined by their cost analysis on file in their contract with the 340b qualifying entity.

A fee of fifteen cents per pill will be added to the dispensing fee for the service of pill splitting. Pill splitting is entirely voluntary for the patient and the pharmacist. Pill splitting will only be permitted under the following circumstances: when Medical Services determines it is cost effective, the pill is scored for ease of splitting, and the pharmacy staff splits the pill. This fee will only be allowed for medications that have been evaluated by the state for cost-effectiveness and entered into the Point-of-Sale system.

TN No. 12-001
Supersedes
TN No. 11-021

Approval Date 1/14/13

Effective Date 10-19-2011