METHOD FOR REIMBURSING INPATIENT HOSPITAL SERVICES

1. Hospitals paid using Prospective Payment System (PPS).

   a. In-state hospital service reimbursement paid to all hospitals and distinct part units, except those hospitals and distinct part units specifically identified in Section 2, will be made on the basis of a Prospective Payment System (PPS). The system generally follows the Medicare PPS in terms of the application of the system. PPS uses diagnostic related groups (DRG) to pay for services upon discharge. Medical education costs are excluded from the PPS.

   b. The base year used for the calculation of the base rate and the capital rate is the year ending June 30, 2007. The base rate and capital rate established for hospitals paid by PPS is effective July 1, 2009. The base rate and capital rate effective shall be increased by 3% effective July 1, 2012.

   c. Vacated.

   d. Effective March 1, 2013 the DRG classification and grouper system is the All Patient Refined Diagnosis Related Grouper version 29.

   e. Vacated

   f. Vacated.

   g. A capital payment will be included in the PPS payment for all discharges. Capital payments may not be paid to a transferring hospital.

   h. Outlier Payments.

      (1) A cost outlier payment is made when costs exceed a threshold of two times the DRG rate or $15,000, whichever is greater. Costs above the threshold will be paid at 60 percent of billed charges.

      (2) A day outlier payment is made when the length of stay for a recipient exceeds one standard deviation from the mean. Each day exceeding the threshold is paid at 60 percent of the per diem rate. The per diem rate is calculated as the hospital's basic DRG payment divided by the national untrimmed arithmetic average length of stay.

      (3) For DRG's 580-640 relating to neonates:

         (a) The day outlier payment is calculated at 80% of the per diem rate once the thresholds in paragraph 2 are met; or

         (b) The cost outlier thresholds are the greater of 1.5 times the DRG rate or $12,000. Costs above the threshold will be paid at 80 percent of billed charges.

based on the hospital's Medicare interim per diem rate decreased by 1% will be made until such time as a cost settlement is made. Cost settlement to reasonable cost for Title XIX services will be based on the Medicare cost report and will occur after the hospital's Medicare cost report has been audited and finalized by the Medicare fiscal intermediary.

g. Payments to hospitals reimbursed on a percentage of charge will be paid for revenue code 278 based on the cost of the supply plus twenty percent for billed charges over $15,000.

3. Disproportionate Share Hospital (DSH) Adjustments.

a. Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive a DSH payment subject to any limitations set forth in this section.

b. The following criteria must be met before a hospital is determined to be eligible for a DSH payment adjustment.

(1) A hospital must have:

(a) A Medicaid inpatient utilization rate of at least 1%

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

The following is a description of the policies that apply to rates and fees established for services other than inpatient hospital care, nursing facility care, and intermediate care for the mentally retarded.

Out-of-state providers are paid the same rates and fees applicable to providers in North Dakota. Medicare crossover claims will be paid based on the lesser of the Medicare coinsurance and deductible or the maximum amount payable for the service per the rates and fees established less the Medicare payment.

1) Outpatient services are paid using a fixed percentage of charges established by the state agency, except for laboratory procedures paid according to item 3 below, dietitian services paid at the lower of the actual charge or maximum allowable charge established by the state agency, ambulatory behavioral healthcare (partial hospitalization) paid a per diem rate established by the state agency and revenue code 278 paid at the cost of the supply plus twenty percent for billed charges over $3,000. Providers shall follow Medicare coding guidelines for appropriate billing of revenue code 278. The fixed percentage of charges for in-state hospitals designated as Critical Access Hospitals will be established using the hospital's most recent audited Medicare cost report. Cost settlement to reasonable cost for outpatient services at instate hospitals designated as Critical Access Hospitals for Title XIX services will be based on the Medicare cost report and will occur after the hospital's Medicare cost report has been audited and finalized by the Medicare fiscal intermediary. The fixed percentage of charges for all other instate hospitals will be established using the hospital's most recent Medicare cost report available as of June 1 of each year. The fixed percentage of charges for out-of-state hospitals shall be the average of the fixed percentage paid to all hospitals categorized as Group 1 Hospitals. Out–of-state hospitals shall be paid for revenue code 278 at the cost of the supply plus twenty percent for billed charges over $3,000 and shall follow Medicare coding guidelines for appropriate billing of revenue code 278. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for dates of service July 1, 2012, as authorized and appropriated by the 2011 Legislative Assembly.

2) Clinic services payment is based on the cost of delivery of the services on a prospective basis as determined by the single state agency from cost data submitted periodically by the clinic. In those years when no cost information is requested by the single state agency, each clinic will receive an inflation increase as determined by the state agency. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual. Payments to participating providers will be made in accordance with 42 CFR 447.206. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for days of service July 1, 2012, as authorized and appropriated by the 2011 Legislative Assembly.

    a) Payment to dental clinics, including mobile dental clinics, is based on the cost of delivery of the service as determined by the single state agency from cost data submitted annually by the clinic. Allowable costs will be determined in accordance with the Medicare Provider Reimbursement Manual. Individual provider rates will be effective October 1, 2012. North Dakota Medicaid providers will receive a three percent inflationary increase in reimbursement effective for days of service October 1, 2012, as authorized and appropriated by the 2011 Legislative Assembly. Providers will be notified of the rates, via letter and/or email correspondence. Except as otherwise noted in the Plan, State developed fee schedule rates are the same for both governmental and private providers.

3) For laboratory services, Medicaid will pay the lower of billed charges, Medicare maximum allowable charge, or fee schedule established by the state agency. Medicaid payment for lab services may not exceed the Medicare rate on a per test basis.

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED MEDICALLY NEEDY GROUP(S):

1. Inpatient Hospital Services other than those provided in an institution for mental diseases.

☒Provided: ☐No Limitations ☒ With Limitations*

2a. Outpatient Hospital Services.

☒Provided: ☐No Limitations ☒ With Limitations*

2b. Rural Health Clinic Services and other Ambulatory Services furnished by a Rural Health Clinic (which are otherwise covered under the plan).

☒Provided: ☒No Limitations ☐ With Limitations*

2c. Federally Qualified Health Center (FQHC) Services and other Ambulatory Services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub.45-4).

☒Provided: ☒No Limitations ☐ With Limitations*

3. Other Laboratory and X-ray Services.

☒Provided: ☒No Limitations ☐ With Limitations*

4a. Nursing Facility Services (other than services in an institution for mental diseases) for individuals 21 years of age of older.

☒Provided: ☒No Limitations ☐ With Limitations*

4b. Early and Periodic Screening, Diagnostic and Treatment Services for individuals under 21 years of age, and treatment of conditions found.*

☒Provided: ☒No Limitations ☐ With Limitations*

4c. Family Planning Services and Supplies for individuals of childbearing age.

☒Provided: ☒No Limitations ☐ With Limitations*

4d. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women.

☒Provided: ☐No Limitations ☒ With Limitations*