Table of Contents

State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-16-0013

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

NOV 17 2016

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

Re: North Dakota 16-0013

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 16-0013. Effective for services on or after July 1, 2016, this amendment updates the DRG APR grouper to version 32. In addition, it provides for additional, clarifying language that out-of-state children's hospital payments will be based on the per diem rate established by the Medicaid agency in the State where the hospital is located.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 16-0013 is approved effective July 1, 2016. The HCFA-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

Kristin Fan
Director

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **16-0013**

2. STATE: **North Dakota**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **July 1, 2016**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ **NEW STATE PLAN** ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR 440.10**

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $0
b. FFY 2017 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A, pages 1 and 5**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A, pages 1 and 5**

10. SUBJECT OF AMENDMENT:
Amends the State Plan to identify the change in the inpatient diagnosis related grouper version and reimbursement for out-of-state children's hospitals

11. 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: Delegated to Single State Medicaid agency

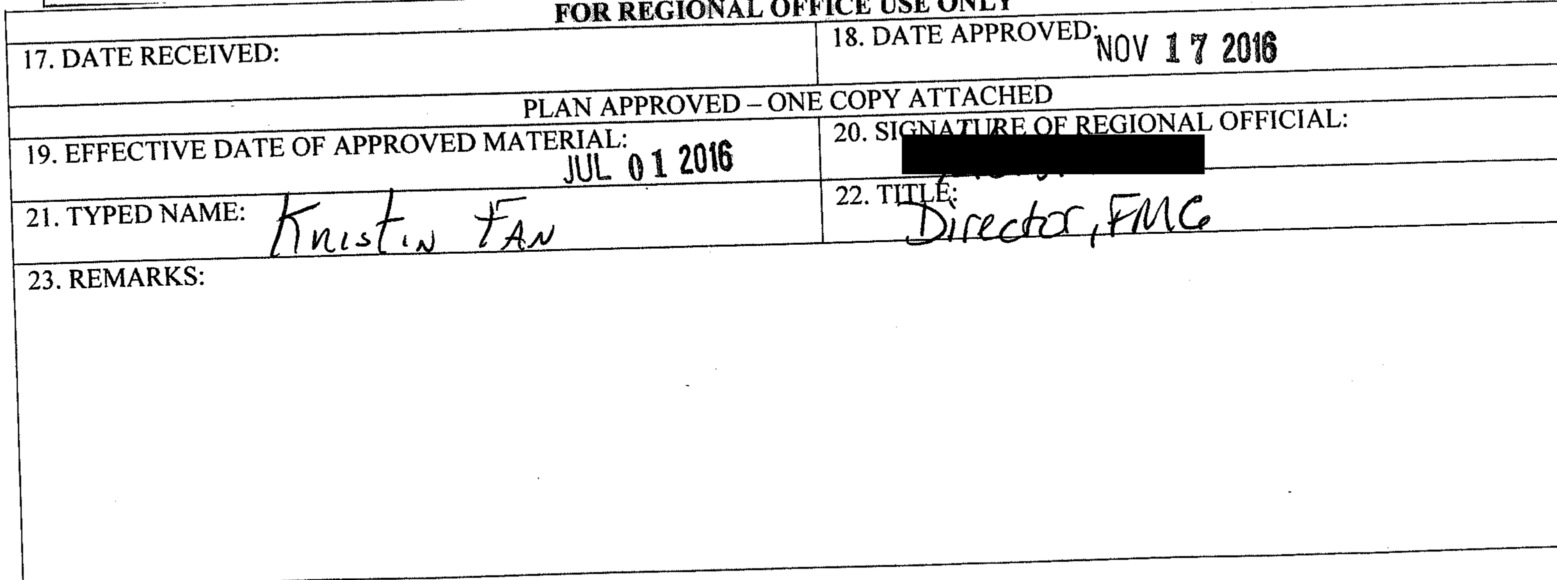
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Maggie D. Anderson**

14. TITLE: **Executive Director, ND Dept. of Human Services**

15. DATE SUBMITTED: **August 30, 2016**

16. RETURN TO:
Maggie D. Anderson, Executive Director
ND Department of Human Services
600 East Boulevard Avenue Dept 325
Bismarck ND 58505-0250



FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: NOV 17 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

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 three percent effective July 1, 2015.

   c. Vacated.

   d. Effective July 1, 2016 the DRG classification and grouper system is the All Patient Refined Diagnosis Related Grouper version 32.

   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.

(3) If eligible, the state psychiatric hospital will receive a DSH payment adjustment calculated as an amount equal to $1.00 plus the state's disproportionate share allotment less the quarterly DSH payment adjustments made to all other eligible hospitals. The DSH payment adjustment to the state hospital will be made quarterly. The quarterly payment will be calculated by dividing the state's annual disproportionate share allotment by four and subtracting all disproportionate share payments made to other eligible hospitals in that quarter. Any adjustments to the state's disproportionate allotment will be corrected in the quarter the adjustment is made.

h. DSH payment adjustments will be limited as follows:

(1) Effective July 1, 1995 the DSH payment adjustment for any eligible hospital may not exceed the greater of the total of the unreimbursed costs of providing services to Medicaid recipients and of providing services to uninsured patients or the limitations set forth in section 1923(g) of the Act.

(2) If requested by the department, eligible hospitals must submit information on unreimbursed costs of providing hospital services to Medicaid recipients and of providing hospital services to uninsured patients before a DSH payment adjustment can be made.

(3) Total DSH payment adjustments paid to all eligible hospitals may not exceed the state's DSH allotment.

i. An independent certified audit will be submitted to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D.

(1) To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the overpayments will be collected and redistributed.

(2) Any overpayments collected will be redistributed to the other hospitals that were eligible and received payments during the corresponding DSH year. The payment will be based on the eligible hospital's proportion of uninsured cost relative to aggregate of uninsured costs of all eligible hospitals who received payments during the corresponding DSH year and who do not exceed their hospital specific DSH limit.

4. Out-of-State Inpatient Hospital Service Payments.

a. Out-of-state inpatient hospital service payments, except as identified below, shall be paid based on a percent of billed charges established by the Medicaid agency which shall not be less than 35%. The percent paid may be adjusted annually on July 1.

b. The department may negotiate a payment methodology for organ transplants performed by out-of-state hospitals.

c. Out-of-state children's hospital payments will be based on the per diem rate established by the Medicaid agency in the state where the hospital is located.