Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs

1. An adjustment factor shall be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care and for purposes of adjusting limitations of direct care costs, other direct care costs, and indirect care costs, but may not be used to adjust property costs.

2. For the rate year beginning January 1, 2020 the adjustment factor is 2 percent.

3. For the rate year beginning January 1, 2021 the adjustment factor is 2.5 percent.

4. For the rate year beginning January 1, 2022, the adjustment factor is 4.5 percent.

5. For the rate year beginning January 1, 2023, the maximum adjustment factor is 3.75 percent.

6. For the rate year beginning January 1, 2024, the maximum adjustment factor is 3.2 percent.

~~6.~~7. For the rate year beginning January 1, 2025, the maximum adjustment factor is 3 percent.

5. The daily rate is established by dividing actual allowable costs plus an inflation factor of three percent by in-house census days effective for dates of service January 1, ~~2024~~2025.

6. A PRTF dissatisfied with the results of a final rate determination may request a reconsideration of the final rate within 30 days of the written notification of a final rate. A PRTF dissatisfied with the results of the Department's decision regarding the request for a reconsideration determination may file an appeal within 30 days of the written notice of the Department's decision regarding the reconsideration determination.

7. Payments to out-of-state PRTFs shall be made based on the rate for comparable services established by the Medicaid agency in the state where the facility is located. If no rate is established by the Medicaid agency in that state, then the per diem rate payable to the out-of-state PRTF shall be the lower of billed charges or the average of the per diem rates in effect for in-state PRTFs at the time of the services are first provided by the out-of-state PRTF, except that a per diem rate higher than the average per diem rate may be negotiated by the state for extraordinary or unusual circumstances on a case by case basis. Negotiated per diem rates may not exceed the cost of the service provide by the PRTF.

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A. Payment for a reserved bed is made:

1. For a recipient absent from a nursing facility:

   a. 15 days maximum for periods of inpatient hospitalization, and

   b. 30 days, per rate year, maximum for therapeutic leave of absences.

2. For a recipient absent from an intermediate care facility for individuals with intellectual disabilities:

   a. 15 days maximum for periods of inpatient hospitalization, and

   b. 30 days, per calendar year, maximum for therapeutic leave of absences.

3. For a recipient absent from a psychiatric residential treatment facility:

   ~~b.~~a. 15 days maximum for periods of inpatient hospitalization.

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TARGETED CASE MANAGEMENT SERVICES
Individuals with a serious mental illness or serious emotional disturbance

Target Group (42 Code of Federal Regulations 441.18(a) (8) (i) and 441.18(a) (9)):

Target Group
To be eligible for this service, individuals
(A) Adults ~~with a serious mental illness (SMI)~~ must:

- Be Medicaid eligible; and
- Be 18 years of age or over~~.~~; and
- Have a serious mental illness and/or substance use disorder (SUD) expected to last a year or longer; and

  ~~The mental disorder must be an identifiable disorder defined in the most current Diagnostic and Statistical Manual (DSM) or the International Classification of Disease (ICD) equivalent with the exception of 'V' and 'Z' codes, substance use disorders, and developmental disabilities unless they co-occur with another diagnosable mental disorder; and~~
- ~~The condition is expected to be of a duration of a year or longer; and~~
- ~~The individual must demonstrate~~ Demonstrate at least a moderate level ~~(25 or more)~~ of functional impairment that interferes with or limits one or more major life activities ~~deficit and disability severity as measured by the most current version of the World Health Organization Disability Assessment Schedule (WHODAS). The self-administered version is required; however, the proxy or clinician-administered versions will be accepted with a documented reason~~; and
- ~~In addition to the clinical diagnostic and functioning requirements above, **one** of the following is required~~Meets at least one of the following criteria:
  - ~~Individual has undergone~~ Undergone psychiatric treatment more intensive than outpatient services more than once related to their mental illness and/or SUD; or
  - ~~Individual has a history~~ History of documented problems resulting from mental illness and/or SUD for at least one year verified by family or local provider; or
  - ~~Individual has~~ Has experienced a single episode of continuous structured supportive residential care other than hospitalization for at least two months.

(B) Children ~~with a serious emotional disturbance (SED~~ must~~)~~:

- Be Medicaid eligible; and
- Be less than 21 years of age; and
- Have a serious emotional disturbance or substance use disorder expected to last a year or longer ~~mental disorder defined in the most current Diagnostic and Statistical Manual (DSM) or the ICD equivalent with the exception of 'V' and 'Z' codes, substance use disorders, and developmental disabilities unless they co-occur with another diagnosable mental disorder~~; and

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- ~~Be expected to have a mental disorder for a duration of a year o longer; and~~
- Demonstrate at least a moderate level of ~~a functional~~ impairment ~~of 25 or more on the WHODAS-Child, which indicates substantial interference~~ which substantially interferes with or limits the child's role ~~of~~ or functioning in family, school, ~~home,~~ or community activities; and
- Be determined:
    a. To be having a psychiatric crisis or emergency which requires emergency intervention to prevent institutional placement; or
    b. To need long-term ~~mental~~ behavioral health services.

Exclusions for the Target Populations

Functional impairments that are temporary and expected responses to stressful events in the environment are not included.

For case management services provided to the target populations in medical institutions:

Target group is comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g) (1) of the Act):

_**X**_ Entire State
___ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a) (10) (B) and 1915(g) (1))

_**X**_ Services are provided in accordance with §1902(a) (10) (B) of the Act.
___ Services are not comparable in amount duration and scope (§1915(g) (1)).

Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted case management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

a. taking individual's history;
b. identifying the individual's needs and completing related documentation; and

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TARGETED CASE MANAGEMENT SERVICES
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c. gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

A comprehensive assessment is conducted initially and repeated at least annually to assess the individual's needs and account for their preferences.

Development (and periodic revision) of a specific care plan based on the information collected through the assessment that

a. specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
b. includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
c. identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

Monitoring and follow-up activities
~~activities~~ Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The care plan is reviewed and updated every six months to reflect the accomplishments and changing needs.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

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TARGETED CASE MANAGEMENT SERVICES
Individuals with a serious mental illness or serious emotional disturbance

For case management services to assist individuals who reside in medical institutions to transition to the community, case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

Qualifications of Agencies:

For dates of service on or after May 1, 2020, an agency must meet all the following criteria:

1. Demonstrate the ability to be available 24 hours, 7 days a week to individuals who need emergency targeted case management services.
2. Ensure supervisors of targeted case management staff have a minimum of a bachelor's degree and experience with case management.
3. Attest that individuals providing targeted case management have reviewed the competencies or standards of practice in one of the following:
   a. The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or
   b. The Case Management Society of America standards of practice.
4. Attest that individuals providing targeted case management have general knowledge, training and/or experience working with individuals with SMI and/or SED.
5. For North Dakota federally recognized Indian Tribes or Indian Tribal Organizations, attest that individual case managers enrolled with ND Medicaid possess the necessary cultural sensitivity and background knowledge to provide appropriate services to the Native American population served.

Qualifications of Individuals providing targeted case management:

Individuals providing TCM:

1. Must have a ~~master's degree, or a~~ bachelor's degree~~, and two years of experience working with special population groups in a direct care setting~~.
2. If the individual does not have a bachelor's degree, they will be allowed to enroll to provide TCM if they have at least five years of paid supervised experience working with individuals with SMI/SED in a role with case management functions such as individual assessment, care plan development and maintenance, referral and appointment scheduling, in addition to monitoring and follow-up activities.

Individuals enrolled and providing targeted case management prior to May 1, 2020 will be deemed qualified to provide targeted case management, if they remain actively providing targeted case management services.

Freedom of choice (42 CFR 441.18(a) (1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

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TARGETED CASE MANAGEMENT SERVICES
Individuals with a serious mental illness or serious emotional disturbance

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g) (1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, and the state will not condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a) (4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a) (7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

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TARGETED CASE MANAGEMENT SERVICES
Individuals with a serious mental illness or serious emotional disturbance

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a) (25) and 1905(c)

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TARGETED CASE MANAGEMENT FOR INDIVIDUALS IN NEED OF LONG TERM CARE SERVICES IN TRIBAL COMMUNITIES

Target Group (42 Code of Federal Regulations 442.18(a)(8)(i) and 441.18(a)(9)):

Targeted Case Management for individuals in need of long term care – In order to receive targeted case management services an individual must (1) Be Medicaid Eligible; (2) Not currently be covered under any other targeted case management system; (3) Be considered, as defined by the North Dakota Department of Human Services to have a need for Long Term Care services~~; (4) Not receiving case management services through an HCBS 1915(c) Waiver~~. Lives in the community and desires to remain there. Be ready for discharge from a hospital within 7 days. Resides in a basic care facility. Not reside in a nursing facility unless it is anticipated that a discharge to alternative care within 6 month.

For case management services provided to individuals in medical institutions:

X Target group is comprised of individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution. Individuals must be an enrolled tribal member or individuals eligible for tribal Community Health Representative (CHR) services. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of state in which services will be provided:

X Entire State
___ Only in the following geographic areas: authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide

Comparability of services:
___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope.

Definition of Services (42 CFR 440.169):
Targeted Case Management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, education and other services. Case Management includes the following assistance:

- Assessment of an individual to determine the need for any medical, education, social or other services. These assessment activities include:
  - Taking client history;

- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- At a minimum includes an initial assessment and annual face-to-face reassessments.

- Development (and periodic revision) of a Specific Care Plan that:
  - Is based on the information collected through the assessment;
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible Individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and Related Activities:
  - To help an eligible individual obtain needed services including activities that help link an individual with:
    - Medical, social, educational providers; or
    - Other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and Follow-up Activities:
  - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate; and
    - If there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.
    - At a minimum this includes an initial assessment to determine need, and if there is a need, ongoing annual face-to-face reassessments.

___ Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 41.18(b)):

In order to ensure that care is properly coordinated, TCM services must be delivered by an ~~individual or an~~ agency that have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled persons.

Individual case managers must at a minimum must hold a ND social work license or must be a Developmental Disabilities program manager. The DD Program manager must be a Qualified Mental Retardation Professional (QMRP) or must have one year experience as a Developmental Disabilities Case Manager in the North Dakota Department of Human Services.

Indian Tribes or Indian Tribal Organization Provider Qualifications:

Targeted case management services must be delivered in a culturally appropriate and relevant manner to enrolled tribal members or individuals eligible for tribal Community Health Representative (CHR) services by qualified staff of federally recognized Indian Tribes or Indian Tribal Organizations.

Qualified staff are defined as individuals who have successfully completed the following:

- The Indian Health Service CHR certification training; and
- The North Dakota State Aging Section Targeted Case Management Process training and annual update trainings; and
- An approved curriculum focused on Native Elder Aging and Caregiving.

Individuals providing targeted case management services must be under the supervision of a professional who has:

- A minimum of an associate degree* preferably in a health or human services related field and at least one year of experience working with the target population; or
- Is a licensed health professional.

* Qualifying experience may be considered in lieu of an associate degree requirement. Qualifying experience is defined as two years' experience coordinating or providing community services and supports.

Any professional supervising targeted case management services must also complete:

- The North Dakota State Aging Section Targeted Case Management Process training; and
- An approved curriculum focused on Native Elder Aging and Caregiving.

If CHR program staff have not yet completed all training requirements, North Dakota Medicaid will reimburse for targeted case management services if the services are provided under the required supervision and the individual providing the services complete the necessary training requirements within one year.
~~Qualifications for staff of federally recognized Indian Tribes or Indian Tribal Organizations performing case management must be able to deliver needed services in a culturally appropriate and relevant manner to enrolled tribal members.~~

~~Staff must have successfully completed either: a) the 120 hour basic Community Health Representative (CHR) Certification Training (provided through Indian Health Service), supplemented by 20 hours of training in Case Management Process *and* 20 hours of training in Gerontology topics; or b) an approved Tribal College Community Health Curriculum, which includes coursework in Case Management principles and Gerontology.~~

~~The Case Management Implementer (the individual providing the direct service) must provide services under the supervision of a licensed health professional (Licensed Practical Nurse,~~

~~Social Worker, Registered Nurse, Physical Therapist, Occupational Therapist, or Medical Doctor).~~

~~Medicaid will reimburse a CHR Program for case management services provided by CHR Program staff that have not yet completed the necessary certification requirements so long as case management services are provided under the supervision of a licensed professional (Licensed Practical Nurse, Social Worker, Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, or Medical Doctor) and the CHR Program staff are actively in the process of completing the necessary certification requirements within two years.~~

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42CFR 431.10(e)]

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities

constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

34. For prescribed drugs, including specific North Dakota Medicaid covered non-legend drugs that are prescribed by an authorized prescriber and legend drugs prescribed by an authorized prescriber, North Dakota Medicaid will reimburse at the following lesser of methodology (in all instances, the professional dispensing fee will be $12.46):

    1. The usual and customary charge to the public, or
    2. North Dakota Medicaid's established Maximum Allowable Cost (MAC) for that drug plus the professional dispensing fee (ND Medicaid's MAC is acquisition cost based and includes all types of medications, including specialty and hemophilia products), or
    3. The current National Average Drug Acquisition Cost (NADAC) for that drug plus the professional dispensing fee, or if there is no NADAC for a drug, the current wholesale acquisition cost (WAC) of that drug plus the professional dispensing fee; In compliance with 42 Code of Federal Regulations (C.F.R.) 447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.
    4. For 340B purchased drugs, the lesser of logic will include the 340B MAC pricing (ceiling price) plus the professional dispensing fee.
        a. Covered entities as described in section 1927 (a)(5)(B) of the Social Security Act are required to bill no more than their actual acquisition cost plus the professional dispensing fee.
        b. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered, unless the State approves an exception.
    5. All Indian Health Service, tribal and urban Indian pharmacies are paid the encounter rate by ND Medicaid regardless of their method of purchasing.
    6. For Federal Supply Schedule purchased drugs, their provider agreements will require them to bill at no more than their actual acquisition cost plus the professional dispensing fee.
    7. Drugs not distributed by a retail community pharmacy (such as a long-term care facility) will be reimbursed as outlined in items 1-6 above and 8-13 below in this section.
    8. Drugs not distributed by a retail community pharmacy and distributed primarily through the mail (such as specialty drugs) will be reimbursed as outlined in items 1-7 above and 9-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.
    9. Clotting factors from Specialty Pharmacy, Hemophilia Treatment Centers (HTC), Center of Excellence will be reimbursed as outlined in items 1-8 above and 10-13 below in this section since ND Medicaid's MAC is acquisition cost based and includes all types of drugs.

10. Drugs acquired at Nominal Price (outside of 340B or FSS) will be reimbursed at no more than the actual acquisition plus the professional dispensing fee while also using the logic as outlined in items 1-9 above and 11-13 below in this section.
11. For Physician Administered Drugs, reimbursement will be the lesser of the Medicare Fee Schedule and all of the logic as outlined in items 1-10 above in this section (with the exception of the professional dispensing fee being included in the calculations). . For Physician Administered Drugs without NADAC or MAC or a Medicare rate, reimbursement will be the lesser of the WAC or the invoice price. No professional dispensing fee will be paid for Physician Administered Drugs.
12. In accordance with 12a.2. of Attachment to Page 5 of Attachment 3.1-A and 12a.2. of Attachment to Page 4 of Attachment 3.1-B investigational drugs will not be allowed for payment.
13. 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.
14. In-state prospective payment system hospitals will be reimbursed for Physician Administered Drugs according to Attachment 4.19-B, item 1.b. Item 4 methodology will apply to these hospitals for 340b purchased drugs. No professional dispensing fee will be paid for 340b purchased drugs in this section.
15. For Federally Qualified Health Centers, prescribed drugs are reimbursed as part of the encounter rate.
16. For out-of-state hospitals, prescribed drugs are reimbursed at the percentage of charges specific to the individual hospital. Prescribed drugs that are considered outside of the normal payment (i.e. high-cost outliers as negotiated between the state agency and the provider) will be paid as outlined in number 11 above.
17. For pharmacy claims that are eligible for invoicing and where other insurance is primary and the other insurance paid more than the state agency's allowed amount as defined above, the state agency will pay up to a maximum of $25 to help make the pharmacy whole.

Section 34 – Nursing Facility Incentive Program

North Dakota Medicaid-certified nursing facilities with Medicaid paid days and with at least ten months of operation in the prior federal fiscal year may be eligible for a Nursing Facility Incentive Program supplemental payment. A nursing facility that has announced that they are closing will not be eligible for the supplemental payment.

Nursing facilities performance in quality measures will be assessed annually over the prior federal fiscal year. Each nursing facility will be awarded a total sum of points based on selected quality measures that are all from publicly reported data and then placed in one of four tiers.

The quality measures are available on the North Dakota Department of Health and Human Services website at the following address: ~~https://www.hhs.nd.gov/nursing-facility-incentive-program~~https://www.hhs.nd.gov/healthcare/medicaid/provider/long-term-care/nfip

~~The base daily incentive rate will be calculated by dividing the total funds of eight million dollars by the total number of eligible nursing facility Medicaid paid days in the prior federal fiscal year. The base incentive payment will be calculated by multiplying the daily incentive rate times by each nursing facility's eligible Medicaid paid days for the prior federal fiscal year.~~
The daily incentive rate per Medicaid day will be calculated by weighting the number of Medicaid days in tiers one, two, and three with respective values of one hundred percent, eighty-five percent, and sixty percent. The total weighted days will then be divided into eight million dollars resulting in a weighted daily incentive rate. The incentive payment will be calculated by multiplying the weighted daily incentive rate times by each nursing facility's eligible Medicaid paid days for the prior federal fiscal year.

For incentive payments made prior to June 30, 2024: the total funds will be four million dollars and the time period of the eligible nursing facility Medicaid paid days will be April 1, 2023 to September 30, 2023.

~~Base incentive~~ Incentive payments will be distributed as follows:

- Nursing facilities in tier 1 will receive 100% of their ~~base~~ incentive payment.
- Nursing facilities in tier 2 will receive 85% of their ~~base~~ incentive payment.
- Nursing facilities in tier 3 will receive 60% of their ~~base~~ incentive payment.
- Nursing facilities in tier 4 are not eligible for an ~~base~~ incentive payment.

~~Any dollars not distributed in the base incentive payment will be distributed in a secondary payment as follows:~~

- ~~20% will be paid to nursing facilities in tier 1 based on their eligible Medicaid paid days for the base incentive payment.~~
- ~~80% will be paid to nursing facilities in tier 1 and tier 2 based on their eligible Medicaid paid days for the base incentive payment.~~

~~Total incentive payments will be the sum of the base incentive payments and the secondary payments.~~ Incentive payments will be made annually by June 30 following the end of the federal fiscal year. Incentive payments will not exceed the total funds.

Complete details including data sources and details on the four tiers are available on the North Dakota Department of Health and Human Services website at the following address: ~~https://www.hhs.nd.gov/nursing-facility-incentive-program~~https://www.hhs.nd.gov/healthcare/medicaid/provider/long-term-care/nfip

This supplemental payment is for state governmental, nonstate governmental and private ownership categories. The supplemental payment established in accordance with this provision may not exceed the difference between the nursing facility Medicaid expenditures and the Medicare upper payment limit, in the aggregate, for nursing facility services, as defined in 42 CFR 447.272.