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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-09-007

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

APR - 7 2010

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

Re: North Dakota 09-007

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-007. Effective for services on or after April 30, 2009, this amendment modifies the methodology to North Dakota's reimbursement section. Specifically, this amendment adds language that provides for a supplemental payment for skilled nursing facilities with less than 31 beds that are owned and operated by a unit of government.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) 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 09-007 is approved effective April 30, 2009. The HCFA-179 and the amended plan page are attached.

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

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and State Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **09-007** 2. STATE: **North Dakota** 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 **April 30, 2009**

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 447.272**	7. FEDERAL BUDGET IMPACT: a. FFY 2009 $ 70,655 b. FFY 2010 $ 181,336
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D, Sub-section 1, Page 67**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D, Sub-section 1, Page 67**

10. SUBJECT OF AMENDMENT:

Amends the ND State Plan to make changes to skilled nursing facility reimbursement

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 Maggie Anderson, Director, Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	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: **April 30, 2009**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 30 2009	[redacted]
21. TYPED NAME: William Lasowski	Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179(07-92) *Instructions on Back*

Section 33 – Supplemental Payment Rates for Non-State Government Owned and Operated Nursing Facilities:

North Dakota nursing facilities with a licensed capacity under 31 beds that are owned and operated by a unit of government (county or municipality) may also receive a supplemental payment for costs in excess of the costs that are included in the established rate for nursing facility care.

To qualify for a supplemental payment, a nursing facility must have costs that result in established rates exceeding the limits applied in accordance with the state plan. The state shall determine a supplemental payment rate for the rate weight of one based on the rate calculated for a facility's inflated prospective costs prior to application of any limits for the rate year less the facility's reimbursement rate for the rate weight of one that is otherwise established in accordance with the state plan governing Medicaid nursing facility reimbursement.

The supplemental payment rate established in accordance with this provision will be the difference between the nursing facility's Medicaid per diem cost per day for the rate weight of one, increased by the adjustment factor identified in Section 24 and the Medicaid nursing facility per diem rate for the rate weight of one established in accordance with the state plan. The supplemental payment will be paid in a lump sum on a quarterly basis for each Medicaid day of care provided during the previous quarter. The Medicaid days of care will be multiplied times the supplemental payment rate in effect for the quarter for which the Medicaid days are reported. The supplemental payment rate must also comply with the Medicare upper payment limit at 42 CFR 447.272.

New facilities requesting and receiving a supplemental payment rate in accordance with these provisions shall have an interim supplemental payment rate established. The interim supplemental payment rate will be subject to retroactive adjustment and settlement, following the same methodology used for the standard nursing facility rates as described in Section 28 – Special Rates.

Section 34- Vacated