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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



Center for Medicaid and State Operations, CMSO

Ms. Maggie D. Anderson, Director Division of Medical Services Department of Human Services 600 East Boulevard Avenue Department 325 Bismarck, ND 58505-0250 APR - 7 2010

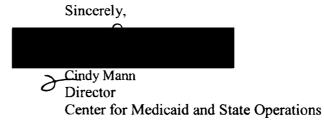
Re: North Dakota 09-007

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION	FORM APPROVED OMB NO. 0938-0193	
TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	09-007	North Dakota
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	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 <u>2009</u> \$ 70,655 b. FFY <u>2010</u> \$ 181,336	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
Attachment 4.19-D, Sub-section 1, Page 67	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	OTHER, AS SPECIFIED: delegated to	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	Maggie Anderson, Director, Medical Services Division	
12 SIGNATURE OF STATE ACENCY OFFICIAL. 16. RETURN TO:		
13. TYPED NAME:	Maggie D. Anderson, Director	
Maggie D. Anderson	Division of Medical Services	
14. TITLE:	ND Department of Human Services	
Director, Division of Medical Services	Bismarck ND 58505-0250	Sept 325
April 30, 2009	Defination IND 58505-0250	
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23 REMARKS		

STATE: North Dakota

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

TN No. <u>09-007</u> Supersedes TN No. <u>99-001</u> Approval Date APR - 7 2010

Effective Date: 4-30-2009