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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-11-009

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 , CHIP, and Survey & Certification

AUG 18 2011

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 11-009

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-009. Effective for services on or after July 1, 2011, this amendment modifies the State plan to clarify the inflation factor used in a PRTF rate setting.

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 11-009 is approved effective July 1, 2011. The HCFA-179 and the amended plan page are attached.

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

Sincerely,

Cindy Mann
Director, CMCS

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: **11-009**

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: **July 1, 2011**

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 Part 455, Subpart D**

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ -0-
b. FFY 2012 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D, Subsection 3, Page 2**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D, Subsection 3, Page 2**

10. SUBJECT OF AMENDMENT:
Amends the State Plan to clarify the inflation factor used in PRTF rate setting.

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: Maggie D. Anderson, Director, Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: Maggie D Anderson

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

14. TITLE: **Director, Division of Medical Services**

15. DATE SUBMITTED: 6/23/2011

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: AUG 18 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL: Penny Thompson

21. TYPED NAME: PENNY THOMPSON

22. TITLE: DEPUTY DIRECTOR, CMCS

23. REMARKS:

5. The daily rate is established by dividing actual allowable costs plus an inflation factor of three percent.

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.