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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-14-002

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 & 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 SERVICES

SEP 03 2014

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

Re: North Dakota 14-002

Dear Ms. Schwab:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-002. Effective for services on or after January 1, 2014, this amendment updates the State plan to provide for a four percent inflationary rate increase for psychiatric residential treatment facilities (PRTFs).

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 (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 14-002 is approved effective January 1, 2014. The HCFA-179 and the amended plan pages are attached.

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

Sincerely,

[redacted]

Cindy Mann
Director

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: **1 4-002**

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: **January 1, 2014**

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 445 Part D

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 **$ 70,874**
b. FFY 2015 **$23,625**

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:
Identify the increase for PRTF Services for January 1, 2014

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:
[redacted]

13. TYPED NAME:
Maggie D. Anderson

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

15. DATE SUBMITTED:
February 20, 2014

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: SEP 03 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, Policy & Financial Mgt CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

5. The daily rate is established by dividing actual allowable costs plus an inflation factor of four percent by in-house census days.

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.