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## Table of Contents

**State/Territory Name:** North Dakota

**State Plan Amendment (SPA) #:** ND-15-0006

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 AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD 21244-1850



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**Financial Management Group**

**NOV 18 2015**

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

Re: North Dakota 15-0006

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-0006. Effective for services on or after July 1, 2015, this amendment provides for updates to the supplemental payments for Intermediate Care Facilities (ICFs) for State Fiscal Year (SFY) 2016.



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 15-0006 is approved effective July 1, 2015. The HCFA-179 and the amended plan page are attached.

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

Sincerely,



Kristin Fan  
Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>15-0006</b>	2. STATE <b>North Dakota</b>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>July 1, 2015</b>	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  <b>42 CFR Part 447 Subpart C; 42 CFR 447.204</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2015</u> \$ <u>329,869</u> b. FFY <u>2016</u> \$ <u>1,319,476</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-D, Subsection 2, Page 31</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 4.19-D, Subsection 2, Page 31</b>	
10. SUBJECT OF AMENDMENT: <b>Amends the State Plan to update the supplemental payment for Intermediate Care Facilities.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <u>Maggie D. Anderson, Executive Director,</u> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <u>Department of Human Services</u>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  <b>Maggie D. Anderson, Executive Director ND Department of Human Services 600 East Boulevard Avenue Dept 325 Bismarck ND 58505-0250</b>	
13. TYPED NAME: <b>Maggie D. Anderson</b>			
14. TITLE: <b>Executive Director, ND Dept. of Human Services</b>			
15. DATE SUBMITTED: <b>August 26, 2015</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED		18. DATE APPROVED: <b>NOV 18 2015</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JUL 01 2015</b>		20. SIGNATURE: 	
21. TYPED NAME: <b>Kristina Fan</b>		22. TITLE: <b>Deputy Director, HCFA</b>	
23. REMARKS			

**Section 22 – Supplemental Payment for Intermediate Care Facility (ICF) Providers**

North Dakota ICF providers that provide services to one or more individuals who meet state adopted criteria thresholds for being behaviorally challenging or medically fragile shall receive a supplemental payment for costs in excess of the budgeted costs that are included in the interim rate for ICF care.

The state shall provide a supplemental payment to each ICF provider based on a total ICF supplemental allotment of 2,638,952 for the period ending June 30, 2016. The allotment to each ICF provider for the supplemental payment is based on the number of individuals, receiving services during May 2015 identified as meeting the state adopted criteria for being behaviorally challenged or medically fragile using the Oregon Assessment tool, times the per client allotment amount calculated by dividing the total amount appropriated for the state fiscal year by the total number of clients statewide who meet the criteria and are receiving any developmental disability services.

The supplemental payment will be paid per quarter beginning July 1, 2015 at the rate of 25% of each provider’s allotment. Supplemental payments received must be offset to allowable salary costs in accordance with Section 12(3)(i) of this subsection when the final rate for the provider is established. The supplemental payment must also comply with the Medicare upper payment limit at 42 CFR 447.272.

The provider allotments for the period ending June 30, 2016 are:

4th Corporation	\$20,620
ABLE, Inc.	\$59,044
Alpha Opportunity	\$8,902
Anne Carlsen Center	\$1,279,868
Development Homes, Inc.	\$98,554
Enable, Inc.	\$177,584
Fraser, Ltd.	\$182,250
Friendship, Inc.	\$207,961
Housing, Industry, Training, Inc.	\$187,193
Lake Region Corporation	\$15,933
Minot Vocational Adjustment Workshop	\$62,333
Open Door Center	\$122,916
Opportunity Foundation	\$22,964
Red River Human Services Foundation	\$21,093
REM-North Dakota	\$155,333
Tri-City Cares, Inc.	\$,16,406