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**State/Territory Name:** North Dakota

**State Plan Amendment (SPA) #:** ND-17-0007

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  
1961 Stout Street, Room 08-148  
Denver, CO 80294



**Region VIII**

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March 31, 2017

Maggie Anderson, Medicaid Director  
Division of Medical Services  
North Dakota Department of Human Services  
600 East Boulevard Avenue, Dept. 325  
Bismarck, ND 58505-0250

RE: North Dakota #17-0007

Dear Ms. Anderson:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 17-0007. This amendment amends the State Plan to update the designee for State Plan submissions.



Please be informed that this State Plan Amendment was approved March 31, 2017 with an effective date of January 1, 2017. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Kirstin Michel at (303) 844-7036.

Sincerely,



Richard C. Allen  
Associate Regional Administrator  
Division for Medicaid & Children's Health Operations

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>17-0007</b>	2. STATE <b>North Dakota</b>
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>January 1, 2017</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 430.12(b)</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2017</u> \$ <u>0</u> b. FFY <u>2018</u> \$ <u>0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Page 89</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Page 89</b>	
10. SUBJECT OF AMENDMENT: <b>Amends the State Plan to update the designee for State Plan submissions.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <u>Maggie D. Anderson, Director,</u> <u>Medical Services Division</u>	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>Maggie D. Anderson, Director Medical Services Division 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>Director, Medical Services Division</b>			
15. DATE SUBMITTED: <b>February 22, 2017</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>February 22, 2017</b>		18. DATE APPROVED: <b>March 31, 2017</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>January 1, 2017</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Richard C. Allen</b>		22. TITLE: <b>ARA, DMCHO</b>	
23. REMARKS:			

Revision: CMS-PM-91-4 (BPD)  
August 1991

OMB No. 0938-

State/Territory: North Dakota

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare & Medicaid Services with such documents.

Not applicable. The Governor --

Does not wish to review any plan material.

Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

North Dakota Department of Human Services, Medical Services Division  
(Designated Single State Agency)

Date: February 22, 2017

Maggie D Anderson  
(Signature)

Director, Medical Services  
(Title)

TN No. 17-0007 Approval Date 3/31/2017 Effective Date 01/01/2017

Supersedes TN No. 94-017

CMS ID: 7982E