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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-17-0009

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

SEP 29 2017

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 17-0009

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D and 4.19-C of your Medicaid State plan submitted under transmittal number (TN) 17-0009. Effective for services on or after April 1, 2017, this amendment provides for updates to the intermediate care facility reimbursement methodology. Specifically, this amendment provides for a payment provision for disaster related evacuation(s).

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 17-0009 is approved effective April 1, 2017. The CMS-179 and the amended plan pages are attached.

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

Sincerely,

[redacted]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **17-0009**

2. STATE: **North Dakota**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **April 1, 2017**

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 and 42 CFR 447.40

7. FEDERAL BUDGET IMPACT:
a. FFY **2017** **$ 0**
b. FFY **2018** **$ 0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19 – C Page 1
Attachment 4.19-D, Subsection 2, page 32

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19 – C Page 1
NEW

10. SUBJECT OF AMENDMENT:

Amends the North Dakota State Plan to allow for an evacuation related payment for Intermediate Care Facilities.

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:
[redacted]

13. TYPED NAME:
Maggie D. Anderson

14. TITLE:
Director, Medical Services Division

15. DATE SUBMITTED:
March 27, 2017

16. RETURN TO:

Maggie D. Anderson, Director
Medical Services Division
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 29 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMC

23. REMARKS:

FORM CMS-179 (07-92)

SECTION 23: Intermediate Care Facility – Evacuation Related Payments

For facilities evacuated in a disaster, the state agency shall make payments to evacuated facilities based on actual allowable costs incurred by the evacuating facilities as a result of the disaster, including payments made to receiving facilities for the care of evacuated residents. The allowable cost for payments made by an evacuating facility to a receiving facility shall be the lesser of actual payments to the receiving facility or fifty percent of the receiving facility's daily rate, less the property component of the rate. The allowable cost for payments made by an evacuating facility to a critical access hospital shall be the lesser of actual payments made to the critical access hospital or fifty percent of the evacuated facility rate in effect during the period of the evacuation. The evacuating facility will continue to receive the daily rate for the evacuated residents.

For clients evacuated during a disaster that may choose to shelter with family or guardians, the state agency may waive the 30-day limit on therapeutic leave of absences as defined in Attachment 4.19-C, Page 1.

Payments made under this provision will not exceed, in the aggregate, the upper payment limit as defined under 42 CFR 447.272. For the purposes of the upper payment limit calculation, a resident day shall only be counted once for any day that an evacuated resident is not in the evacuating facility but is in another location.

STATE: North Dakota

A. Payment for a reserved bed is made:

1. For a recipient absent from a nursing facility:

    a. 15 days maximum for periods of inpatient hospitalization, and

    b. 24 days, per rate year, maximum for therapeutic leave of absences.

2. For a recipient absent from an intermediate care facility for individuals with intellectual disabilities:

    a. 15 days maximum for periods of inpatient hospitalization, and

    b. 30 days, per calendar year, maximum for therapeutic leave of absences.