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**State/Territory Name:** North Dakota

**State Plan Amendment (SPA) #:** ND-09-023

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



**Center for Medicaid and State Operations, CMSO**

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

DEC 17 2009

Re: North Dakota 09-023

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-023. Effective for services on or after July 1, 2009, this amendment modifies the reimbursement methodology to North Dakota's inpatient hospital reimbursement section. Specifically, this amendment provides for a supplemental payment to qualifying Prospective Payment System (PPS) hospitals.

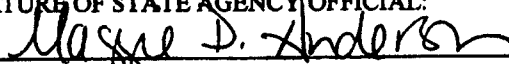
We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-023 is approved effective July 1, 2009. 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

Center for Medicaid and State Operations

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>09-023</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, 2009</b>	
5. TYPE OF PLAN MATERIAL (Check One): <input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>42CFR447 subpart C</b>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2009</u> \$ <u>997,208</u> b. FFY <u>2010</u> \$ <u>3,930,180</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-A, Page 8 (new)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: <b>Amends the State Plan to provide for a supplemental payment to PPS hospitals.</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: <b>Maggie D. Anderson, Director, Medical Services Division</b>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>Maggie D. Anderson, Director Division of Medical Services 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, Division of Medical Services</b>			
15. DATE SUBMITTED: <b>September 29, 2009</b>			

17. DATE RECEIVED		18. EFFECTIVE DATE OF APPROVAL	
19. PLAN APPROVED - ONE COPY ATTACHED		20. SIGNATURE OF REGIONAL ADMINISTRATOR	
21. TYPED NAME		22. SIGNATURE OF REGIONAL ADMINISTRATOR	
23. REMARKS			

**Supplemental Payment for Inpatient Hospital Services provided by Hospitals paid using PPS.**

Effective July 1, 2009, North Dakota hospitals that are paid a PPS rate for inpatient hospital services shall receive a supplemental payment payable quarterly with the first payment being made no sooner than the quarter ending December 31, 2009 and the final payment being made no later than the quarter ending September 30, 2015.

To qualify for a supplemental payment, a hospital's interim cost-to-charge ratio payable for outpatient services must be less than the hospital's cost-to-charge ratio in effect June 30, 2009.

The annual supplemental payment shall not exceed the percentage shown below for each fiscal year times the hospital's Medicaid operating costs for inpatient services as of June 30, 2007.

The annual supplemental payment made in accordance with this provision shall not exceed the difference between the hospital's inpatient Medicaid expenditures and the Medicare upper payment limit for the hospital.

Fiscal Year	Maximum Supplemental Payment Percentage
2010	30%
2011	25%
2012	20%
2013	15%
2014	10%
2015	5%