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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-16-0005

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



Financial Management Group

MAY 16 2016

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 16-0005

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-0005. Effective for services on or after January 1, 2016, this amendment provides for a three percent inflationary increase for psychiatric residential treatment facility (PRTF) services. Please note that expenditures for PRTF services should be claimed on line 2A on the Form CMS-64 expenditure report.


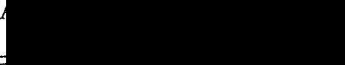

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 16-0005 is approved effective January 1, 2016. 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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 16-0005	2. STATE North Dakota
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		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 January 1, 2016	
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:		7. FEDERAL BUDGET IMPACT: a. FFY <u>2016</u> \$ <u>108,090</u> b. FFY <u>2017</u> \$ <u>144,120</u>	
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, 2016			
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: Maggie D. Anderson, Executive Director, Department of Human Services			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Maggie D. Anderson, Executive Director ND Department of Human Services 600 East Boulevard Avenue Dept 325 Bismarck ND 58505-0250	
13. TYPED NAME: Maggie D. Anderson			
14. TITLE: Executive Director, Department of Human Services			
15. DATE SUBMITTED: March 24, 2016			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: MAY 16 2016	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: IAN 01 2016		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: 		22. TITLE: Director, FMC	
23. REMARKS:			

5. The daily rate is established by dividing actual allowable costs plus an inflation factor of three percent by in-house census days effective for dates of service January 1, 2016.
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.