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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-17-0018

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

DEC 13 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 17-0018

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 17-0018. Effective for services on or after July 1, 2017, this amendment extends the supplemental payment provision for critical access hospitals (CAHs) through December 31, 2019.

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 17-0018 is approved effective July 1, 2017. The HCFA-179 and the amended plan page are attached.

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

Sincerely,

A black rectangular box redacting the signature of Kristin Fan.

Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: <div style="text-align: center; font-size: 1.2em;">17-0018</div>	2. STATE <div style="text-align: center; font-size: 1.2em;">North Dakota</div>
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <div style="text-align: center; font-size: 1.2em;">July 1, 2017</div>	
5. TYPE OF PLAN MATERIAL (Check One): <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT </div> <div style="text-align: center; font-size: 0.8em;"> COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) </div>			
6. FEDERAL STATUTE/REGULATION CITATION: <div style="text-align: center; font-size: 1.1em;">42 CFR 447 subpart C</div>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2017</u> \$ <u>0</u> b. FFY <u>2018</u> \$ <u>753,335</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <div style="text-align: center; font-size: 1.1em;">Attachment 4.19-A, page 9</div>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <div style="text-align: center; font-size: 1.1em;">Attachment 4.19-A, page 9</div>	
10. SUBJECT OF AMENDMENT: Amends the State Plan to update the supplement payment for Critical Access Hospitals.			
11. GOVERNOR'S REVIEW (Check One): <div style="display: flex; justify-content: space-between;"> <div> <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 </div> <div> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <u>Maggie D. Anderson, Director,</u> <u>Medical Services Division</u> </div> </div>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: <div style="background-color: black; width: 100%; height: 20px;"></div>		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	
13. TYPED NAME: <div style="text-align: center; font-size: 1.1em;">Maggie D. Anderson</div>		17. DATE RECEIVED: <div style="text-align: center; font-size: 1.1em;">SEP 01 2017</div>	
14. TITLE: <div style="text-align: center; font-size: 1.1em;">Director, Medical Services Division</div>			
15. DATE SUBMITTED: <div style="text-align: center; font-size: 1.1em;">September 20, 2017</div>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: DEC 13 2017	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: center; font-size: 1.1em;">JUL 01 2017</div>		20. SIGNATURE OF REGIONAL OFFICIAL: <div style="background-color: black; width: 100%; height: 20px;"></div>	
21. TYPED NAME: <div style="text-align: center; font-size: 1.1em;">Kristin FAN</div>		22. TITLE: <div style="text-align: center; font-size: 1.1em;">Director, FMS</div>	
23. REMARKS:			

Supplemental Payment for Inpatient Hospital Services provided by Critical Access Hospitals.

Effective July 1, 2017, a North Dakota critical access hospital shall receive three supplemental payments payable with the first payment being made no sooner than the quarter ending March 31, 2018 but not later than the quarter ending June 30, 2018, the second payment being made no sooner than the quarter ending September 30, 2018 but no later than the quarter ending December 31, 2018 and the third payment being made no sooner than the quarter ending March 31, 2019 but no later than the quarter ending June 30, 2019. The supplemental payment shall be made in combination with the cost settlement to reasonable costs.

The purpose of the supplemental payments is to provide additional payment to qualifying hospitals for inpatient services provided to Medicaid eligible individuals. The calculation of the supplemental payment shall be made based on the hospital's costs for inpatient and outpatient laboratory and certified registered nurse anesthetists services provided to Medicaid eligible individuals as reported on the hospital's most recent Medicare cost report that has been audited and finalized by the Medicare fiscal intermediary less the payment, from all funding sources, received during the same cost report period for covered laboratory and certified registered nurse anesthetist services provided to Medicaid eligible individuals.

The supplemental payment established in accordance with this provision may not exceed the difference between the inpatient Medicaid expenditures and the Medicare upper payment limit (UPL), in the aggregate, for inpatient hospital services, as defined in 42 CFR 447.272. If a payment is made during the first, second or third quarter of the state fiscal year (SFY), it will not exceed 25, 50 or 75 percent of the available UPL, respectively. If the payment amount is not paid in its entirety due to its exceeding the UPL availability for any given quarter, then the remainder not paid during that quarter will be paid in the following quarter, up to the available UPL room left for the SFY. Qualifying providers are exempt from the cost limitations on page 2 of this section.