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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 18-0001

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
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

JUN 05 2018

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 18-0001

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0001. Effective for services on or after April 1, 2018, this amendment provides for updates to the intermediate care facility for individuals with intellectual disabilities (ICF/IID) reimbursement methodology. Specifically, this amendment transitions from a retrospective, cost-based reimbursement system to a client-focused, fee for service system.

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 18-0001 is approved effective April 1, 2018. 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: **18-0001**	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, 2018**	

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:	7. FEDERAL BUDGET IMPACT:
42 CFR Part 447.272, 42 CFR 456.360	a. FFY 2018 $ 0.00 b. FFY 2019 $ 0.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Subsection 2, Page A **Attachment 4.19-D, Subsection 2, Pages 1 - 38** **Attachment 3.-1.A Page 7** **Section 4.14(d) Page 49** **Section 4.14(e) Page 50** **Attachment 4.14-A Page 1**	**Attachment 4.19-D, Subsection 2, Page A** **Attachment 4.19-D, Subsection 2, Page i through 33; A1–A4; B1-B4; and C1-C6** **Attachment 3.-1.A Page 7** **Section 4.14(d) Page 49** **Section 4.14(e) Page 50** **Attachment 4.14-B Page 1**

10. SUBJECT OF AMENDMENT:

Amends the State Plan to update the payment methodology for Intermediate Care Facilities, and updates pages related to Utilization Review.

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]	16. RETURN TO:
13. TYPED NAME: **Maggie D. Anderson**	**Maggie D. Anderson, Director** **Medical Services Division** **ND Department of Human Services** **600 East Boulevard Avenue Dept 325** **Bismarck ND 58505-0250**
14. TITLE: **Director, Medical Services Division**	
15. DATE SUBMITTED: 6-1-2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUN 05 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMC.

23. REMARKS:

Vacated

Rate Setting for Intermediate Care Facilities

Section 1 - Definitions

In this chapter, unless the context or subject matter requires otherwise:

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Administrative cost" means those costs that are necessary to operate the business but are not client related.

3. "Allowable cost" means the program's actual and reasonable cost after appropriate adjustments for nonallowable costs, income, offsets, and limitations.

4. "Assessment score" means the client score from the standard assessment tool administered by the department or its designee.

5. "Bad debts" means those amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing covered services that are eligible for reimbursement through Medicaid federal financial participation.

6. "Basic services" means all of the services that providers deliver to clients, including services that are not specific to an intellectual or developmental disability.

7. "Board" means all food and dietary supply costs.

8. "Capital asset" means a facilities building, land improvements, fixed equipment, movable equipment, lease hold improvements, and all additions to or replacements of those assets used for client care.

9. "Client" means an individual eligible for services coordinated through developmental disabilities program management on whose behalf services are provided or purchased.

10. "Client authorized representative" means a person designated as a guardian for the client.

11. "Client representative" means a parent, client authorized representative, or relative, to the third degree of kinship, of an individual with an intellectual or developmental disability.

12. "Community contribution" means a contribution to a civic organization or sponsorship of community activities. Community contribution does not include a donation to a charity.

13. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

14. "Day Habilitation" means a day program of scheduled activities, formalized training, and staff support to promote skill development for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

15. "Department" means North Dakota Department of Human Services.

16. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

17. "Depreciable asset" means a capital asset or other asset for which the cost must be capitalized for statement of costs purposes.

18. "Depreciation guidelines" means the American Hospital Association's guidelines as published by American Hospital Publishing, Inc., in the most recently published "Estimated Useful Lives of Depreciable Hospital Assets."

19. "Direct care staff" means employees who are actively providing support to clients receiving a service from a provider.

20. "Direct care wage" means the wage level that is used as the basis of the payment system.

21. "Direct program support costs" means costs that are specific to the service provision of a client, including medical and program supplies.

22. "Documentation" means the furnishing of written records including, original invoices, contracts, time cards, and work papers prepared to complete reports or for filing with the department.

23. "Employment related expenses" means employee benefits including federal Insurance Contributions Act, unemployment insurance, medical insurance, workers' compensation, retirement, disability, long-term care insurance, dental, vision, life, accrued paid time off, and unrecovered medical costs furnished at the provider's cost.

24. "Employment support" means ongoing supports to assist a client in maintaining paid employment in an integrated setting. Services are designed for clients who need intensive ongoing support to perform in a work setting. Service includes on-the job or off-the-job employment-related support for clients needing intervention to assist them in maintaining employment, including job development. Employment support includes individual employment support and small group employment support.

25. "Facility-based" means a facility for individuals with intellectual or developmental disabilities licensed by the department to provide day services. This definition is not to be construed to include areas of the building determined by the department to exist primarily for nontraining.

26. "Fair market value" means value at which an asset could be sold in the open market in an arms-length transaction between unrelated parties.

27. "Fixed equipment" means equipment used for client care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

28. "Generally accepted accounting principles" means the accounting principles approved by the American Institute of Certified Public Accountants.

29. "Historical cost" means those costs incurred and recorded on the facility's accounting records as a result of an arms-length transaction between unrelated parties.

30. "Hospital leave day" means any day that a client is not in the facility, but is in an acute care setting as an inpatient and is expected to return to the facility. A hospital leave day is only available to clients residing in an intermediate care facility for individuals with intellectual disabilities.

31. "Interest" means the cost incurred with the use of borrowed funds.

32. "In-house client day" means a day that a client was actually receiving services in the intermediate care facility and was not on therapeutic leave, in the hospital, or absent.

33. "Indirect program support costs" means costs that are neither direct care nor administrative, such as program development, supervision and quality assurance, and are not separately billable.

34. "Intermediate care facility for individuals with intellectual disabilities" means a residential health facility operated pursuant to title 42, Code of Federal Regulations, parts 442 and 483, et seq.

35. "Land improvements" means any improvement to the land surrounding the facility used for client care and identified as such in the depreciation guidelines.

36. "Life-changing event" means a change in a client's life that will affect his or her support needs for six months or more, including a significant medical event, a crisis situation, a change in living arrangement, aging caregiver, significant medical or behavioral health event in the life of a caregiver, significant change in family functioning, or trauma.

37. "Medical assistance program" means the program which pays the cost of health care provided to eligible clients pursuant to North Dakota Century Code chapter 50-24.1.

38. "Movable equipment" means moveable care and support services equipment generally used in a facility, including equipment identified as major moveable equipment in the depreciation guidelines.

39. "Net investment in fixed assets" means the cost, less accumulated depreciation and the balance of notes and mortgages payable.

40. "Person-centered service plan" means an individual plan that identifies service needs of the eligible client, the services to be provided, and is developed by the developmental disabilities program manager and the client or client authorized representative, or both, considering all relevant input.

41. "Prevocational services" means formalized training, experiences, and staff supports designed to prepare clients for paid employment in integrated community settings. Services are structured to develop general abilities and skills that support employability in a work setting. Services are not directed at teaching job-specific skills, but at specific habilitative goals outlined in the client's person-centered service plan.

42. "Program support" means the direct and indirect program support costs that support providing services to client.

43. "Program support staff" means employees whose duties are associated with client care but who are not actively providing direct support services to consumers receiving a service from a provider agency.

44. "Property costs" means the cost category for allowable costs to operate the owned or leased property.

45. "Provider agency" means the organization or individual who has executed a Medicaid agreement with the department to provide services to individuals with intellectual or developmental disabilities.

46. "Rate Matrix" means the standard fee schedule established by the department which is utilized to determine the final per diem rate based on the standardized assessment score.

47. "Reasonable cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

48. "Related organization" means an organization which a provider agency is, to a

significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider agency. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the action or policies of an organization or institution.

49. "Relief staff" means the replacement of direct care staff when the regular direct care staff are on leave and there is a cost component in the direct care hourly rate that covers the cost of relief staff.

50. "Residential services" means services provided in an intermediate care facility for individuals with intellectual disabilities.

51. "Room" means the cost associated with the provision of shelter, housekeeping staff or purchased housekeeping services and the maintenance thereof, including depreciation and interest or lease payments of a vehicle used for transportation of residents.

52. "Service" means the provision of living arrangements and programs of daily activities subject to licensure by the department.

53. "Staff training" means an organized program to improve staff performance.

54, "Statement of Costs" means the department prescribed form used by approved providers for reporting all costs.

55. "Statement of costs year" means the fiscal year from July first through June thirtieth.

56. "Standardized Assessment Tool" means the Inventory for Clients and Agency Planning assessment for clients age birth through fifteen and Supports Intensity Scale assessment for clients age sixteen and older.

57. "Therapeutic leave day" means any day that a client is not in the intermediate care facility for individuals with intellectual disabilities, nursing facility, swing-bed facility, transitional care unit, sub-acute unit, another intermediate care facility for individuals with intellectual disabilities, a basic care facility, or an acute care setting, or if not in an institutional setting, is not receiving home and community based waiver services and is expected to return to the facility. A therapeutic leave day is only available to clients residing in an intermediate care facility for individuals with intellectual disabilities.

58. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

59. "Units of service" for billing purposes means:

a. In residential services, one client served for one 24-hour day;

b. In day habilitation, prevocational and employment service, one client served for one 15 minute unit; and

The day of admission and the day of death, but not the day of discharge, are treated as a day served for residential services.

60. "Vacancy" means an opening in residential services where a consumer has not been admitted. A vacancy can occur when a client leaves a residence with no intent to return, or in a residence that has capacity for more clients than those who are currently living in the facility.

Section 2 - Application

This subsection of the state plan will be applied to providers of services to individuals with intellectual or developmental disabilities, except distinct parts of state institutions for individuals with intellectual or developmental disabilities which are certified as intermediate care facilities for individuals with intellectual or developmental disabilities, starting the first day of a facility's first fiscal year which begins on or after July 1, 1985; provided, however, that neither this section, nor the effective date, shall preclude the application and implementation of some or all of the provisions of this chapter through contract or through official statements of department policy. Specific sections of this plan will be applied to services provided in distinct parts of state institutions certified as intermediate care facilities for individuals with intellectual disabilities. The applicable sections are section 1; section 2; subsection 1, 4, and 5 of section 3; section 4; subsections 8 through 12 of section 5; section 7; section 8; section 9; subsections 1 through 10, 12 through 19, 21 through 29, 32, 34 through 37, 40, 42 through 44, 46 through 48, and 50 through 52 of section 10; section 11; and sections 12 through 17.

Payment to state-government operated intermediate care facilities will be based on the cost of delivery of the service as determined by the single state agency from cost data submitted annually by the facility. Allowable costs will be determined in accordance with the MEDICARE PROVIDER REIMBURSEMENT MANUAL. Annual cost-settlement shall be required to ensure state-government facilities are paid no more than cost.

Section 3 - Eligibility for Payment

Provider agencies of service are eligible for payment for the costs of rendered services contingent upon the following:

1. The provider agency, other than a state owned or operated provider agency, is required to hold a current valid license, issued pursuant to the provisions of the Department authorizing the delivery of the service.

2. The provider agency's clients have on file with the department a current person

centered service plan.

3. The provider agency has a current valid provider agency agreement with the Department.

4. The provider agency adopts and uses a system of accounting prescribed by the Department.

5. The provider agency participates in the financial audit, program audit and other review processes established by the Department.

6. The provider agency is in compliance with all documentation requirements as prescribed by the Department.

7. Provider agency, as a condition of eligibility for payment for services provided to individuals with intellectual or developmental disabilities shall accept, as payment in full, sums paid in accordance with the final established rate of payment.

Section 4 - Financial Reporting Requirements

1. Records

   a. The provider agency shall maintain on the premises the required census records and financial information sufficient to provide for a proper state and federal audit or review. Data must be available for any cost on the statement of costs as of the audit date to fully support the statement item.

   b. Where several programs are associated with a group and their accounting and reports are centrally prepared, additional fiscal information must be submitted for costs, undocumented at the reporting facility, with the statement of costs or provided prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost.

   c. Each provider agency shall maintain, for a period of not less than six years following the date of submission of the statement of costs to the department, financial and statistical records of the period covered by such statement of costs which are accurate and in sufficient detail to substantiate the cost data reported. If an audit has begun, but has not been finally resolved, the financial and statutory records relating to the audit must be retained until final resolution. Each provider agency shall make such records available upon reasonable demand to representatives of the department or to the secretary of health and human services or representatives thereof.

2. Census Records

   a. Adequate census records for all clients regardless of payer source, must be prepared and maintained on a daily basis by the provider agency to allow for proper audit of the census data. The daily census records must include:

(1) Identification of the client;

(2) Entries for all days that services are offered including the duration of service, and not just by exception; and

(3) Identification of type of day, i.e., hospital or in-house client day.

b. A maximum of fifteen days per occurrence may be allowed for payment by the medical assistance program for hospital leave day in an intermediate care facility for individuals with intellectual disabilities. Hospital leave days in excess of fifteen consecutive days are not billable to the medical assistance program.

c. A maximum of thirty therapeutic leave days per client per calendar year may be allowed for payment by the medical assistance program in an intermediate care facility for individuals with intellectual disabilities. Therapeutic leave days in excess of thirty per calendar year are not billable to the medical assistance program, except as provided for on page 38 of Attachment 4.19-D Subsection 2.

3. Accounting and Reporting Requirements.

a. The accounting system must be double entry.

b. The basis of accounting for reporting purposes must be accrual in accordance with generally accepted accounting principles. Rate setting procedures shall prevail if conflicts occur between rate setting procedures and generally accepted accounting principles.

c. To properly facilitate auditing, the accounting system must be maintained in such a manner that cost accounts will be grouped by cost center and be readily traceable to the statement of costs.

d. A provider who offers intermediate care facility for individuals with intellectual disabilities services may have an independent certified public accountant or the department may complete an audit of provider agency during the statement of costs year of each year to ensure the provider agency is in compliance with applicable state and federal regulations.

e. For each provider agency that choose to have an independent certified public accountant complete a department compliance audit report in compliance with state and federal regulations, shall provide to the department no later than October first of each year:

(1) A statement of costs for the statement of cost year on forms prescribed by the department that will be distributed to enrolled providers.

(2) A copy of an audited report of the provider agency's financial records from an independent certified public accountant. The audit must be conducted in accordance with generally accepted auditing standards. The information must be reconciled to each provider agency's statement of costs and must include:

(a) A statement of assets and liabilities;

(b) An operations statement;

(c) A statement disclosing contract income and consumer wages;

(d) A statement of consumer fees or payments and their distribution including private pay individuals;

(e) A statement of the assets and liabilities of any related organizations;

(f) A statement of ownership for the provider agency, including the name, address, and proportion of ownership of each owner;

[1] If a privately held or closely held corporation or partnership has an ownership interest in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the provider agency's statement of costs must be identified regardless of the proportion of ownership interest; or

[2] If a publicly held corporation has an ownership interest of fifteen percent or more in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of fifteen percent or more;

(g) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the provider agency's facilities or a certification that the content of the document remains unchanged since the most recent statement given pursuant to this subsection;

(h) Supplemental information reconciling the costs on the financial

statements with costs on the statement of costs; and

(i) Independent audit report must comply with this chapter and follow:

[1] Medicare and Medicaid guidance and provider reimbursement manual;

[2] Government auditing standards;

[3] North Dakota Century Code chapters 25-01.2 and 25-04;

[4] Title 2, 42 and 45 Code of Federal Regulations, American institution of certified public accountants, financial accounting standards board, and government accounting standards board rules and regulations; and

[5] All other applicable state and federal regulations.

(3) The following information upon request by the department:

(a) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs;

(b) Audited financial statements for any home or corporate office organization, excluding individual intellectual or developmental disabilities provider agencies of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year; and

(c) Audited financial statements for every organization that the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year.

f. For each provider agency that choose not to have an independent certified public accountant complete a department compliance audit report in compliance with state and federal regulations, shall provide to the department no later than October first of each year:

(1) A statement of costs for the statement of cost year on forms prescribed

by the department that will be distributed to enrolled providers;

(2) Except for state-owned facilities and provider agencies that do not have an independent audit completed annually, a copy of an audited report of the provider agency's financial records from an independent certified public accountant. The audit must be conducted in accordance with generally accepted auditing standards. The information must be reconciled to each provider agency's statement of costs;

(3) A statement of assets and liabilities;

(4) An operations statement;

(5) A statement disclosing contract income and consumer wages;

(6) A statement of consumer fees or payments and their distribution including private pay individuals;

(7) A statement of the assets and liabilities of any related organizations;

(8) A statement of ownership for the provider agency, including the name, address, and proportion of ownership of each owner;

(a) If a privately held or closely held corporation or partnership has an ownership interest in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed in the provider agency's statement of costs must be identified regardless of the proportion of ownership interest; or

(b) If a publicly held corporation has an ownership interest of fifteen percent or more in the provider agency, the provider agency shall report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of fifteen percent or more;

(9) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the provider agency's facilities or a certification that the content of the document remains unchanged since the most recent statement given pursuant to this subsection;

(10) Supplemental information reconciling the costs on the financial statements with costs on the statement of costs; and

(11) The following information upon request by the department:

(a) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services claimed as allowable costs;

(b) Audited financial statements for any home or corporate office organization, excluding individual intellectual or developmental disabilities provider agencies of a chain organization owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year; and

(c) Audited financial statements for every organization that the facility conducts business and is owned in whole or in part by an individual or entity that has an ownership interest in the facility, together with supplemental information that reconciles costs on the financial statements to costs for the report year.

g. A statement of costs must contain the actual costs, adjustments for non-allowable costs, and units of service. The mailing of a statement of costs by registered mail, return receipt requested, ensures documentation of the filing date.

h. Adjustments made by the audit unit, to determine allowable cost, though not meeting the criteria of fraud or abuse on their initial identification, may, if repeated on future cost filings, be considered as possible fraud or abuse.

i. The provider agency shall make all adjustments, allocations, and projections necessary to arrive at allowable costs. The department may reject any statement of costs when the information filed is incomplete or inaccurate. If a statement of costs is rejected, the department may reduce the current payment rate to ninety-five percent of its most recently established rate until the information is completely and accurately filed.

4. Auditing. In order to properly validate the accuracy and reasonableness of cost information reported by the provider agency, the department shall provide for audits as necessary.

a. A provider agency shall submit its statement of costs by October 1 of the statement of costs year.

b. A provider agency may request, and the department may grant, one thirty-day extension of the due date of the statement of costs for good cause.

(1) In the event a provider agency fails to file the required statement of costs on or before the due date, the department may reduce the current payment rate to ninety-five percent of its most recently established rate.

(2) Reinstatement of the rate must occur on the first of the month beginning after receipt of the required information, but is not retroactive.

c. The preliminary audit report shall be submitted to the provider agency no later than six months after the department receives the provider agency's statement of costs. The provider agency shall be notified by facsimile transmission or electronic mail.

d. The provider agency may submit information, within fifteen days after notification to explain why the provider agency believes the desk adjustment is incorrect. The Department shall review the information and make appropriate adjustments.

e. The final audit report shall be submitted to the provider agency within sixty days of the department's receipt of the provider agency's response.

f. Provider agencies shall submit requests for information and responses to the department in writing. In computing any period of time prescribed or allowed in this subsection, the day of the act, event, or default from which the designated period of time begins to run may not be included. The last day of the period so computed must be included, unless it is a Saturday, a Sunday or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. In determining whether the deadlines described in subsections c, d, or e, have been met, the department may not count any day that sufficient information has not been timely provided by a provider agency when the provider agency has shown good cause for its inability to provide the required information within the time periods prescribed in any one of those subsections.

5. Penalties for False Reports

a. A false report is when a provider agency knowingly supplies inaccurate or false information in a required statement of costs and supporting documentation that results in inaccurate costs.

b. If a false report is received, the Department may:

(1) Place the provider agency's license on restricted status as defined in North Dakota Administrative Code;

(2) Terminate the department's agreement with the provider agency;

(3) Refer to law enforcement for investigation and prosecution under applicable state or federal law; or

(4) Use any combination of the foregoing actions.

Section 5 - Rate Payments

1. The direct care hourly rate and components for each service are issued in a rate matrix established by the department for services on or after April 1, 2018. The matrix is available at: http://www.nd.gov/dhs/services/disabilities/docs/rate-matrix.pdf

   The components are:

   a. The direct care hourly rate for intermediate care facilities for individuals with intellectual or developmental disabilities must include direct care wage, employment related costs, relief staff, administrative cost, and program support including room and board. Building depreciation and related interest costs will be calculated either by an established percentage, or if a facility is acquired or built after January 1, 2010, the provider agency may choose the actual depreciation and related interest costs relating to the facility for the life of the building to be added to the rate. For facilities acquired after January 1, 2010, subsection 3.c of section 12 must be followed in determining remaining useful life. After the depreciable life is complete the established percentage for building depreciation and related interest costs will be utilized.

   b. The direct care hourly rate for independent habilitation, day habilitation, prevocational services, individual employment supports and small group employment supports must include direct care wage, employment related expenses, relief staff, program support, and administrative costs.

2. For day habilitation, prevocational and individual and small group supported employment supports, the maximum authorized direct care staff hours for a client are:

   a. The direct care staff hours in a twenty-four hour period identified by the multiplier based on the department identified assessment score from the standard assessment tool.

   b. The sum of the authorized hours for the year for each of the above services will be multiplied by the rate matrix for each service to determine each

client's annual authorized individual budget. The individual budget may be managed directly by the client, client's authorized representative, or the provider agency.

c. The established payment must be calculated by multiplying the rate from the rate matrix times the direct care staff hours identified by the multiplier based on the client's assessment score from the standard assessment tool, except for residential services provided in an intermediate care facility for individuals with intellectual disabilities, for which the established rate shall be the sum of all services identified for the client.

3. Base Staffing Rate:

a. A provider agency shall receive a base staffing rate when opening a new intermediate care facility for individuals with an intellectual disabilities, including prior to title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] certification and survey requirements.

b. A base staffing rate must be calculated to ensure staffing is available to provide active treatment twenty four hours per day. If the assessment score hours for the clients initially residing in the home are below the staffing levels needed to provide this level of staffing, the difference in hours will be considered the amount needed to establish the base staffing rate.

c. A base staffing rate is effective for an intermediate care facility for individuals with intellectual disabilities on the date it is licensed by the department.

d. A provider agency shall receive a base staffing rate until the setting is fully occupied or for three months, whichever comes first.

4. Vacancy:

a. An intermediate care facility for individuals with intellectual disabilities may receive a vacancy rate add-on in the event of a vacancy.

b. A provider agency shall request the vacancy rate add-on within fifteen days of the vacancy.

c. A vacancy rate add-on is available only for licensed intermediate care facilities for individuals with intellectual disabilities.

d. The vacancy rate add-on is calculated using the rate of the client who vacated the setting. The vacancy rate add-on is equally applied to all other client rates in the setting.

e. A provider agency shall receive a vacancy rate add-on until the vacancy is filled but shall not exceed three months.

5. Outliers:

If the client's medical or behavioral needs are higher than what the multiplier assigns based on the assessment score, the client's team may request outlier hours be approved for the client. If approved, additional staffing will be included in the individual budget for the client and will be part of the per diem.

6. Income from client production must be applied to client wages and the cost of production. The department will not participate in the gains or losses associated with client production conducted pursuant to the applicable provision of title 29 , Code of Federal Regulations, part 525.

7. No payments may be solicited or received by a provider from a client or any other person to supplement the established rate of payment.

8. The rate of payment established must be no greater than the rate charged to a private payor for the same or similar service.

9. Limitations:

a. The department shall accumulate and analyze statistics on costs incurred by provider agencies. Statistics may be used to establish reasonable ceiling limitations for needed services. Limitations may be established on the basis of cost of comparable facilities and services, or audited costs, and may be applied as ceilings on the overall costs, on the costs of providing services, or on the costs of specific areas of operations. The department may implement ceilings at any time, based upon the statistics available, or as required by guidelines, regulations, rules, or statutes.

b. The department shall review, on an ongoing basis, aggregate payments to intermediate care facilities for individuals with intellectual disabilities to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. If aggregate payments to facilities exceed estimated payments under Medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under Medicare payment principles.

c. Provider agencies may not be reimbursed for services, rendered to client, which exceed the rated occupancy of any facility as established by a fire prevention authority.

d. Provider agencies of residential services shall offer services to each client

three hundred sixty-five days per year, except for leap years in which three hundred sixty-six days must be offered. Provider agencies may not be reimbursed for those days in which services are not offered to consumer.

e. Provider agencies of day habilitation shall offer services to each client eight hours per day two hundred sixty days per year, except leap years in which two hundred sixty-one days must be offered, less any state-recognized holidays, unless a holiday exception is approved by the department. Provider agencies may not be reimbursed for hours of service in which the consumer is not in attendance.

f. Provider agencies of day habilitation to clients of intermediate care facilities for individuals with intellectual disabilities shall bill the intermediate care facility for individuals with intellectual disabilities the day habilitation rate established for the client.

10. Adjustments and review procedures are as follows:

a. Adjustments to the statement of costs may be made to correct errors. Statement of costs must be reviewed taking into consideration prior years' adjustments. The provider agency shall be notified by facsimile transmission or electronic mail of any adjustments based on the desk review. A provider agency may submit information, within fifteen days after notification, to explain why the desk adjustment is incorrect. The department shall review the information and make appropriate adjustments.

b. A provider agency may submit a request for reconsideration of the final statement of costs review in writing to the developmental disabilities division within fifteen days of the date of the final statement of costs review notification. A request for reconsideration must provide new evidence indicating why a new determination should be made or explain how the department has incorrectly interpreted the law.

c. A provider agency may appeal a decision within thirty days after mailing of the written notice of the decision on a request for reconsideration of the final review of the statement of costs.

Section 6 - Assessments

1. An assessment must be completed within ninety days for a client who has been determined eligible to receive intellectual or developmental disabilities services and is receiving a service that requires an assessment score to determine reimbursement. The assessment effective date is the first date the client began receiving a service.

2. A reassessment must be completed every thirty-six months for a client aged

sixteen or older or every twelve months for a client under age sixteen, or more frequently if a life-changing event occurs.

a. A reassessment based on a life-changing event may be requested by a client, a client authorized representative, or an employee of a provider agency. Requests for reassessment must be made in writing to the appropriate department regional office.

b. The assessment effective date is reset upon completion of a reassessment as a result of a life-changing event.

Section 7 – Cost Centers

The cost centers where direct and indirect costs are allocated on a provider agency's statement of costs may include:

1. Administration:

   a. Administration staff salaries and fringe benefits;

   b. Accreditation;

   c. Advertising and recruitment;

   d. Contracted services;

   e. Depreciation;

   f. Dues, subscriptions, and memberships;

   g. Home office costs;

   h. Other equipment not related to client care;

   i. Office supplies;

   j. Postage and freight;

   k. Printing;

   l. Employee travel;

   m. Employee training;

   n. Interest;

o. Maintenance supplies;

p. Rental of building;

q. Repairs;

r. Insurance;

s. Telephone and internet;

t. Utilities;

u. Property taxes and specials; and

v. Other costs not identified elsewhere.

2. Indirect program support costs:

a. Program support staff salaries and fringe benefits;

b. Consultants;

c. Employee travel;

d. Employee training;

e. Moveable equipment;

f. Other vehicle repair costs; and

g. Telephone, internet, and cable located in common areas of a residential setting or intermediate care facility for individuals with intellectual disabilities.

3. Provider agency shall disclose to the department direct care costs for staff that provide direct care and nursing services separately for the annual statement of costs. Costs shall only include:

a. Direct care staff salaries and fringe benefits; and

b. Contracted costs for services purchased to actively provide support to clients receiving a service from a provider agency.

4. Direct Program Support Costs:

a. Costs allowable for all services:

(1) Day habilitation pass through;

(2) Fixed equipment;

(3) Medical supplies;

(4) Program Supplies; and

(5) Vehicle repair costs for vehicles used to transport clients.

b. Additional costs only allowable for facility-based day habilitation:

(1) Household supplies;

(2) Housekeeping staff or purchased housekeeping services;

(3) Insurance;

(4) Interest;

(5) Transportation of clients;

(6) Vehicle purchase or lease;

(7) Vehicle depreciation;

(8) Rental of building;

(9) Utilities;

(10) Maintenance supplies;

(11) Property taxes and specials; and

(12) Repairs.

5. Room:

a. Depreciation;

b. Transportation of clients, including vehicle insurance and gas;

c. Vehicle depreciation or lease;

d. Interest;

e. Rental of building;

f. Repairs;

g. Insurance;

h. Utilities;

i. Property taxes and specials;

j. Household supplies;

k. Housekeeping staff or purchased housekeeping services, including lawn and snow removal services; and

l. Maintenance supplies.

6. Board:

a. Food; and

b. Dietary supplies.

7. Other Costs:

a. Other program or services; and

b. Production:

(1) Advertising;

(2) Client salaries and fringe benefits;

(3) Production materials; and

(4) Production supplies.

Section 8 - Statement of Cost Allocations

1. The statement of costs provides for the identification of the allowable expenditures and basic services subject to reimbursement by the department. Where costs are incurred solely for a basic service, the costs must be assigned directly to that

basic service. Where costs are incurred jointly for two or more basic services, and not able to be directly assigned, the costs must be allocated as follows:

a. Personnel. The total cost of all staff identified in payroll records must be listed by position title and distributed to basic services. Time studies may be performed for one week at least quarterly for allocation. Where no time studies exist, the applicable units must be used for allocation. Where there is no definition of a unit of service, the unit of service for residential services shall be used.

b. Fringe benefits. The cost of fringe benefits must be allocated to basic services based on the ratio of the basic service personnel costs to total personnel costs. Personnel costs on which no fringe benefits are paid are excluded.

c. Equipment. The total cost of all equipment, whether rented, leased, purchased, or depreciated, must be distributed to basic services based on usage or applicable units.

d. Real property cost. The total of all property costs, whether rented, leased, purchased, or depreciated, must be allocated based on direct square footage. Where multiple usage of direct use area occurs, the allocation is first done by square footage and then by applicable units.

e. Travel. The total of all unassigned travel costs must be included in administrative costs.

f. Supplies. The total of all unassigned supply costs must be included with administrative costs.

g. Food services. The total of all food costs must be allocated based on meals served. Where the number of meals served has not been identified, applicable units must be used.

h. Insurance and bonds. The total of all such costs except insurance costs representing real property costs or vehicle insurance costs applicable to vehicles used for one or more basic services, must be included as administrative costs.

i. Indirect program support costs. Total indirect program support costs, not including personnel and fringe benefits, must be allocated to basic service categories, exclusive of room, board and production, based on actual units of service. When determining the day habilitation ratio of indirect program support costs, total day habilitation units will be divided by eight and rounded to the nearest whole number.

j. Administrative costs. Total administrative costs must be allocated to all service categories, exclusive of room, board, and production, based upon the ratio of the basic service cost to total costs excluding administrative and production costs. The percentage calculated for residential services must

be based on total costs for training, room, and board for the specific residential service with the allocation made only to training.

Section 9 - Adjustment to Cost and Cost Limitation

1. Provider agencies under contract with the department to provide services to individuals with intellectual or developmental disabilities who provide intermediate care facilities for individuals with intellectual disabilities shall submit a statement of costs to the Department by October first of each year.

2. Provider agencies shall disclose all costs and all revenues.

3. Provider agencies shall identify income to offset costs where applicable in order that state financial participation not supplant or duplicate other funding sources. Income must be offset up to the total of appropriate allowable costs. If actual costs are not identifiable, income must be offset up to the total of costs described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each cost category. These sources, and the cost to be offset, must include the following:

   a. Fees, the cost of the service or time for which the fee was imposed excluding those fees based on cost as established by the department.

   b. Insurance recoveries income, costs reported in the current year to the extent of costs allowed in the prior or current year for that loss.

   c. Rental income, cost of space in facilities or for equipment included in the rate of reimbursement.

   d. Telephone and internet income from consumers, staff, or guests, cost of the service.

   e. Rental assistance or subsidy when not reported as third party income, total costs.

   f. Interest or investment income, interest expense.

   g. Medical payments, cost of medical services included in the rate of reimbursement as appropriate.

   h. Respite care income when received for a reserved bed cost.

   i. Other income to the provider agency from local, state, or federal units of government may be determined by the department to be an offset to cost.

4. Payments to a provider agency by its vendors are considered as discounts, refunds, or rebates in determining allowable costs under the program even though these payments may be treated as "contributions" or "unrestricted grants" by the provider agency and the vendor. However, such payments may represent a true donation or grant, and as such will not be offset against costs. Examples include, but are not limited to, when:

a. Payments are made by a vendor in response to building or other fundraising campaigns in which community wide contributions are solicited.

b. Payments are in addition to discounts, refunds, or rebates, which have been customarily allowed under arrangements between the provider agency and the vendor.

c. The volume or value of purchases is so nominal that no relationship to the contribution can be inferred.

d. The contributor is not engaged in business with the provider or a facility related to the provider agency.

5. If an owner or other official of a provider agency directly receives from a vendor monetary payments or goods or services for the owner's or official's own personal use as a result of the provider agency's purchases from the vendor, the value of such payments, goods, or services constitutes a type of refund or rebate and must be applied as a reduction of the provider agency's costs for goods or services purchased from the vendor.

6. Where the purchasing function for a provider agency is performed by a central unit or organization, all discounts, allowances, refunds, and rebates must be credited to the costs of the provider agency in accordance with the instructions above. These may not be treated as income of the central purchasing function or used to reduce the administrative costs of that function. Such administrative costs are, however, properly allocable to the facilities serviced by the central purchasing function.

7. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased. They must be used to reduce the specific costs to which they apply. If possible, they must accrue to the period to which they apply. If not, they will reduce costs in the period in which they are received. The reduction to cost for supplies or services must be used to reduce the total cost of the goods or services for all clients without regard to whether the goods or supplies are designated for all clients or a specific group.

   a. "Purchase discounts" include cash discounts, trade, and quantity discounts. "Cash discount" is for prepaying for paying within a certain time of receipt of invoice. "Trade discount" is a reduction of cost granted certain customers. "Quantity discounts" are reductions of price because of the size of the order.

   b. Allowances are reductions granted or accepted by the creditor for damage, delay, shortage, imperfection, or other cause, excluding discounts and refunds.

   c. Refunds are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or return purchases.

   d. Rebates represent refunds of a part of the cost of goods or services. Rebates differ from quantity discounts in that it is based on dollar value of

purchases, not quantity of purchases.

c. "Other cost-related income" includes amounts generated through the sale of a previously expensed item, e.g., supplies or equipment.

Section 10 - Nonallowable Costs

Nonallowable costs include:

1. Advertising designed to encourage potential consumers to select a particular provider agency.

2. Amortization of noncompetitive agreements.

3. Bad debt expense .

4. Barber and beautician services.

5. Basic research.

6. Fees paid to a member of a board of directors for meetings attended to the extent that the fees exceed the compensation paid per day to a member of the legislative council pursuant to North Dakota Century Code section 54-35-10.

7. Concession and vending machine costs.

8. Contributions or charitable donations.

9. Corporate costs, such as organization costs, reorganization costs, and other costs not related to client services.

10. Costs for which payment is available from another primary third party payor or for which the department determines that payment may lawfully be demanded from any source.

11. Costs of functions performed by clients in a residential setting which are typical of functions of any person living in their own home, such as keeping the home sanitary, performing ordinary chores, lawn mowing, laundry, cooking, and dishwashing. These activities shall be an integral element of an individual program plan consistent with the client's level of function.

12. Costs of donations or memberships in sports, health, fraternal or social clubs or organizations, such as Elks, YMCA, or country clubs.

13. Costs, including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to vendor.

14. Costs which are incurred by the provider agency's subcontractors, or by the lessor

of property which the provider agency leases, and which becomes an element in the subcontractor's or lessor's charge to the provider, if such costs would have not been allowable under this section had they been incurred by a provider agency directly furnishing the subcontracted services, or owning the leased property.

15. Depreciation on assets acquired with federal or state grants.

16. Education costs incurred for the provision of services to clients who are, could be, or could have been, included in a student census. Education costs do not include costs incurred for a client, defined as a "student with disabilities" by subsection 2 of North Dakota Century Code chapter 15.1-32, who is enrolled in a school district pursuant to an interdepartmental plan of transition.

17. Employee benefits not offered to all full-time employees.

18. Entertainment costs including activities.

19. Equipment costs for any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates to the satisfaction of the department that any particular use of the equipment was related to client services.

20. Expense or liabilities established through or under threat of litigation against the state of North Dakota or any of its agencies; provided, that reasonable insurance expense may not be limited by this subsection.

21. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, such as Lions, Chamber of Commerce, Kiwanis, in excess of $1,500 per statement of costs period.

22. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose.

23. Funeral and cemetery costs.

24. Goodwill.

25. Home office costs when unallowable if incurred by facilities in a chain organization.

26. Travel not directly related to industry conferences, state or federally sponsored activities, or client services.

27. Interest cost related to money borrowed for funding depreciation.

28. Items or services, such as telephone, television, and radio, which are located in a client's room and furnished primarily for the convenience of the clients.

29. Top management personnel insurance.

30. Laboratory salaries and supplies.

31. The cost of education unless:

    a. The education was provided by an accredited academic or technical educational facility;

    b. The costs were for materials, books, or tuition;

    c. The employee was enrolled in a course of study intended to prepare the employee for a position at the facility and is in a position; and

    d. The facility claims the cost of the education at a rate that does not exceed one dollar and twenty-five cents per hour of work performed by the employee in the position for which the employee received education at the provider agency's cost provided the amount claimed per employee may not exceed two thousand five hundred dollars per year or an aggregate of ten thousand dollars per employee and in any event may not exceed the cost to the facility of the employee's education.

32. Meals and food service in day service programs.

33. Membership fees or dues for professional organizations exceeding three thousand dollars in any statement of cost year.

34. Miscellaneous expenses not related to client services.

35. a. Except as provided in subdivisions b, c, and d payments to a member of the governing board of the provider agency, a member of the governing board of a related organization, or a family member of a member of those governing boards, including a spouse and an individual in the following relationship to a member or to a spouse of a member: parent, stepparent, child, stepchild, grand parent, step-grandparent, grandchild, step-grandchild, brother, sister, half-brother, half-sister, stepbrother, and stepsister.

    b. Payments made to a member of the governing board of the provider agency to reimburse that member for reasonable and actual costs incurred by that member in the conduct of the provider agency's business may be allowed.

    c. Payments for a service or product unavailable from another source at a lower cost may be allowed.

    d. Wages allowed are limited to those wages paid to a family member of a member of the board and the amount must be consistent with wages paid to anyone else who would hold the same or similar position and the position is such that if the family member were not to hold the position, the provider would hire someone else to do the job.

36. Penalties, fines, and related interest and bank charges other than regular service charges.

37. Personal purchases.

38. Pharmacy salaries.

39. Physician and dentist salaries.

40. a. For facility-based day habilitation programs, production costs, such as client salaries and benefits, supplies, and material representing unfinished or finished goods or products that are assembled, altered, or modified.

    b. For non-facility-based day habilitation programs, production costs, such as client salaries and benefits, supplies, and materials representing unfinished or finished goods or products that are assembled, altered, or modified, square footage, and equipment.

    c. For employment supports, in additional to subdivisions a and b, costs of employing clients, including preproduction and postproduction costs for supplies, materials, property, and equipment, and property costs other than an office, office supplies, and equipment for the supervisor, job coach, and support staff.

    d. Total production-related legal fees in excess of five thousand dollars in any fiscal period.

41. Religious salaries, space, and supplies.

42. Salary costs of employees determined by the department to be inadequately trained to assume assigned responsibilities, but where an election has been made to not participate in appropriate training approved by the department.

43. Salary costs of employees who fail to meet the functional competency standards established or approved by the department.

44. Travel of clients visiting relatives or acquaintances in or out of state.

45. Mileage reimbursement in excess of the standard mileage rate established by the state of North Dakota and meal reimbursement in excess of rates established by the General Services Administration for the destination city.

46. Undocumented expenditures.

47. Value of donated goods or services.

48. Vehicle and aircraft costs not directly related to provider business or client services.

49. X-ray salaries and supplies.

50. Alcohol and tobacco products.

51. Political contributions.

52. Salaries or costs of a lobbyist.

Section 11 – Allowable Bad Debt Expense

1. Bad debts for charges incurred on or after July 1, 2005, and fees paid for the collections of those bad debts are allowable only as provided in this section.

2. A bad debt expense must result from nonpayment of the payment rate for an individual who is no longer receiving services from the provider claiming the bad debt expense.

3. The provider must provide documentation to the department which verifies that the provider made reasonable collection efforts, the debt could not be collected, and there is no likelihood of future recovery. Reasonable collection efforts include maintaining written documentation that, in making those collection efforts, the provider received the assistance of an attorney licensed to practice law.

4. In no circumstance may the allowable expense for the collection fee exceed the amount of the bad debt.

5. A bad debt expense shall not be allowed when it resulted from the provider's failure to comply with any applicable laws or regulations.

6. Before any bad debt expense may be allowed, the provider must have a written policy that limits the potential for bad debts and the provider must provide written documentation that shows it has taken action to limit bad debts for individuals who refuse to or cannot make payments.

7. Allowable bad debt expense may not exceed debt associated with 120 days of services provided for any one individual.

8. Payments on outstanding accounts receivables shall be applied to the oldest invoices for covered services first, and then all subsequent charges until the balance is paid in full.

9. Allowable finance charges on bad debts described in this section are allowable only if the finance charges have been offset as interest income.

Section 12 - Depreciation

1. The principles of reimbursement for provider agency costs require that payment for services include depreciation on depreciable assets that are used to provide allowable services to clients. This includes assets that may have been fully or partially depreciated on the books of the provider agency, but are in use at the time the provider agency enters the program. The useful lives of these assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. Depreciation is recognized as an allocation of the cost of an asset over its estimated useful life.

If any depreciated personal property is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the statement of costs. The facility shall use the sale price in computing the gain or loss on the disposition of the assets.

2. Special assessments in excess of one thousand dollars paid in a lump sum must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as billed by the taxing authority.

3. Depreciation methods:

   a. The straight-line method of depreciation must be used. All accelerated methods of depreciation, including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, may not be used. The method and procedure for computing depreciation must be applied on a basis consistent from year to year and detailed schedules of individual assets must be maintained. If the books of account reflect depreciation different than that submitted on the statement of costs, a reconciliation must be prepared.

   b. For all assets obtained prior to August 1, 1997, depreciation will be computed using a useful life of ten years for all items except vehicles, which must be four years, and buildings, which must be twenty-five years or more. For assets other than vehicles and building obtained after August 1, 1997, a provider agency may use the American Hospital Association guidelines as published by the American Hospital Publishing, Inc., in "Estimated Useful Lives of Depreciable Hospital Assets," most recent edition, to determine the useful life or the composite useful life of ten years. Whichever useful life methodology is chosen, the provider may not thereafter use the other option without the department's prior written approval. A useful life of ten years must be used for all equipment not identified in the American Hospital Association depreciation guidelines.

   c. A provider agency acquiring assets as an ongoing operation shall use as a basis for determining depreciation:

      (1) The estimated remaining life, as determined by a qualified appraiser, for land improvements, buildings, and fixed equipment; and

      (2) (a) A composite remaining useful life for movable equipment, determined from the seller's records; or

          (b) The remaining useful life for movable equipment, determined from the seller's records.

4. Acquisitions are treated as follows:

   a. If a depreciable asset has, at the time of its acquisition, a historical cost of at least five thousand dollars, its cost must be capitalized and depreciated in accordance with subdivision b of subsection 2. Cost during the construction

of an asset, such as architectural, consulting and legal fees, interest, etc., should be capitalized as a part of the cost of the asset.

b. Major repair and maintenance costs on equipment or buildings must be capitalized if they exceed five thousand dollars per project and will be depreciated in accordance with subdivision b of subsection 2.

5. Proper records will provide accountability for the capital assets and other assets and also provide adequate means by which depreciation can be computed and established as an allowable client-related cost.

6. The basis for depreciation is the lower of the purchase price or fair market value at the time of purchase. In the case of a trade-in, fair market value will consist of the sum of the book value of the trade-in plus the cash paid.

7. For the depreciation and reimbursement purposes, donated depreciable assets may be recorded and depreciated based on their fair market value. In the case where the provider agency's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal must be made. An appraisal made by a recognized appraisal expert will be accepted for deprecation.

8. No provision shall be made for increased costs due to the sale of a facility.

Section 13 - Interest Expense

1. In general:
   a. To be allowable under the program, interest must be:

      (1) Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required;

      (2) Identifiable in the provider agency's accounting records;

      (3) Related to the reporting period in which the costs are incurred;

      (4) Necessary and proper for the operation, maintenance, or acquisition of the provider agency's facilities used therein;

      (5) Unrelated to funds borrowed to purchase assets in excess of cost or fair market value; and

      (6) When borrowed for the purpose of making capital expenditures for assets that were owned by any other hospital, facility, or service provider agency on or after July 18, 1984, limited to that amount of interest cost which such hospital, facility, or service provider may have reported, for rate setting purposes, had the asset undergone neither refinancing nor a change of ownership.

   b. In such cases where it was necessary to issue bonds for financing, any bond premium or discount must be accounted for and written off over the life of the bond issue.

2. Interest paid by the provider agency to partners, stockholders, or related organizations of the provider agency is not allowable as a cost.

3. A provider agency may combine or "pool" various funds in order to maximize the return on investment. Where funds are pooled, proper records must be maintained to preserve the identity of each fund in order to permit the earned income to be related to its source. Income earned on gifts and grants does not reduce allowable interest expense.

4. Funded depreciation requirements are as follows:

   a. Funding of depreciation is the practice of setting aside cash or other liquid assets to be used for replacement of the assets depreciated or for other capital purposes. This provision is recommended as a means of conserving funds for the replacement of depreciable assets. It is expected that the funds will be invested to earn revenues. The revenues generated by this investment will not be considered as a reduction of allowable interest expense provided such revenues remain in the fund.

   b. The deposits are, in effect, made from the cash generated by the noncash expense depreciation and do not include interest income. Deposits to the funded depreciation account are generally in an amount equal to the depreciation expense charged to costs each year. In order to qualify for all provisions of funding depreciation, the minimum deposits to the account must be fifty percent of the depreciation expensed that year. Deposits in excess of accumulated depreciation are allowable: however, the interest income generated by the "extra" deposits will be considered as a reduction of allowable interest expense.

   c. Monthly or annual deposits representing depreciation must be in the funded depreciation account for six months or more to be considered as valid funding transactions. Deposits of less than six months are not eligible for the benefits of a funded depreciation account. However, if deposits invested before the six-month period remain in the account after the six-month period, the investment income for the entire period will not reduce the allowable interest expensed in that period. Total funded depreciation in excess of accumulated depreciation on client-related assets will be considered as ordinary investments and the income therefrom will be used to offset interest expense.

   d. Withdrawals for the acquisition of capital assets, the payment of mortgage principal on these assets and for other capital expenditures are on a first-in, first-out basis.

   e. The provider agency may not use the funds in the funded depreciation account for purposes other than the improvement, replacement, or expansion of facilities or equipment replacement or acquisition related to client services.

   f. Existing funded depreciation accounts must be used for all capital outlays in

excess of one thousand dollars except with regard to those assets purchased exclusively with donated funds or from the operating fund, provided no amount was borrowed to complete the purchase. Should funds be borrowed, or other provisions not be met, the entire interest for the funded depreciation income account will be offset up to the entire interest expense paid by the facility for the year in question.

Section 14 - Related Organization

1. Costs applicable to services, facilities, and supplies furnished to a provider agency by a related organization shall not exceed the lower of the cost to the related organization or the reasonable costs of services, facilities, or supplies purchased elsewhere primarily in the local market. Provider agencies must identify such related organizations and costs in the statement of costs. An appropriate statement of cost and allocations must be submitted with the statement of costs. For cost reporting purposes, management fees will be considered administrative costs.

2. A chain organization consists of a group of two or more service provider agencies which are owned, leased, or through any other device, controlled by one business entity.

3. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a chain is normally not a provider agency in itself, it may furnish to the individual provider agency, central administration or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services is includable in the provider agency's allowable costs under the program. Any services provided by the home office which are included in cost as payments to an outside provider agency will be considered a duplication of costs and not be allowed.

4. If the home office makes a loan to or borrows money from one of the components of a chain organization, the interest paid is not an allowable cost and interest income is not used to offset interest expense.

5. Payments, to related organizations, by the provider agency shall be limited to the actual and reasonable cost of the service received or the product purchased.

6. Provider agency shall document financial transactions between the provider agency and the related organization. The terms of such transactions must be similar as those obtained by a prudent buyer negotiating at arm's length with a willing and knowledgeable seller.

Section 15 - Rental Expense Paid to a Related Organization

1. A provider agency may lease a facility from a related organization within the meaning of the principles of reimbursement. In such a case, the rent paid to the lessor by the provider agency is not allowable as a cost. Provider agency's rent payments shall not exceed the actual cost of mortgage payments of principal and

interest. The cost of ownership of the facility would, however, be an allowable cost to the provider agency. Generally, these would be costs such as depreciation, interest on the mortgage, real estate taxes, and other property expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider agency. Therefore, the owner's equity in the leased assets is includable in the equity capital of the provider agency.

2. In order to be considered an allowable cost, the home office cost must be directly related to those services performed for individual provider agencies and relate to client services. Documentation as to the time spent, the services provided, the hourly valuation of services and the allocation method used must be available to substantiate the reasonableness of the cost.

Section 16 - Taxes

1. General.

   a. Taxes assessed against the provider agency, in accordance with the levying enactments of the several states and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax cost may not include fines, penalties, or those taxes listed in subsection 2.

2. The following taxes are not allowable as costs:

   a. Federal income and excess profit taxes, including any interest or penalties paid thereon.

   b. State or local income and excess profit taxes.

   c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfers of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

   d. Taxes from which exemptions are available to the provider.

   e. Special assessments in excess of $1,000 paid in a lump sum must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as billed by the taxing authority.

   f. Taxes on property which is not used in the provision of covered services.

   h. Taxes including sales taxes levied against clients and collected and remitted by the provider agency.

   i. Self-employment (FICA) taxes applicable to persons including individual proprietors, partners, or members of a joint venture.

Section 17 - Personal Incidental Funds

1. Each client is allowed to retain a specific monthly amount of income for personal needs. This monthly allowance is not to be applied toward the client's cost of care.

2. Provider agencies managing client funds must maintain a current client account record in a form and manner prescribed by the department. Copies of the client account record must be provided to the client without charge.

3. The department may conduct audits of client account records in conjunction with regular field audits.

4. The department uses the amount of a client's income to determine:

   a. Eligibility for medical assistance benefits.

   b. Amount of income and other resources which must be applied toward the client's care.

   c. Amount of income and other resources which can be retained by the client.

5. Charges by the program for items or services furnished to clients will be allowed as a charge against the client or outside sources, only if the items or services are not included in the payment rate as routine items and services and separate charges are also recorded by the facility for all clients receiving these items or services directly from the program. All such charges must be for direct, identifiable services or supplies furnished an individual client. A periodic "flat" charge for routine items, such as beverages or incidentals will not be allowed. Charges may be made only after services are performed or items are delivered, and charges are not to exceed charges to all classes of clients for similar services.

6. If client funds are deposited in a bank, they must be deposited in an account separate and apart from any other bank accounts of the facility. Any interest earned on this account will be credited to the applicable client's accounts.

7. Failure to properly record the receipt and disposition of personal incidental funds will constitute grounds for suspension of provider agency payments.

8. Client personal incidental funds must not be expended for the purchases of meals served in licensed day habilitation/employment supports and pre-vocation service programs nor may the purchase of such meals be a condition for admission to such programs.

SECTION 18: 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 limits on the payment for a reserved bed 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.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☒ Provided: ☒ No Limitations ☐ With Limitations*
☐ Not Provided

b. Including such services in a public institution (of distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No Limitations ☐ With Limitations*
☐ Not Provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No Limitations ☐ With Limitations*
☐ Not Provided

16.a. Limitations for Psychiatric Residential Treatment Facilities.

☒ Provided: ☐ No Limitations ☒ With Limitations*
☐ Not Provided

17. Nurse-midwife services.

☒ Provided: ☒ No Limitations ☐ With Limitations*
☐ Not Provided

18. Hospice care (in accordance with section 1905(o) of the Act.)

☒ Provided: ☒ No Limitations ☐ With Limitations*
☐ Not Provided ☒ Provided in accordance with section 2302 of the Affordable Care Act

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: North Dakota

Utilization Review Intermediate Care for Individuals with Intellectual Disabilities

1. Recipients in Intermediate Care Facilities with Intellectual Disabilities (ICF-IID) will be reviewed as follows:

A. Admission Review
A physician must certify initial ICF-IID admission. The physician may be facility-based or may be practicing outside of the facility.

B. Continued Stay Review
A physician, nurse practitioner or physician assistant will certify the need for continued care of each Medicaid recipient in an ICF/IID no later than twelve months after the date of admission review and at least every twelve months thereafter. The physician, nurse practitioner or physician assistant may be facility-based or may be practicing outside of the facility.

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State: North Dakota

OMB NO. 0938-0193

RESERVED

Revision: HCFA-PM-85-3 (BERC)
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State: North Dakota

OMB NO. 0938-0193

Citation		
42 CFR 456.2 50 FR 15312	4.14 ☒(e)	The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through: ☐ Facility-based review. ☐ Direct review by personnel of the medical assistance unit of the state agency. ☐ Personnel under contract to the medical assistance unit of the state agency. ☐ Utilization and quality control peer review organizations. ☒ Another method as described in ATTACHMENT 4.14-A. ☐ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used. ☐ Not applicable. Intermediate care facility services are not provided under this plan.