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State/Territory Name: North Dakota

State Plan Amendment (SPA) #: 20-0006

This file contains the following documents in the order listed:

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

June 22, 2020

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

Re: North Dakota 20-0006

Dear Ms. Knapp:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 20-0006. Effective for services on or after April 1, 2020, this amendment amends the state plan to update the reimbursement methodology specific to vacancies within an intermediate care facility for individuals with intellectual disabilities (ICF/IID)

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 20-0006 is approved effective April 1, 2020. 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]

Karen Shields
Acting 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: **20-0006**	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, 2020**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ **NEW STATE PLAN** ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **42 CFR Part 447.272; 42 CFR 456.360**	7. FEDERAL BUDGET IMPACT: a. FFY **2020** **$0** b. FFY **2021** **$0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D. Subsection 2, pages 4, 6, 7, 15, 16, 17, 23 & 24**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D. Subsection 2, pages 4, 6, 7, 15, 16, 17, 23 & 24**

10. SUBJECT OF AMENDMENT:
Amends the State Plan to update the reimbursement methodology regarding a vacancy for Intermediate Care Facility Services.

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:
Caprice Knapp, Director
Medical Services Division

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Caprice Knapp, Director** **Medical Services Division** **ND Department of Human Services** **600 East Boulevard Avenue Dept 325** **Bismarck ND 58505-0250**
13. TYPED NAME: **Caprice Knapp**	
14. TITLE: **Director, Medical Services Division**	
15. DATE SUBMITTED: **April 9, 2020**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 6/22/20
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/20	20[redacted]:
21. TYPED NAME: Karen Shields	22. TITLE: Acting Group Director

23. REMARKS:

FORM CMS-179 (07-92)

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 for individuals with intellectual disabilities setting 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.

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. Vacated.

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 an intermediate care facility for individuals with intellectual disabilities, 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 an intermediate care facility for individuals with intellectual disabilities.

60. "Vacancy factor" means a cost component of the rate intended to cover costs when a client is no longer in the setting, with no intent to return.

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

(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, 2020. 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, vacancy factor and program support including room and board. Program support may include extraordinary nursing consult, assessment, and intervention need that is separate from direct support hours and cannot be delegated to direct support staff. 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 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 intermediate care facilities for individuals with intellectual disabilities, day habilitation, prevocational and individual and small group supported employment supports, the maximum authorized assessment score hours for a client:

   a. Must be calculated by multiplying the rate from the rate matrix times the hours identified by the multiplier based on the client's assessment score from the standardized assessment tool, except for residential supports 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.

b. Vacated.

c. Vacated.

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. Vacated

e. Vacated.

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 intermediate care facilities for individuals with intellectual disabilities shall offer services to each client

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 department must use the unit of service for billing purposes.

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.

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: