Table of Contents

State/Territory Name: North Dakota

State Plan Amendment (SPA) #: ND-26-0010

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

August 13, 2026

Krista Fremming, Interim Medicaid Director
North Dakota Department of Health and Human Services
600 E Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

RE: North Dakota PACE State Plan Amendment (SPA) ND-26-0010

Dear Director Fremming:

The Centers for Medicare & Medicaid Services (CMS) completed the review of North Dakota's PACE SPA ND-26-0010, submitted on May 28, 2026. The purpose of this SPA is to revise the PACE rate development methodology to align with current state processes and federal requirements, and to relocate the Post-Eligibility Treatment of Income (PETI) election pages within the state plan using the updated preprint, without updating the election language.

We conducted our review of your submission according to statutory requirements in Title XIX of the Social Security Act and its implementing regulations. This letter is to inform you that North Dakota Medicaid PACE State Plan Amendment ND-26-0010 is approved with an effective date of July 1, 2026.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Kijhana.Glasco@cms.hhs.gov or (303) 844-7131.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations & Oversight

Enclosures

cc: Alice Hogan, CMS DHCBSO
Angela Cimino, CMS DHPC
Justin Myrowitz, CMS DHPC
LeeAnn Thiel, North Dakota
Jan Stokke, North Dakota
Jodi Hulm, North Dakota
Erik Elkins, North Dakota

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26-0010

2. STATE: ND

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 460

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment to Page 11 of Attachment 3.1-A, page 1;
Attachment to Page 10 of Attachment 3.1-B, page 1;
Supplement 3 to Attachment 3.1-A, pages 1-7;
Supplement 3 of Attachment 3.1-B, page 1;
Attachment 4.19-B, page 8

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment to Page 11 of Attachment 3.1-A, pages 1-7 (TN 08-017); Attachment to Page 10 of Attachment 3.1-B, pages 1-7 (TN 08-017); Supplement 3 to Attachment 3.1-A; Supplement 3 to Attachment 3.1-B (TN 21-0016); Attachment 4.19-B, page 8 (TN 07-007)

9. SUBJECT OF AMENDMENT
Amends the State Plan to update the PACE rate development methodology to align with current state processes and federal requi

10. 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:
Krista Fremming, Interim Director
Medical Services Division

11 SIGNATURE OF STATE AGENCY OFFICIAL
Krista Fremming

13. TITLE
Interim Medical Services Director

14. DATE SUBMITTED
January 26, 2026

15. RETURN TO
Krista Fremming, Interim Director
Medical Services Division
ND Department of Health and Human Services
600 East Boulevard Avenue Dept 325
Bismarck ND 58505-0250

FOR CMS USE ONLY

16. DATE RECEIVED
May 28, 2026

17. DATE APPROVED
August 13, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2026

19. SIGNATURE OF APPROVING

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations & Oversight

22. REMARKS

Instructions on Back

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

State: North Dakota

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State: North Dakota

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PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.
North Dakota Department of Health and Human Services, Division of Medical Services, 600 East Boulevard Avenue Dept 325, Bismarck, ND 58505-0250

I. Post Eligibility

A. Regular Post Eligibility

The state applies post-eligibility treatment of income rules to PACE participants who are eligible under section 1902(a)(10)(A)(ii)(VI) of the Act (42 C.F.R. §435.217 of the regulations). **Yes ____ No _X__**
Post-eligibility for states that have elected to apply the rules to PACE participants

Note: Section 2404 of the Affordable Care Act mandated that, for the five-year period beginning January 1, 2014, the definition of an "institutionalized spouse" in section 1924(h)(1) of the Social Security Act include all married individuals eligible for certain home and community-based services (HCBS), including HCBS delivered through 1915(c) waivers. As of this writing, the ACA provision has been extended through September 30, 2027. This means that married individuals eligible in the eligibility group described at 42 C.F.R. §435.217 must have their post-eligibility treatment-of-income rules determined under the rules described in section 1924(d). Because states that elect to apply post-eligibility treatment-of-income rules to PACE participants may only do so to the same extent the rules are applied to individuals eligibility under 42 C.F.R. §435.217, application of the post-eligibility treatment-of-income rules must be applied to married individuals receiving PACE services consistent with the provisions described herein under "Spousal post-eligibility" so long as the amendment to section 1924 of the Act made by the ACA remains in effect.

1. 1634 and SSI States

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.726, and, where applicable, section 1924 of the Act. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):
   1.The amount deducted is equal to:
   (a) _____The SSI federal benefit rate
   (b) _____Medically Needy Income Level (MNIL)
   (c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act
   (d) _____Percentage of the Federal Poverty Level: _____%

(e) _____Other (specify):_____
2._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3._____The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:
The amount deducted for the PACE enrollee's spouse is equal to:
1.____ The SSI federal benefit rate
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Level Standard
4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.726(c)(4).

2. 209(b) States

The State applies the post-eligibility rules to individuals who are receiving PACE services and are eligible under 42 C.F.R. §435.217 consistent with the rules of 42 C.F.R. §435.735, and, where applicable, section 1924 of the Act. Payment for PACE services

is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

1. Allowances for the maintenance needs of the individual (check one):
   1.The amount deducted is equal to:
      (a) _____The SSI federal benefit rate
      (b) _____Medically Needy Income Level (MNIL)
      (c) _____The special income level standard for the institutionalized individuals eligible under section 1902(a)(10)(A)(ii)(V) of the Act
      (d) _____Percentage of the Federal Poverty Level: _____%
      (e) _____Other (specify):_____
   2._____The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   3._____The following formula is used to determine the needs allowance:
   _____
   _____

Note: If the amount protected for a PACE enrollee in item 1 is equal to, or greater than, the PACE enrollee's income, enter N/A in items 2 and 3.

2. Allowance for the maintenance needs of the spouse:
   The amount deducted for the PACE enrollee's spouse is equal to:
   1.____ The more restrictive income standard established under 42 C.F.R. §435.121
   2.____ Optional State Supplement Standard
   3.____ Medically Needy Income Level Standard
   4.____ The following dollar amount (provided it does not exceed the amount(s) described in 1-3): $_____
   5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
   6.____ Not applicable (N/A)

3. Allowance of the maintenance needs of the family (check one):
   1.____ AFDC need standard
   2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

   3.____ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
   4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
   5.____ The amount is determined using the following formula:
   _____
   _____

6.____ Other
7.____ Not applicable (N/A)

4. Allowance for medical and remedial care expenses, as described in 42 CFR 435.735 (c)(4).

B. Spousal Post Eligibility

State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance consistent with the minimum monthly maintenance needs allowance described in section 1924(d), a family allowance, for each family member, calculated as directed by section 1924(d)(1)(C), and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.
Yes ____ No _X__

Note: states must elect the use the post-eligibility treatment-of-income rules in section 1924 of the Act in the circumstances described in the preface to this section.

(a.) Allowances for the needs of the:
1. Individual (check one)
(A).____The following standard included under the State plan (check one):
1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B).____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C)_____The following formula is used to determine the needs allowance:
_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:
_____
_____
_____
_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1._ _ Rates are set at a percent of the amount that would otherwise have been paid for a comparable population.
2.___ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3.___ Adjusted Community Rate (please describe)
4._X_ Other (please describe)

Development of the amounts that would otherwise have been paid (AWOP)

North Dakota uses an actuarial firm to calculate the AWOP for the population eligible for, but not enrolled in, the Program of All-Inclusive Care for the Elderly (PACE).

The PACE-comparable population is identified from Medicaid claims and eligibility data and includes individuals age 55 years and older who meet nursing home level of care, and includes:

a. Individuals residing in nursing homes on a long-term basis, and
b. Individuals meeting the nursing home level of care who receive services in a home and community-based setting.

Base data consists of the most recent and complete Medicaid claims and eligibility data available (within three years of the rating period). The data is validated for completeness and reasonableness and reflects all Medicaid-covered services for the PACE-comparable population. Only claims that were approved and paid are included.

AWOPs are developed by establishing appropriate rating cohorts and analyzing Medicaid claims data across categories of service (COS). The AWOPs are developed by establishing appropriate rate categories which may be based on factors such as age, geographic region, and eligibility status (i.e., dual eligible and Medicaid-only).

A series of adjustments are applied to the base data to project cost experience to the applicable rating period. These adjustments include, but are not limited to:

1. Completion factors for incurred but not reported (IBNR) claims;
2. Adjustments for changes in provider reimbursement (e.g. Nursing Facility, HCBS, FQHC, RHC, and other fee schedule updates);
3. Prospective trend assumptions to account for expected changes in utilization and unit cost;
4. Application of pharmacy rebates to reflect net drug costs;

5. Inclusion of costs paid outside the claims system where applicable (e/g/ critical access hospital cost settlements);
6. Third-party liability; and
7. An adjustment for State administrative costs associated with the FFS program.

The AWOPs reflect total Medicaid state plan expenditures and are calculated gross of patient liability.

After applying adjustments, separate per-member-per month (PMPM) costs are developed for institutional (nursing facility) and non-institutional (HCBS) populations. These costs are blended using the observed distribution of the PACE-comparable population to produce a single AWOP for each rate category. Regional and age factors are applied, where appropriate, to reflect cost variation across populations and geographic regions.

Final AWOPs are established prospectively for each twelve month rating period.

Determination of the PACE Capitation Rate

North Dakota establishes a PACE capitation rate for each rate cell. The final capitation rates are developed with consideration to both the AWOPs and projected PACE program costs, as well as the following:

1. Expected cost savings associated with the PACE model relative to the FFS delivery system by rate cell;
2. Benchmark against historical (as reported by PACE organization(s)) (PO) and projected financial and utilization experience;
3. Benchmark against combined HCBS and LTC reimbursement changes;
4. Rate negotiations between North Dakota and PO(s);
5. Benchmarking against other PACE programs, as appropriate.

A combination of the factors listed above are utilized to guide the State's selection of the PACE rate in each calendar year, which will be described in the rate certification submitted to CMS. North Dakota assures that the final rates will be set at amounts that are less than the corresponding AWOPs.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to CMS for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of

participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.
North Dakota Department of Health and Human Services, Division of Medical Services, 600 East Boulevard Avenue Dept 325, Bismarck, ND 58505-0250

Refer to Supplement 3 to Attachment 3.1-A for the specifics of post eligibility treatment of income.

State: North Dakota

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