DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

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

AUG 27 2009

Re: North Dakota 09-001

Dear Ms. Anderson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-001. Effective for services on or after January 1, 2009, this amendment modifies the reimbursement methodology to North Dakota's nursing facility reimbursement section. Specifically, this amendment updates rate limits and its base year cost reporting period to June 30, 2006; updates the per bed limitation basis; modifies the inflation trending factor; revises nursing costs to include cognitive impaired individuals; and, removes obsolete language.

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 09-001 is approved effective January 1, 2009. The HCFA-179 and the amended plan pages are attached.

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

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **09 – 001**	2. STATE **North Dakota**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2009**	

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 Subpart B 483.1**	7. FEDERAL BUDGET IMPACT: a. FFY **2009** $ 259,646 b. FFY **2010** $ 442,399
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D, Sub-section 1, Page "i", page 13, page 36 & 37, page 46, 47, 48 & 48a, and page A-1 (previously vacated).**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D, Sub-section 1, Page "i", page 13, page 36 & 37, page 46, 47, 48 & 48a, and page A-1 (previously vacated).**

10. SUBJECT OF AMENDMENT:

To include legislatively approved individuals in the nursing cost category; provide legislatively approved exception to the valuation basis of assets for certain facilities; reestablish the per bed limitation and limit rates as approved by the ND Legislative Assembly; and delete obsolete information.

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:	16. RETURN TO:
13. TYPED NAME: **Maggie D. Anderson**	**Maggie D. Anderson, Director** **Division of Medical Services** **ND Department of Human Services** **600 East Boulevard Avenue Dept 325** **Bismarck ND 58505-0250**
14. TITLE: **Director, Division of Medical Services**	
15. DATE SUBMITTED: **December 09, 2008**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 6-22-09
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2009	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

State: North Dakota

Attachment 4.19-D
Sub-section 1

Table of Contents

Section 7 - Direct Care Costs

Direct care costs include only those costs identified in this section.

1. Therapies:

   a. Salary and employment benefits for speech, occupational, and physical therapists or for personnel, who are not reported in subsection 2, performing therapy under the direction of a licensed therapist.

   b. The cost of non-capitalized therapy equipment or supplies used to directly provide therapy, not including office supplies such as forms or pens.

   c. Training which is required to maintain licensure, certification or professional standards and the related travel costs.

2. Nursing:

   a. Salary and employment benefits for the director of nursing, nursing supervisors, inservice trainers for nursing staff, registered nurses, licensed practical nurses, quality assurance personnel, certified nurse aides, individuals providing assistance with activities of daily living, individuals with a cognitive impairment who provide care-related services and who require the direction or supervision of a registered nurse in order to perform those services, and ward clerks.

   b. Routine nursing care supplies including items that are furnished routinely and relatively uniformly to all residents; items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities; and items used by individual residents that are reusable, vary by the needs of an individual, and are expected to be available in the facility.

   c. Training which is required to maintain licensure, certification or professional standards requirements and the related travel costs.

   d. Routine hair care, including grooming, shampooing, and cutting.

   e. The cost of noncapitalized wheelchairs.

purchaser has the burden of proving that the transaction was a bona fide sale. Purchases where the buyer and seller are related organizations are not bona fide.

(1) The cost basis of a facility and its depreciable assets acquired in a bona fide sale after October 1, 1985 is limited to the lowest of:

(a) Purchase price paid by the purchaser;

(b) Fair market value at the time of the sale; or

(c) The seller's cost basis, increased by one-half of the increase in the consumer price index for all urban consumers, United States city average, all items, from the date of acquisition by the seller to the date of acquisition by the buyer, less accumulated depreciation recognized for cost reporting purposes.

b. In a sale not bona fide, the cost basis of an acquired facility and its depreciable assets is the seller's cost basis, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer.

c. The cost basis of a facility and its depreciable assets acquired by donation or for a nominal amount is the cost basis of the seller or donor, less accumulated depreciation recognized for cost reporting purposes as of the end of the report year immediately preceding the date of acquisition by the buyer or donee.

d. In order to calculate the increase over the seller's cost basis, an increase may be allowed, under paragraph (c), only for assets with a historical cost basis established separately and distinctly in the seller's depreciable asset records.

e. The limitations of paragraph (c) shall not apply to the valuation basis of assets acquired as on ongoing operation between July 1, 1985 and July 1, 2000.

f. For purposes of this subsection, "date of acquisition" means the date when ownership of the depreciable asset transfers from the transferor to the transferee such that both are bound by the transaction. For purposes of transfers of real property, the date of acquisition is the date of delivery of the instrument transferring ownership. For purposes of titled personal property, the date of acquisition is the date the transferee receives a title acceptable for registration. For purposes of all other capital assets, the date of acquisition is the date the transferee possesses both the asset and an instrument, describing the asset, which conveys the property to the transferees.

7. An adjustment may not be allowed for any depreciable cost that exceeded the basis in effect for rate periods prior to January 1, 1996.

8. A per bed cost limitation based on single and double occupancy must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation or remodeling.

   a. The per bed limitation basis for double occupancy at July 1, 2008 is $92,423.

   b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by 1.34.

   c. The double and single occupancy per bed limitation must be adjusted annually on July 1 using the consumer price index for all urban consumers, United States city average, all items, for the twelve month period ending the preceding May 31.

   d. The per bed limitation in effect at the time a construction, renovation, or remodeling project is put in service must be multiplied times the number of beds in double and single occupancy rooms to establish the maximum allowable cost basis of buildings and fixed equipment.

   e. The cost basis of a facility's buildings and fixed equipment must be limited to the lower of the recorded cost of total facility buildings and fixed equipment or the per bed limitation.

   f. The per bed limitation is not applicable to projects started or approved by the state health council before July 1, 1994.

Section 24 - Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs

1. An appropriate economic change index may be used for purposes of adjusting historical costs for direct care, other direct care, and indirect care and for purposes of adjusting limitations of direct care costs, other direct care costs, and indirect care costs, but may not be used to adjust property costs.

2. For the rate year beginning January 1, 2009 the appropriate economic change index is five percent.

Section 25 - Rate Limits and Incentives

1. Limits - All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in Section 5 - Exclusions must be used to establish a limit rate for the Direct Care, Other Direct Care, and Indirect Care cost categories. The base year is the report year ended June 30, 2006. Base year costs may not be adjusted in any manner or for any reason not provided for in this section.

   a. The limit rate for each of the cost categories will be established as follows:

      (1) Historical costs for the report year ended June 30, 2006, as adjusted must be used to establish rates for all facilities in the Direct Care, Other Direct Care and Indirect Care cost categories. The rates as established must be ranked from low to high for each cost category.

      (2) For the rate year beginning January 1, 2009, the limit rate for each cost category is:

         (a) For the Direct Care cost category, $110.61;

         (b) For the Other Direct Care cost category, $21.29; and

         (c) For the Indirect Care cost category, $52.19.

      (3) For rate years beginning on or after January 1, 2010, the limit rate for each cost category is calculated based on the limit rate in effect for the previous rate year multiplied by the adjustment factor applicable to the rate year as determined in paragraph 1 of Section 24-Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs.

b. A facility which has an actual rate that exceeds the limit rate for a cost category will receive the limit rate.

2. The department will review, on an ongoing basis, aggregate payments to nursing facilities 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 nursing facilities exceed estimated payments under Medicare, the department will 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.

3. The department shall accumulate and analyze statistics on costs incurred by the nursing facilities. These statistics may be used to establish reasonable ceiling limitations taking into consideration relevant factors including resident needs, nursing hours necessary to meet resident needs, size of the nursing facility and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing facility.

4. The department shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs. For the rate year beginning January 1, 2009, the department shall establish limits for cost categories using the June 30, 2006, cost report year as the base period. The limit rates shall be the median rate plus 20 percent for the Direct Care cost category; the median rate plus 20 percent for the Other Direct care category; and the median rate plus 10 percent for the Indirect Care cost category. Until a new base period is established, the department shall adjust the limits annually by the adjustment factor set forth in Section 24 – Adjustment Factors for Direct Care, Other Direct Care and Indirect Care Costs and the limit rate for those rate years may not fall below the median rate for the cost category of the applicable cost report year.

5. For a facility with an actual rate below the limit rate for Indirect Care costs, an incentive amount equal to 70% times the difference between the actual rate, exclusive of inflation indices, and the limit rate, in effect at the end of the year immediately preceding the rate year, up to a maximum of $2.60, or the difference between the actual rate, inclusive of the adjustment factor and the limit rate for indirect care costs, whichever is less will be included as part of the Indirect Care cost rate.

6. A facility will receive an operating margin of 3% based on the lesser of the actual Direct Care and Other Direct Care rates, exclusive of inflation indices, or the limit rate, in effect at the end of the year immediately preceding the rate year. The 3% operating margin will then be added to the rate for the Direct Care and Other Direct Care cost categories.

7. The actual rate for indirect care costs and property costs must be the lesser of the rate established using:

   a. Actual census for the report year; or

   b. Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year:

      (2) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

8. The department may waive or reduce the application of paragraph 7 if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:

   a. The facility has reduced licensed capacity; or

   b. The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year which would be affected by subdivision d.