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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-11-002

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

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, CHIP, and Survey & Certification

Mary Dalton
Acting Medicaid Director
Department of Public Health and
Human Services
P.O. Box 4210
Helena, MT 59604-4210

DEC 14 2010

Re: Montana 11-002

Dear Ms. Dalton:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-002. Effective for services on or after October 1, 2010, this amendment modifies the State Fiscal Year (SFY) quarter in which supplemental DSH payments, continuity of care payments, and hospital reimbursement adjustment payments will be paid to eligible providers.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C. We are now ready to approve Medicaid State plan amendment TN 11-002 effective October 1, 2010. The HCFA-179 and the amended plan pages are attached.

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

Sincerely,

[redacted]

Cindy Mann
Director, CMSC

cc: Brett Williams, DPHHS

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: 11-002

2. STATE: Montana

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: 10/01/2010

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 447.272

7. FEDERAL BUDGET IMPACT:
a. SFY 11 ~~No Impact~~ 8.1 Million
b. SFY 12 ~~Budget Neutral~~ No Impact
Per ... by B. Stor

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 9-11 of Attachment 4.19A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages 9-11 of Attachment 4.19A

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to change the state fiscal year (SFY) quarter in which DSH payments, continuity of care payments, and hospital reimbursement adjustment payments will be paid to eligible providers.

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:

12. S[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 11-9-10

16. RETURN TO:
Montana Dept of Public Health and Human Services
Mary E. Dalton
Attn: Jo Thompson
PO Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 12-14-10

PLAN APPROVED - ONE [redacted]

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 1 - 2010

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

TOTAL P.01

Hospitals must be located within the borders of the state of Montana to be eligible for routine or supplemental disproportionate share payments.

Supplemental disproportionate share payments will be made during the second quarter of the state fiscal year (SFY).

The total DSH payment made to the hospital shall not exceed the costs of furnishing hospital services by the hospital to individuals who either are eligible for medical assistance under the state plan or have no health insurance (or other source of third party coverage), as established in Section 1923 of the Social Security Act and the Benefits Improvement and Protection Act of 2000 (BIPA).

G. HOSPITAL BASED AND FREE STANDING INPATIENT PSYCHIATRIC SERVICES

1. Hospital based and free standing inpatient psychiatric services are reimbursed using the inpatient prospective payment method described in section A of this document.

2. The Department will reimburse in-state PRTF's an all-inclusive bundled per-diem interim rate as in attachment 4.19D, service 16.

3. All Montana providers of hospital based inpatient psychiatric services for individuals under age 21 shall be eligible to receive, in addition to per-diem reimbursement, an annual continuity of care payment. The continuity of care payments will completely or partially reimburse providers for their otherwise un-reimbursed costs of providing care to Medicaid clients. Total Medicaid payments to a provider of hospital based inpatient psychiatric services for individuals under age 21 will not exceed the Medicaid costs of that provider.

The amount of the continuity of care payment for each qualifying provider will be determined based upon the following formula:

CCP = [M/D] x P

Where:

1. CCP equals calculated continuity of care payment.
2. M equals the number of Medicaid days provided by the facility for which the CCP is being calculated.
3. D equals the total number of Medicaid days provided by all facilities eligible to receive a CCP.
4. P equals the total amount to be paid via the Continuity of Care Payment. The State's share of "p" will be the total amount of revenue generated by Montana's hospital utilization fee, less all of the following:
   (A) the amount expended as match for supplemental DSH payments

The Medicaid days figures shall be from the department's paid Medicaid claim data for the most recent calendar year that ended at least 12 months prior to the calculation of the continuity of care payments.
Continuity of care payments (CCP) will be paid during the second quarter of the state fiscal year (SFY).

H. HOSPITAL REIMBURSEMENT ADJUSTOR

All hospitals located in Montana that provide inpatient hospital services are eligible for a Hospital Reimbursement Adjustment Payment. The payment consists of two separately calculated amounts.
In order to maintain access and quality in the most rural areas of Montana, critical access hospitals shall receive both components of the HRA. All other hospitals shall receive only Part 1, as defined below in (1). For the purposes of determining HRA payment amounts, the following apply:

(1) Part 1 of the HRA payment will be based upon Medicaid inpatient utilization, and will be computed as follows: HRA1=[M/D]+P. For the purposes of calculating Part 1 of the HRA, the following apply:

HRA1=(M/D)+P

Where:

(i) "HRA I" represents the calculated Part 1 HRA payment.
(ii) "M" equals the number of Medicaid inpatient days provided by the hospital for which the payment amount is being calculated.
(iii) "D" equals the total number of Medicaid inpatient days provided by all hospitals eligible to receive an HRA payment.
(iv) "P" equals the total amount to be paid via Part 1 of the HRA. The state's share of "P" will be the total amount of revenue generated by Montana's hospital utilization fee, less all of the following:
  (A) the amount expended as match for supplemental DSH payments.
  (B) the amount expended as match for continuity of care payments; and
  (C) the amount expended as match for Part 2 of the HRA.

The Medicaid inpatient day numbers used to calculate Part 1 of the HRA must be from the department's paid claims data from the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments.

(2) Part 2 of the HRA payment will be based upon total Medicaid billed charges, and will be computed as follows: HRA2=[J/D]P. For the purposes of calculating Part 2 of the HRA, the following apply:

HRA2=(J/D)P

Where:

(i) "HRA2" represents the calculated Part 2 HRA payment.

(ii) "J" equals amount of charges billed to Medicaid by the hospital for which the payment is being calculated.

(iii) "D" equals the total amount of charges billed to Medicaid by all hospitals eligible to receive Part 2 of the HRA payment.

(iv) "P" equals the total amount to be paid via Part 2 of the HRA. The state's share of "P" will be a minimal portion of the total revenue generated by Montana's hospital utilization fee.

(A) the amount expended as match for supplemental DSH Payments.
(B) the amount expended as match for continuity of care payments; and
(C) the amount expended as match for Part 1 of the HRA.

The total Medicaid billed charge amounts used to calculate part 2 of the HRA must be from the department's paid claims data from the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments. The state will make Hospital Reimbursement Adjustment payments during the second quarter of the state fiscal year (SFY). This reimbursement will be excluded from cost settlement.

I. APPEAL RIGHTS

Providers contesting the computation of interim payments or final settlement for coding errors resulting in incorrect DRG assignment; medical necessity determinations; outlier determinations; or, determinations of readmission and transfer shall have the opportunity for a fair hearing in accordance with the procedures set forth in ARM 37.5.310.