Table of Contents

State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-11-027

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

SEP 27 2011

Ms. Mary E. Dalton
Montana Department of Public
Health and Human Services
P.O. Box 4210
Helena, MT 59604

Re: Montana 11-027

Dear Ms Dalton:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-027. Effective for services on or after August 1, 2011, this amendment updates reimbursement for inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 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 11-027 is approved effective August 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

APPROVED

Cindy Mann
Director, CMCS

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: 11-027

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
08/01/2011

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. FY 11 $324,531 total FFP
b. FY 12 ($1,287,031 total FFP)
c. FY 13 ($1,299,109 total FFP)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, Inpatient Hospital Services
Pages 4,5, 9-16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Inpatient Hospital Services
Pages 4,5, 9-16

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to update reimbursement for inpatient hospital 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:
Single Agency Director Review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 9/20/2011

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: SEP 27 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

12. Interim Claims and Late Charges

Hospitals subject to the inpatient hospital prospective payment reimbursement method may only interim bill when the recipient has been a patient at least 30 days, is Medicaid eligible for a minimum of these 30 days, and has received prior authorization, in which case the hospital may bill every 30 days. Interim claims are paid by a per diem amount multiplied by the number of covered Medicaid eligible days. Upon patient discharge, the hospital should credit all interim claim payments and bill a complete admit through a discharge claim.

The Department will not accept late charges (type of bill = 115). Instead, hospitals are instructed to adjust earlier claims if appropriate.

13. Payment for Capital

Capital cost is included in the DRG-based payment as described above and will not be paid separately.

14. Prior Authorization

Out of state inpatient hospital claims are required to have prior authorization. Out of state inpatient hospital claims that are not prior authorized will be paid at a reduced percentage of the APR-DRG payment.

i) Out of state inpatient hospital claims will be reimbursed according to the reimbursement methodology described in Montana Administrative Rule 37.86.2947.

15. Health Care-Acquired Conditions (HAC) and Other Provider Preventable Conditions

Montana Medicaid will adopt the base line health care-acquired conditions as identified by Medicare. The following reimbursement changes will apply:

i) For claims with dates of payment on or after August 1, 2011, when a health care-acquired condition occurs during hospitalization and the condition was not present on admission, claims shall be paid as though the diagnosis is not present.

Montana Medicaid will adopt the base line for other provider preventable conditions as identified by Medicare. The following reimbursement changes will apply:

i) Payment will be denied for these conditions in any Health Care Setting as identified in Attachments 4.19A and 4.19B and any other settings where these events may occur. For any Montana Medicaid claim with dates of payment on or after August 1, 2011, that contains one of these diagnosis codes, these claims will be denied and will not be reimbursed.

B. EXEMPT HOSPITALS, SERVICES, AND COSTS

1. Exempt Providers

The following providers are exempt from the Inpatient Prospective Payment Method described in Subsection A. In the interest of clarity, this list includes acute care hospitals as well as facilities that provide similar inpatient services.

i) Indian Health Service hospitals
ii) The Montana State Hospital
iii) Psychiatric residential treatment facilities as defined in Section 16 of the supplement to attachments 3.1A and 3.1B of Montana's State Medicaid plan. See Subsection J below.
iv) Critical access hospitals
v) Hospitals located in Montana counties that were classified by the U.S. Department of Agriculture as "rural" or "very rural" as of July 1, 1993. These hospitals are referred to as exempt hospitals.

2. Exempt Services and Costs

The following services are exempt from the Inpatient Prospective Payment Method described in Subsection A even when provided by hospitals that are otherwise subject to prospective payment.

i) Services where Medicare is the primary payer (crossover claims)
ii) Certified Registered Nurse Anesthetist costs as defined by Medicare. See subsection C.

3. Health Care-Acquired Conditions (HAC)and Other Provider Preventable Conditions

Montana Medicaid will adopt the base line health care-acquired conditions as identified by Medicare. The following reimbursement changes will apply:

i) For claims with dates of payment on or after August 1, 2011, when a health care-acquired condition occurs during hospitalization and the condition was not present on admission, any charges/costs associated with a health care-acquired condition will be removed from the claim during cost settlement or retrospective review.

Montana Medicaid will adopt the base line for other provider preventable conditions as identified by Medicare. The following reimbursement changes will apply:

i) Payment will be denied for these conditions in any Health Care Setting as identified in Attachments 4.19A and 4.19B and any other settings where these events may occur. For any Montana Medicaid claim with dates of payment on or after August 1, 2011, that contains one of these diagnosis codes, these claims will be denied and will not be reimbursed.

B) The hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term Obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

C) Section B does not apply to a hospital which:

i) The inpatients are predominately individuals under 18 years of age; or

ii) Does not offer non-emergency obstetric services as of December 22, 1987.

The sum of all supplemental disproportionate share payments will be equal to the remaining federal allotment after all routine disproportionate share payments are made, plus the state financial participation. Each qualifying facility will receive a portion of the total available amount based on the number of Medicaid paid inpatient days provided as a percentage of the total number on Medicaid paid inpatient days provided by all of the facilities eligible for a supplemental disproportionate share payment. Critical Access Hospitals and other facilities paid outside of the prospective payment system shall receive a uniform increased proportion of the total funding available for supplemental DSH payments. This increased proportion is intended to maintain access to hospital services in critical rural areas of Montana.

Hospitals that qualify for both routine and supplemental DSH payments will receive payments under both methodologies.

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 third 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. AUDITS AND RECOVERY OF OVERPAYMENTS

The department may perform audits or desk reviews pursuant to Administrative Rules of Montana (ARM) 37.40.346. If at any time during an audit or desk review, the department discovers evidence suggesting fraud or abuse by a provider, such evidence along with the last audit report regarding said provider, shall be referred to the state's Medicaid Fraud Unit.

The department shall submit an independent certified audit to the Centers for Medicare and Medicaid Services (CMS) for each Medicaid state plan rate year consistent with 42 CFR 455 Section(D). Should the department determine there was an overpayment paid to a provider based upon the most recent audit or desk review, the department will immediately recover the overpayment pursuant to Administrative Rules of Montana (ARM) 37.86.2820. The amount of the overpayment will be redistributed to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be distributed pursuant to Administrative Rules of Montana (ARM)37.86.2925 and will be subject to hospital-specific upper payment limits.

H. 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 third quarter of the state fiscal year (SFY).

I. 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 third quarter of the state fiscal year (SFY). This reimbursement will be excluded from cost settlement.

J. GRADUATE MEDICAL EDUCATION

In addition to Medicaid payments, a Graduate Medical Education (GME) payment for the purpose of partially funding providers for their otherwise unreimbursed costs of providing care to Medicaid clients as part of the primary care residency program to an eligible hospital located in Montana.

The state portion of the GME pool amount for state fiscal year (SFY) 2012 is $319,366.

The department will make an annual payment in August of each year to an eligible hospital. Payment will be calculated based upon the eligible hospital's inpatient Medicaid utilization per year. An eligible hospital's prior year as filed cost report will be used as a proxy for the following state fiscal year's payment. Should an eligible hospital report no full time equivalents (FTE) participating in the GME program for any given program year or portion thereof, the eligible hospital will not receive payment for those time periods of non-participation. The GME payment regarding the primary care residency program shall be computed as follows:

(1) Step one shall be to divide the total Graduate Medical Education Full Time Equivalent (GMEFTE) count for each eligible facility based upon the most recently filed cost report by the Total Graduate Medical Education Full Time

Equivalent (TGMEFTE) for all eligible facilities to determine the Hospital Percentage of Graduate Medical Education (HPGME);

$$\frac{\text{GMEFTE}}{\text{TGMEFTE}} = \text{HPGME}$$

(2) Step two shall be to divide the Hospital Specific Medicaid Inpatient Days (HSMID) by the total Hospital Specific Inpatient Days (HSID) for eligible hospitals to compute the Facility Specific Medicaid Hospital Day percentage (FSMHDP);

$$\frac{\text{HSMID}}{\text{HSID}} = \text{FSMHDP}$$

(3) Step three shall be to add together the Facility Specific Medicaid Hospital Day Percentage (FSMHDP) for all eligible hospitals to determine a Total Medicaid Hospital Day Percentage (TMHDP);

$$\text{FSMHDP} + \text{FSMHDP} + \text{FSMHDP} + \text{FSMHDP} = \text{TMHDP}$$

(4) Step four shall be to divide each hospital's Facility Specific Medicaid Hospital Day Percentage (FSMHDP) by the Total Medicaid Hospital Day Percentage (TMHDP) to determine the Facility Specific Medicaid Utilization Percentage (FSMUP);

$$\frac{\text{FSMHDP}}{\text{TMHDP}} = \text{FSMUP}$$

(5) Step five shall be to divide the Hospital Specific Medicaid Inpatient Days (HSMID) by the Total Medicaid Inpatient Days (TMID) of all eligible hospitals to compute the Facility Share of Medicaid Utilization (FSMU);

$$\frac{\text{HSMID}}{\text{TMID}} = \text{FSMU}$$

(6) Step six shall be to add the percentage of the Facility Specific Medicaid Utilization Percentage (FSMUP) plus the Facility Share of Medicaid Utilization (FSMU) plus the Hospital Percentage of Graduate Medical Education (HPGME) divided by three to acquire the Average Medicaid Utilization (AMU) specific to each eligible hospital; and

$$\frac{\text{FSMUP} + \text{FSMU} + \text{HPGME}}{3} = \text{AMU}$$

(7) Step seven shall be the allocation of funds to each eligible hospital based on the facility specific percentage of Average Medicaid Utilization (AMU) as described in step (6).

The GME payment shall comply with the following criteria:

(i) If the eligible hospital's cost of hospital services do not exceed the total Montana Medicaid allowed payments for hospital care, the eligible hospital will receive a GME payment as calculated in section (I) above.

(ii) As filed cost reports from eligible hospitals and information from the Medicaid paid claims database will be used for calculations.

(iii) The GME payment must be for services derived from Medicaid paid claims.

(A) Dates of service must occur within the eligible hospital's fiscal year end; and

(B) The hospital's fiscal year must be the year immediately prior to the payment date.

(iv) At the end of the contract period, the department will reconcile the total Medicaid payments including the Medicaid GME payments to ensure that the total of these payments do not exceed the Medicaid Upper Payment Limit (UPL) for the fiscal year.

The following is an example of how the graduate medical education (GME) payment will be calculated based on four hospitals with eight full time equivalent (FTE) residents per facility:

	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Totals
GME FTE Count Facility	8	8	8	8	32
Facility Percent of Residents	25.00%	25.00%	25.00%	25.00%	100.00%
Medicaid Inpt days**	9232	8195	3680	7872	
Medicaid Inpt days in Formula	9232	8195	3680	7872	28979
Total hospital specific inpt days**	64269	53867	39725	26235	
Hospital Medicaid % of total days	14.36%	15.21%	9.26%	30.01%	68.85%
Facility Specific Medicaid Utilization Rate	21%	22%	13%	44%	
Medicaid Inpt days	9232	8195	3680	7872	28979
Facility Share of Medicaid Utilization	31.86%	28.28%	12.70%	27.16%	100.00%
straight avg of 3 percentages	25.91%	25.13%	17.05%	31.92%	100.00%
Allocation of Funds	$258,263	$250,469	$169,981	$ 318,160	$996,875

K. 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.

L. PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Montana Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

1. Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A):

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Montana Medicaid will adopt the base line health care-acquired conditions as identified by Medicare. The following reimbursement changes will apply:

Prospective Payment (PPS) Hospitals
For claims with dates of payment on or after August 1, 2011, when a health care-acquired condition occurs during hospitalization and the condition was not present on admission, claims shall be paid as though the diagnosis is not present. Reimbursement for PPS Hospitals regarding health care-acquired conditions is identified on page 4, number 15, of Attachment 4.19A.

Critical Access Hospitals (CAH)
For claims with dates of payment on or after August 1, 2011, when a health care-acquired condition occurs during hospitalization and the condition was not present on admission, any charges/costs associated with a health care-acquired condition will be removed from the claim during cost settlement or retrospective review. Reimbursement for Critical Access Hospitals regarding health care-acquired conditions is identified on page 5, number 3, of Attachment 4.19A.

2. Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(A) and 4.19(B):

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Montana Medicaid will adopt the base line for other provider preventable conditions as identified by Medicare. The following reimbursement changes will apply:

Payment will be denied for these conditions in any Health Care Setting as identified in Attachments 4.19A and 4.19B and any other settings where these events may occur. For any Montana Medicaid claim with dates of payment on or after August 1, 2011, that contains one of these diagnosis codes, these claims will be denied and will not be reimbursed. Reimbursement for PPS Hospitals regarding other provider preventable conditions is identified on page 4, number 15, of Attachment 4.19A. Reimbursement for Critical Access Hospitals regarding other provider preventable conditions is identified on page 5, number 3, of Attachment 4.19A.

_____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example - 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan: