average case mix index and the statewide average Medicaid case mix index.

(i) The Medicaid average case mix index for each facility to be used in rate setting will be the simple average of each facility's four Medicaid case mix indices calculated for the periods of February 1 of the current year and November 1, August 1 and May 1 of the year immediately preceding the current year. The statewide average Medicaid case mix index will be the weighted average of each facility's four quarter average Medicaid case mix index to be used in rate setting.

(c) The statewide price for nursing facility services will be determined each year through a public process. Factors that could be considered in the establishment of this price include the cost of providing nursing facility services, Medicaid recipients access to nursing facility services, and the quality of nursing facility care.

(d) The total payment rate available for the period July 1, 2011 through June 30, 2012 will be the rate as computed in (2), plus any additional amount computed in ARM 37.40.311 and 37.40.361.

(3) Providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the Medicaid program in a newly constructed facility shall have a rate set at the statewide median price of $161.96 as computed on July 1, 2011. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred.

(4) For ICF/MR services provided by nursing facilities

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party' means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity;

(ii) ,A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3) (b) (i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3) (b) Ci) ; or

(iii) a sole proprietorship, partnership corporation or other entity in which a person, described in (3) (b) (i) or (ii) has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions -or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal medicare law, regulation or policy or related case law regarding changes in ownership under the medicare program are not applicable..

(5) As required in ARM 37.40.306, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the medicaid program in accordance with applicable requirements -

(6) Any change in provider, corporate or other business ownership structure or operation of the facility that results in a change in the National Provider Identifier (NPI) will require a provider to seek a new medicaid provider enrollment. If the NPI is transferred with the facility, then only a provider file update is required to change the federal tax identification number and ownership information. A written request must be made to the department if the NPI is transferred with the facility. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AND, 1994 MAR p. 1881, Eff. 7/8/94; AND, 1995 MAR p. 1227, Eff. 7/1/95; AND, 1997 MAR p. 76, Eff. 1/17/97; AND, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

senior and long term care division. Approvals will be effective for one month intervals and reapproval must be obtained monthly.

(b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of five consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and non-licensed.

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average medicaid case mix index (CMI) used for rate setting determined in accordance with ARM 37.40.320 from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS) information for the resident in order to determine the difference in case mix for this resident from the average case mix for all medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and five consecutive day nursing time documentation review.

(3) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(a) If the items listed in (1)(a) through (1)(ax) are also covered by the medicare program and provided to a medicaid recipient who is also a medicare recipient, reimbursement will be limited to the lower of the medicare prevailing charge or the amount allowed under (3). Such items may not be billed to the medicaid program for days of service for which medicare Part A coverage is in effect.

(b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by

OS Notification

State/Title/Plan Number:	**Montana 11-028**
Type of Action:	**SPA approval**
Required Date for State Notification:	**December 25, 2011**
Fiscal Impact:	**FFY 2011 ($2,816,353) FFP** **FFY 2012 ($8,449,059) FFP**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: This plan, effective for services on or after August 1, 2011, provides for reimbursement changes for nursing facilities. Specifically, for SFY 2012, the amendment implements (1) a 2% reduction in nursing facility rates as a result of the expiration one the one-time only provider rate increases that went into effect in FY 2010, and was held constant in FY 2011. The 2010 provider rate increase was paid for with one-time only funding appropriated by Montana's 61st Legislative session meeting in 2009. This one-time only funding was not included in the base budget for SFY 2012; (2) updates the Montana Administrative Rules to reference the current fiscal year; (3) updates the current statewide median price from $164 to $162; (4) incorporates the legislative funding amount of $3,862,986 for the direct care wage increase component of the rate within the plan language; and, (5) provides for other minor clarifications.

The State considered but rejected eliminating optional services because of the impact on vulnerable Medicaid clients who would lose coverage for services. For these reasons, the State pursued the across the board provider rate decrease. The State predicts that the changes in the estimated average payment rate will have no adverse short term or long term impact on the availability of services on a statewide or geographic area basis, on the type of care furnished or on the extent of provider participation (447.255(b)).

Montana contracts with Myers and Stauffer, LC, to prepare an annual analysis for each nursing facility's cost of providing nursing facility services to Medicaid recipients, and each