## Table of Contents

**State/Territory Name: Montana**

**State Plan Amendment (SPA) #: MT-13-029**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CENTERS FOR MEDICARE & MEDICAID SERVICES

**Region VIII**

January 29, 2014

Mary Dalton, Medicaid & Health Services Manager
Montana Department of Health & Human Services
1400 Broadway
PO Box 202951
Helena, MT 59620

Re: SPA MT-13-029

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-13-029. This SPA amends Physician Services to update fees by 5.7% and the date of the fee schedule.

Please be informed that this State Plan Amendment was approved today with an effective date of July 1, 2013. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Cindy Smith at 303-844-7041.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

Cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson

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: 13-029

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
July 1, 2013

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:
Section 1902(a)(30)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $488,030(3 months)
b. FFY 2014 $1,979,498(12 months)
c. FFY 2015 $1,546,223(9 months)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B, Pages 1 and 2 of 5, Service 5a Physician Services
Supplement to Attachment 3.1A/B, Service 5a Physician Services
Attachment 4.19B, Service 12a, Outpatient Drug Services

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19B, Pages 1 and 2 of 5, Service 5a Physician Services
Supplement to Attachment 3.1A/B, Service 5a Physician Services
Attachment 4.19B, Service 12a, Outpatient Drug Services

10. SUBJECT OF AMENDMENT:
Amend Service 5a Physician Services to update fees by 5.7% and the date of the fee schedule. Notice of Public Hearing on Proposed Amendment, MAR Notice No. 37-636. To relocate physician administered drugs from Physicians' Services, Service 5a to Outpatient Drug Services, Service 12a.

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:
[redacted]

13. TYPED NAME: **Mary E. Dalton**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: **6/27/13**

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

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: **June 27, 2013**

18. DATE APPROVED: **January 29, 2014**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **July 1, 2013**

20. SIGNATURE OF REGIONAL OFFICIAL: **/s/**

21. TYPED NAME: **Richard C. Allen**

22. TITLE: **ARA, DMCHO**

23. REMARKS:

FORM HCFA-179 (07-92)

Supplement to
Attachment 3.1B

Service 5a
Physicians' Services

MONTANA

The following limitations apply to Physicians' Services:

1. Physicians' Services for conditions or ailments that are generally considered cosmetic in nature are not a benefit of the Medicaid Program except in such cases where it can be demonstrated that the physical well-being and psycho-social well-being of the recipient are severely affected in a detrimental manner. The determination of whether a service is cosmetic will be made by the Department or its designated review organization.

2. Services considered experimental are not a benefit of the Montana Medicaid Program. Experimental services include:

   a. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

   b. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services, or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

   c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

Supplement to
Attachment 3.1A

Service 5a
Physicians' Services

MONTANA

The following limitations apply to Physicians' Services:

1. Physicians' Services for conditions or ailments that are generally considered cosmetic in nature are not a benefit of the Medicaid Program except in such cases where it can be demonstrated that the physical well-being and psycho-social well-being of the recipient are severely affected in a detrimental manner. The determination of whether a service is cosmetic will be made by the Department or its designated review organization.

2. Services considered experimental are not a benefit of the Montana Medicaid Program. Experimental services include:

   a. All procedures and items, including prescribed drugs, considered experimental by the U.S. Department of Health and Human Services or any other appropriate federal agency.

   b. All procedures and items, including prescribed drugs, provided as part of a control study, approved by the Department of Health and Human Services, or any other appropriate federal agency to demonstrate whether the item, prescribed drug or procedure is safe and effective in curing/preventing, correcting or alleviating the effects of certain medical conditions.

   c. All procedures and items, including prescribed drugs, which may be subject to question but are not covered in #1 and #2 above, will be evaluated by the Department's designated medical review organization.

MONTANA

I. Reimbursement for Physician Services shall be:

A. The lower of:

1. The provider's usual and customary charge for the service; or

2. Reimbursement provided in accordance with the methodology described In Number II.

II. The Department's fee schedule for Physician Services is determined:

A. In accordance with the Resource Based Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), or Medicare's base and time units for anesthesia services, which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adjuster (either plus or minus) to affect the fee.

B. RBRVS means the version of the Medicare resource based relative value scale contained in the Medicare Physician Fee Schedule (MPFS)adopted by the Centers for Medicare and Medicaid Services (CMS).

C. RVU means a numerical value assigned in the RBRVS to each procedure code used to bill for services provided by a health care provider. The RVU assigned to a particular code expresses the relative effort and expense expended by a provider in providing one service as compared with another service.

MONTANA

D. The RVUs are adopted from the RBRVS.

1. If Medicare sets RVUs, the Medicare RVUs are applicable;
2. If Medicare does not set RVUs but Medicaid sets RVUs, the Medicaid RVUs are set in the following manner:

a) convert the existing dollar value of a fee to an RVU value;
b) evaluate the RVU of similar services and assign an RVU value; or
c) convert the average by report dollar value of a fee to an RVU value.

E. If neither Medicare nor Medicaid sets RVUs, then reimbursement is 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings. The "by report" methodology will end by 6/30/14.

F. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician services. The agency's fee schedule rate was set as of July 1, 2013 and is effective for services provided on or after that date. All rates are published at www.mtmedicaid.org.

MONTANA

Reimbursement for drugs shall not exceed the lowest of:

1. The Estimated Acquisition Cost (EAC) of the drug plus a dispensing fee, or;
2. Federal Upper Limit (FUL) of the drug plus a dispensing fee, or;
3. The State Maximum Allowable Cost (SMAC) of the drug, in the case of multi-source (generic), plus a dispensing fee, or,
4. The provider's usual and customary charge of the drug to the general public.

Exception The FUL limitation shall not apply in a case where a physician certifies in his/her own handwriting the specific brand is medically necessary for a particular recipient. An example of an acceptable certification is the handwritten notation "Brand Necessary" or "Brand Required." A check off box on a form or rubber stamp is not acceptable.

Exception: For outpatient drugs provided to Medicaid recipients in state institutions, reimbursement will conform to the state contract for pharmacy services; or for institutions not participating in the state contract for pharmacy services, reimbursement will be the actual cost of the drug and dispensing fee. In either case, reimbursement will not exceed, in the aggregate, the EAC or FUL or the SMAC plus the dispensing fee.

The EAC is established by the state agency using the Federal definition of EAC as a guideline: that is, "Estimated Acquisition Cost" means the state agency's best estimate of what price providers generally pay for a particular drug.

The EAC, which includes single source, brand necessary and drugs other than multi-source, is established using the following methodology:

> Drugs paid by their Average Wholesale Price (AWP) will be paid at AWP less 15 percent or Wholesale Acquisition Cost (WAC) plus 2 percent. If the state agency determines that acquisition cost is lower than AWP less 15 percent or WAC plus 2 percent then the state agency may set an allowable acquisition cost based on data provided by the drug pricing file contractor.

The SMAC for multiple-source drugs shall be equal to the state average acquisition cost per drug determined by direct pharmacy survey, wholesale survey and other relevant cost information.

A variable dispensing fee will be established by the state agency. The dispensing fee is based on the pharmacy's average cost of filling a prescription. The average cost of filling a prescription will be based on the direct and indirect costs that can be allocated to the cost of the prescription department and that of filling a prescription, as determined from the Montana dispensing fee questionnaire. A provider's failure to submit, upon request, the dispensing fee questionnaire property completed will result in the assignment of the minimum dispensing fee offered. A copy of the Montana dispensing fee questionnaire is available upon request from the department.

MONTANA

Dispensing fees shall be established as follows:

1. The dispensing fees assigned shall range between
   (i) a minimum of $2.00 and a maximum of $4.94 for brand name and nonpreferred generic drugs; and
   (ii) a minimum of $2.00 and a maximum of $6.52 for preferred brand name and generic drugs and generic drugs not identified on the preferred list.
2. Out-of-state providers will be assigned a $3.50 dispensing fee.
3. If the individual provider's usual and customary average dispensing fee for filling prescription is less than the foregoing method of determining the dispensing fee, then the lesser dispensing fee shall be applied in the computation of the payment to the pharmacy provider.

In-state pharmacy providers that are new to the Montana Medicaid program will be assigned the maximum dispensing fee in (1) until a dispensing fee questionnaire can be completed for six months of operation. At that time, a new dispensing fee will be assigned which will be the lower of the dispensing fee calculated for the pharmacy or the maximum allowed dispensing fee provided in (1). Failure to comply with the six months dispensing fee questionnaire requirement will result in assignment of dispensing fee of $2.00.

An additional dispensing fee of $0.75 will be paid for "unit dose" prescriptions. This "unit dose" dispensing fee will offset the additional cost of packaging supplies and materials which are directly related to filling "unit dose" prescriptions by the individual pharmacy and is in addition to the regular dispensing fee allowed. Only one unit dose dispensing fee will be allowed each month for each prescribed medication. A dispensing fee will not be paid for a unit dose prescription packaged by the drug manufacturer.

The pharmacist vaccine administration fee shall be $21.32 for the first vaccine and $13.38 for each additional vaccine administered. This fee will be provided in lieu of the dispensing fee for any covered vaccine.

An additional compounding fee based on level of effort will be paid for compounded prescriptions. Montana Medicaid shall reimburse pharmacies for compounding drugs only if the client's drug therapy needs cannot be met by commercially available dosage strengths and/or forms of the therapy. Reimbursement for each drug component shall be determined in accordance with "lower of" pricing methodology. The compounding fee for each compounded drug shall be based on the level of effort required by the pharmacist. The levels of effort compounding fees payable are level 1: $12.50, level 2: $17 50, and level 3: $22.50.

Physician Administered Drugs

The Department requires that National Drug Codes (NDC) must be submitted for all physician administered drugs. Montana Medicaid will cover only those physician administered drugs manufactured by companies that have a signed rebate agreement with CMS. Reimbursement for physician-administered drugs is made according to the department's fee schedule or the provider's usual and customary charge, whichever is lower. The physician administered drug fee schedule is updated effective the 1st day of each quarter as determined by:

1. The Medicare Average Sales Price (ASP) methodology (of ASP+6%) if there is an ASP fee; or
2. The estimated acquisition cost (EAC) as defined above;