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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-14-025

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Region VIII

December 4, 2014

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

Re: SPA MT-14-025

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-14-025. This SPA amends Prosthetic Devices Services to include language to clarify the methodology used for pricing and remove the by report language.

Please be informed that this State Plan Amendment was approved today with an effective date of July 1, 2014. We are enclosing the summary page and the amended plan page(s).

In order to track expenditures associated with this amendment, Montana should follow the CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual (SMM).

For those individuals whose expenditures qualify for the newly eligible federal medical assistance percentage report on the Form CMS-64.9 VIII and those not enrolled in the new adult group, claims should be reported on the Form CMS-64.9 Base.

This amendment would affect expenditures reported on Line 33.

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
Mary Eve Kulawik

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: 14-025

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, 2014

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 2014 $0
b. FFY 2015 $0
c. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page(s) 1 and 2 of 2
Attachment 419B
Methods & Standards for Establishing Payment Rates
Service 12.c Prosthetic Devices

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page 1 of 1
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 12.c Prosthetic Devices

10. SUBJECT OF AMENDMENT:
Amend Prosthetic Devices Service, 12.c to include language to clarify the methodology used for pricing and remove the by report language from the State Plan. The Attachment 41.9B Introduction Page updates the effective date of the fee schedule. This SPA is budget neutral.

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 6/21/2014

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **6/21/14**

18. DATE APPROVED: **12/4/14**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **7/1/14**

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

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

22. TITLE: **ARA, DMCHO**

23. REMARKS:

MONTANA

I. Reimbursement for Prosthetic Devices shall be the lowest of the following:

A. The provider's Usual and Customary Charge (UCC) amount submitted on the claim to Medicaid; or

B. The Department's fee schedule maintained in accordance with the methodology described below.

II. The Department's Prosthetic Devices Fee Schedule will include fees set and maintained according to the following methodology:

- 100% of the Medicare Region D allowable fee;
- For all items for which no Medicare allowable fee is available, the Department's fee schedule amount will be 75% of the provider's UCC;
- The amount of the provider's UCC may not exceed the reasonable charge usually and customarily charged by the provider to all payers:
  - The charge will be considered reasonable if less than or equal to the manufacturer's suggested list price. The Department's policy base for the percentage of charges methodology is the MSRP. A similar method is used by Noridian, the Jurisdiction D, DME MAC.
  - For items without a manufacturer's suggested list price, the charge will be considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount.
  - For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

Montana

- o Items having no product retail list price, such as items customized by the provider, will be reimbursed at 75% of the provider's UCC as defined above.

- The Department's Prosthetic Devices Fee Schedule for items billed under generic or miscellaneous codes will be 75% of the provider's UCC as defined in 1.B.

III. The agency's rates were set as of the date on the Attachment 4.19B Introduction Page and are published on the agency's website www.mtmedicaid.org. Unless otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.