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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-16-0005

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 AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

NOV 20 2017

Ms. Marie Matthews
State Medicaid Director
Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: Montana 16-0005

Dear Ms. Matthews:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-0005. Effective for services on or after July 1, 2016, this amendment provides for clarification used in establishing reimbursement rates for services provided in institutions for mental diseases (IMDs). In addition, this amendment updates the list of service limitations within Attachment 3.1-A and 3.1-B for intermediate care facility (ICF) services provided in an IMD.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) 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 TN 16-0005 is approved effective July 1, 2016. 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]

Kristin Fan
Director

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: 16-0005

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
07/01/2016

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Parts 440.140 and 440.160

7. FEDERAL BUDGET IMPACT:

a. FFY 2016 (3 months) $0
b. FFY 2017 (12 months) $0
c. FFY 2018 (9 months) $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

- Supplement to Attachment 3.1A , Service 14(c), Intermediate Care Facility Services for Individuals Age 65 or Older in IMDs, Pages 1 and 2 of 2
- Supplement to Attachment 3.1B, Service 14(c), Intermediate Care Facility Services for Individuals Age 65 or Older in IMDs, Pages 1 and 2 of 2
- Attachment 4.19D, Service 14, IMDs, Page 1 of 1

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

- Supplement to Attachment 3.1A , Service 14(c), Intermediate Care Facility Services for Individuals Age 65 or Older in IMDs, Pages 1 and 2 of 2
- Supplement to Attachment 3.1B, Service 14(c), Intermediate Care Facility Services for Individuals Age 65 or Older in IMDs, Pages 1 and 2 of 2
- Attachment 4.19D, Service 14, IMDs, Page 1 of 1

10. SUBJECT OF AMENDMENT:

1) Update the IMD reimbursement rate methodology; and 2) update the list of service limitations in Intermediate Care Facility Services provided in IMDs.

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: Marie Matthews

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 9-29-17

16. RETURN TO:

Montana Department of Public Health and Human Services
Marie Matthews
Attn: Mary Eve Kulawik
PO Box 4210
Helena MT 59620

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: NOV 20 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMCo

23. REMARKS:

Supplement to
Attachment 4.19D

Service 14
Institutions for Mental Diseases

MONTANA

The following methods are used for establishing reimbursement rates for inpatient hospital and intermediate care facility services provided in institutions for mental diseases (IMDs):

A. For Non-Medicare certified facilities:

1. Payment rates will be effective for rate years beginning July 1 of each year. The Department will establish a rate by October 1 of each rate year. The rate will be based upon estimated allowable cost per day for the rate year. The estimated allowable cost per day will be determined by dividing total estimated allowable costs for the rate year by the previous year's average bed day usage.

B. For Medicare certified facilities:

1. The Department will establish an interim rate by October 1 of each rate year. The interim rate will be based upon estimated allowable cost per day for the rate year. The estimated allowable cost per day will be determined by dividing total estimated allowable costs for the current rate year by the previous year's average bed day usage. The interim payment rate will be limited by the Department's estimate of the upper payment rate limit in accordance with 42 CFR 447.272.

2. The difference between the final rate and the interim payment rate will be settled through the Medicare cost report settlement process as described in the approved service 1 Inpatient Hospital Services State Plan, Attachment 4.19A. Reasonable cost reimbursement is the method used because Montana's state-managed IMDs are unique facilities in the state relative to other facilities.

Supplement to Attachment 3.1A
Service 14(c)
Nursing Facility Services for
Individuals Age 65 or Older in
Institutions for Mental Diseases

MONTANA

The following limitations apply to Intermediate Care Facility Services for Individuals Age 65 or Older in Institutions for Mental Disease:

A. Services considered experimental are not a benefit of the Montana Medicaid Program..

Experimental services include:

1. 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.
2. 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.
3. 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.

B. Items or services that are not included in the payment benefit for services rendered by a nursing facility in the Montana Medicaid Program, but for which the resident may be charged include:

1. Vitamins, multivitamins;
2. Calcium supplements;
3. Nasal decongestants and antihistamines;
4. Special requests by a nursing home resident for a specific item or brand that is different from that which the facility routinely stocks or provides as a requirement or condition of participation and that is covered under the Medicaid per diem rate (e.g., special lotion, powder, diapers);
5. Cosmetics;
6. Tobacco products and accessories;
7. Personal dry cleaning; and
8. Less-than-effective drugs (exclusive of stock items).

Supplement to Attachment 3.1B
Service 14(c)
Nursing Facility Services for
Individuals Age 65 or Older in
Institutions for Mental Diseases

MONTANA

The following limitations apply to Intermediate Care Facility Services for Individuals Age 65 or Older in Institutions for Mental Disease:

A. Services considered experimental are not a benefit of the Montana Medicaid Program.

Experimental services include:

1. 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.
2. 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.
3. 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.

B. Items or services that are not included in the payment benefit for services rendered by a nursing facility in the Montana Medicaid Program, but for which the resident may be charged include:

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2. Calcium supplements;
3. Nasal decongestants and antihistamines;
4. Special requests by a nursing home resident for a specific item or brand that is different from that which the facility routinely stocks or provides as a requirement or condition of participation and that is covered under the Medicaid per diem rate (e.g., special lotion, powder, diapers);
5. Cosmetics;
6. Tobacco products and accessories;
7. Personal dry cleaning; and
8. Less-than-effective drugs (exclusive of stock items).