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State/Territory Name: Montana

State Plan Amendment (SPA) #: 17-0024

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
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

MAR 14 2018

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

Re: Montana 17-0024

Dear Ms. Matthews:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 17-0024. Effective for services on or after January 1, 2018, this amendment updates the reimbursement methodology by providing for a 2.99 percent reduction for inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 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 TN 17-0024 is approved effective January 1, 2018. 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: 17-0024

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
01/01/18

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
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
FFY 18 (9 months) ($ 1,594,452)
FFY 19 (12 months) ($ 2,194,025)
FFY 20 (3 months) ($ 548,506)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, Service 1, Inpatient Hospital Services
Pages 1, 2, and 6.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Service 1, Inpatient Hospital Services
Pages 1, 2, and 6.

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to clarify that the Medicaid grouper is updated when updates are published. In addition, we are requesting to remove the reference of "millions of" in the description of the national database. We added the word "acute" to the base rate for Long Term Acute Care hospital facilities. The effective date of the APR-DRG calculator was added to the State Plan. The state plan has also been updated to reflect the change in reimbursement percentage for critical access hospitals. Base rates, policy adjustors, and outlier thresholds were modified and displayed within the posted APR-DRG calculator.

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:
Original Submit 12-26-17 | Resubmitted 2-28-18

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: MAR 14 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2018

20. [redacted] AL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMCO

23. REMARKS:

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

A. MONTANA MEDICAID PROSPECTIVE PAYMENT (DRG) REIMBURSEMENT

Except as specified in Subsection B, the Inpatient Prospective Payment Method applies to all inpatient stays in all acute care general, rehabilitation and mental health (psychiatric/substance abuse treatment) hospitals and units located in Montana or out-of-state.

1. Primacy of Medicaid Policy

Some features of the Medicaid Inpatient Prospective Payment Method are patterned after similar payment policies used by Medicare. When specific details of the payment method differ between Medicaid and Medicare, then the Medicaid policy prevails.

2. APR-DRG Reimbursement

For admissions dated October 1, 2016 and after, the Department will reimburse hospitals the lesser of a per-stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs) or billed charges. APR-DRGs classify each case based on information contained on the inpatient Medicaid claim such as diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG determines the reimbursement when the DRG Relative Weight is multiplied by the DRG Base Price.

The APR-DRG relative weights values, average national length of stay (ALOS), outlier thresholds, and APR-DRG grouper are contained in the APR-DRG Calculator effective January 1, 2018. The APR-DRG calculator can be referenced on the state's website: https://medicaidprovider.mt.gov/.

Hospitals reimbursed using the Inpatient Prospective Payment Method are not subject to retrospective cost reimbursement.

3. DRG Relative Weights

For each DRG a relative weight factor is assigned. The relative weight is applied to determine the DRG Base Payment that will be paid for each admit-through-discharge case regardless of the specific services provided or the length of stay. The DRG relative weight is a weight assigned that reflects the typical resources consumed. DRG weights are reviewed and updated annually by the Department. The weights are adapted from national databases of inpatient stays and are then "re-centered" so that the average Montana Medicaid stay in a base year has a weight of 1.00.

When the Department determines that adjustments to relative weights for specific DRGs are appropriate to meet Medicaid policy goals related to access to quality care, a "policy adjustor" will be explicitly applied to increase or decrease these relative weights. Policy adjustors are intended to be budget neutral, that is, they change payments for one type of service relative to other types without increasing or decreasing payments overall.

4. DRG Base Price

There are three different base prices for stays in acute care hospitals. These three base prices consist of the Montana average base rate, a base rate for Long Term Acute Care (LTAC) hospital facilities, and the base rate for Center of Excellence hospitals. The base price is a dollar amount that is reviewed by the Department each year. Changes in the DRG Base Price are subject to the public notice requirements of the Montana Code Annotated.

5. DRG Base Payment

For each stay, the DRG Base Payment equals the DRG Relative Weight multiplied by the DRG Base Price.

6. Cost Outlier Payments

It is recognized that there are occasional stays that are extraordinarily costly in relation to other stays within the same DRG because of the severity of the illness or complicating conditions. These variations are recognized by the Cost Outlier Payment which is an add-on payment for expenses that are not predictable by the diagnosis, procedures performed, and other statistical data captured by the DRG grouper.

Cost outlier stays are stays that exceed the cost outlier threshold for the DRG. To determine if a hospital stay exceeds the cost outlier threshold, the Montana Medicaid program excludes all services that are not medically necessary. Montana Medicaid then converts the charge information for medically necessary services into the estimated cost of the stay by applying the hospital specific cost-to-charge ratio (CCR) for in-state hospitals and Center of Excellence Hospitals and the statewide average CCR for all other out-of-state facilities, including border hospitals. The estimated cost for medically necessary services is then compared to the cost outlier threshold for the appropriate DRG to determine if the stay qualifies for reimbursement as a cost outlier. Costs exceeding the threshold are multiplied by a marginal cost ratio to determine the Cost Outlier Payment.

7. Transfer Payment Adjustments

The transfer payment adjustment applies when a patient is transferred to another acute care hospital. It does not apply when a patient is discharged to a post-acute setting such as a skilled nursing facility. The receiving hospital is not impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

In the transfer payment adjustment, payment is calculated as if the member were not a transfer, then payment is adjusted. The DRG Base Payment is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount.

Hospitals subject to retrospective reasonable cost reimbursement shall receive interim payments weekly or bi-weekly during the facility's fiscal year by submitting claims to the Department's fiscal intermediary. Effective January 1, 2018, interim reimbursement is based on the provider's specific inpatient cost-to-charge ratio (CCR), less 2.99%. The inpatient CCR is determined by Montana Medicaid's contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recently settled Medicare cost report. If a provider fails to submit financial information to compute the rate, the provider will be reimbursed at 50% of its usual and customary billed charges. Hospital providers are required to submit the CMS 2552-10 to the Medicare Fiscal Intermediary (FI) and the Department within five months of their fiscal year end. The FI either audits or desk reviews the cost report, and sends the Department the "as adjusted" cost report. Medicaid settlements are made from the "as adjusted" cost report.

For each exempt hospital, reimbursement for reasonable costs of inpatient hospital services shall be limited to 101% of allowable costs or the upper payment limit (UPL). Effective January 1, 2018, Critical Access Hospitals (CAH) will be reimbursed 97.98% of allowable costs for inpatient hospital services. For cost report periods ending on or prior to December 31, 2017, final cost settlements for CAH facilities will be reimbursed at 101% of allowable costs. For cost report periods ending on or after January 1, 2018, final cost settlements for CAH facilities will be reimbursed at 97.98% of allowable costs.

For services where Medicare is the primary payer (crossover claims) are not reimbursed using retrospective cost principles. Reimbursement for these services is the remaining coinsurance and deductible. Certified Registered Nurse Anesthetist costs as defined by Medicare are reimbursed using retrospective cost principles.

D. TRANSFERS

All transfers are subject to review for medical necessity of the initial as well as subsequent hospitalizations and the medical necessity of the transfer itself. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

E. READMISSIONS

All readmissions are subject to review for medical necessity of the initial as well as the subsequent hospitalization and the medical necessity of the readmission itself. Reimbursement cannot be made to a provider unless the service provided was medically necessary. Readmissions may be reviewed on a retrospective basis to determine if additional payment for the case is warranted.