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State/Territory Name: Montana

State Plan Amendment (SPA) #: 17-0025

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

REGION VIII - DENVER

March 1, 2018

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

Re: SPA MT-17-0025

Dear Ms. Matthews:

We have approved the State Plan Amendment (SPA) submitted under transmittal number MT-17-0025. The amendment implements a statewide 2.99% rate reduction for Outpatient Hospital services, including outpatient laboratory services.

Please be informed that this State Plan Amendment was approved February 28, 2018, with an effective date of January 1, 2018. We are enclosing the summary page and the amended plan page(s).

The State assures that the change in reimbursement for Outpatient Hospital services is not expected to have an effect on access to care for Medicaid beneficiaries. The State did not receive public comments specific to the reimbursement reduction to Outpatient Hospital services, and the State provided evidence from analysis reflected in a revised Addendum to Montana Medicaid 2016 Access Monitoring Plan that revealed consistent beneficiary utilization and provider enrollment. Based on this information, CMS infers that the amendment does not affect consistency with the access to care requirements described in §1902(a)(30)(A) of the Social Security Act. While this SPA results in an overall decrease in State expenditures for Outpatient Hospital Services, it was determined to be a nominal change in overall reimbursement as described in State Medicaid Director Letter (SMDL) #17-004.

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.

For Outpatient Hospital Services, the expenditures should be reported on: Line 6A – Regular Payments.

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

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

cc: Sheila Hogan, Department Director
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: 17-0025

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 440.20
1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
FFY 18 (9 months) ($1,777,838)
FFY 19 (12 months) ($2,477,775)
FFY 20 (3 months) ($619,443)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, Service 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 1through 4, 6 and 7.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B, Services 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 1through 4, 6 and 7.

10. SUBJECT OF AMENDMENT:
The purpose of the proposed state plan amendment is to update and set provider rates to take into consideration the funding appropriated by the 65th Montana Legislature. The 2.99% rate reduction also applies to outpatient labs, and cost settlement and interim reimbursement rates for Critical Access Hospitals. Prior to this change, Montana Medicaid followed Medicare reimbursement at a cost settlement and interim rate of 101%.

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: 2-24-18

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: December 26, 2017

18. DATE APPROVED: February 28, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard C. Allen

22. TITLE: ARA, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

A. COST BASED RETROSPECTIVE REIMBURSEMENT

1. Interim Reimbursement

Facilities defined as Critical Access Hospitals (CAH) will be reimbursed on a cost-based retrospective basis.

Cost of hospital services will be determined for inpatient and outpatient care separately. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15-1, and is subject to the exceptions and limitations provided in the Department’s Administrative Rules. CMS Publication 15-1 is a manual published by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services, which provides guidelines and policies to implement Medicare regulations and establish principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

Critical Access Hospital (CAH) facilities will be reimbursed on an interim basis during the facility’s fiscal year. Effective January 1, 2018, interim reimbursement is based on the provider’s specific outpatient cost-to-charge ratio (CCR), less 2.99%. The outpatient CCR is determined by Montana Medicaid’s contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider’s most recent Medicaid cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report which is necessary to determine the outpatient cost to charge ratio, the provider’s interim rate will be 50% of its usual and customary charges.

B. PROSPECTIVE REIMBURSEMENT

In-state PPS (Prospective Payment System) hospitals are paid under the OPPS (Outpatient Prospective Payment System) for outpatient claims. Such hospitals may be classified as sole community hospitals or non-sole community hospitals.

Border hospitals are those hospitals that are located within 100 miles of the border of the state of Montana.

Out-of-state hospitals are those hospitals that are located beyond 100 miles of the border of the state of Montana.

Unless otherwise specified, the following outpatient hospital services for in-state PPS, border and out-of-state facilities will be reimbursed under a prospective payment methodology for each service as follows:

1. Outpatient Prospective Payment System, Ambulatory Payment Classification (APC) Groups

Outpatient hospital services that are not provided by Critical Access Hospitals (CAH) will be reimbursed on a predetermined rate-per-service basis. These services are classified according to a list of APC groups published annually in the Code of Federal Regulation (CFR). APC group reimbursement is based on the CPT or HCPCS code associated with the service and may be an all-inclusive bundled payment per service. These bundled services may include some or all of the following services: nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment, and other outpatient hospital services. The Department follows Medicare’s grouping of services by APC as published annually in the CFR. The Department will update Medicare’s changes quarterly.

a) The Department uses a Medicaid conversion factor effective for services provided on and after January 1, 2018, to establish a rate that is less than the rate established by Medicare’s conversion factor. This rate will periodically be re-evaluated by the Department. All rates are published on the agency’s website at http://medicaidprovider.mt.gov. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

b) This Medicaid conversion factor effective for services provided on and after January 1, 2018, is the same for all APC groups and for all facilities. The APC fee equals the Medicare specific weight for the APC times the Medicaid conversion factor. These rates are updated quarterly when the Medicare update is published. All rates are published on the agency’s website at http://medicaidprovider.mt.gov. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

c) The total claim reimbursement will be the lower of the provider’s claim charge or the reimbursement as calculated using OPPS.

d) If two or more surgical procedures are performed on the same patient at the same hospital on the same day, the most expensive procedure will pay at 100% of that APC; and the other procedures will pay at 50% of their APC, if appropriate.

e) Procedures started on a patient but discontinued before completion will be paid at 50% of that APC.

f) A separate payment will be made for observation care using criteria established by Medicare with the exception of obstetric complications. Observation care that does not meet Medicare's criteria will be considered bundled into the APC for other services.

(i) When billing observation services, the appropriate procedure codes must be used and the units field on the claim must reflect the number of hours provided. Observation services must be a direct admit or have a high level clinic visit, high level critical care, or high level ER visit to qualify. The service must be at least eight hours in length.
(ii) Obstetric observation must have a qualifying diagnosis and must be at least one hour in length of service.

g) Medicare has set guidelines for procedures it has determined should be performed in an inpatient setting only. The Department follows Medicare guidelines for procedures defined as "inpatient only".

2. Outpatient Payment Methodology Paid Under OPPS

Outpatient services will be reimbursed as follows:

a) For each outpatient service or procedure, the fee is 100% of the Ambulatory Payment Classification (APC) rate. Some codes price by APC, but bundle so they pay at zero.
b) Where no APC rate has been assigned, outpatient services will be paid by the applicable Medicare fee.
   (i) Effective January 1, 2018, for laboratory services, if there is a Medicare fee for the code, the system will price at 58.206% of the Medicare fee for non-sole community hospitals; and 60.1462% of the Medicare fee for sole community hospitals. If the codes bundle to a lab panel or ATP panel, the system will also pay 58.206% or 60.1462% of the bundled fee, depending on the hospital status.
c) If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates were set as of January 1, 2018, and are effective for services on or after that date. All rates are published on the agency's website at http://medicaidprovider.mt.gov. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

d) If Medicaid does not have an established fee and the code is allowed by Medicaid, outpatient hospital specific cost-to-charge ratio will be used to determine payment.

e)

(i) The provider's outpatient cost-to-charge ratio is determined by Montana's contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicaid cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the outpatient cost-to-charge ratio, the provider's rate will be the average statewide cost-to-charge ratio for PPS hospitals.

3. Emergency Department Services for OPPS Hospitals

Emergency department services provided by hospitals that are not Critical Access Hospitals (CAH) will be reimbursed based on the APC methodology with the exception of ER visits using CPT codes 99281 and 99282, which will be reimbursed based upon the clinic visit APC weight.

Professional services are separately billable according to the applicable rules governing medical billing. In addition to the APC rate specified for each emergency department visit, Medicaid will reimburse providers separately for OPPS covered laboratory, imaging, and other diagnostic services provided during emergency visits.

4. Dialysis Services

Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413, subpart H. The facilities composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services. The provider must furnish all of the necessary dialysis services, equipment, laboratory services, drugs, and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, CMS Publication 15-1.

For purposes of specifying the services covered by the composite rate and the services that are separately billable, the department adopts and incorporates by reference CMS Publication 15-1.

a) The facility component of provider based services that are provided in a Critical Access Hospital (CAH) will be interim reimbursed a hospital specific outpatient cost-to-charge ratio.
b) Provider based entities providing obstetric services must bill as a non-provider based provider.
c) Vaccines for Children (VFC) services must be billed as a non-provider based provider.
d) Montana Medicaid does not recognize out of state provider based status.

8. Partial hospitalization services will be reimbursed using the lower of the following two rates:
   a) The provider’s usual and customary claim charges for the service; or
   b) The department’s Mental Health Fee Schedule. This is a bundled rate for acute full-day programs and sub-acute half-day programs.

9. If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates were set as of January 1, 2018, and are effective for services on or after that date. All rates are published on the agency’s website at http://medicaidprovider.mt.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

D. COST REPORTING AND COST SETTLEMENTS

All in-state PPS Hospitals and Critical Access Hospitals will be required to submit a Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records that will enable the facility to fully complete the cost report. Upon receipt of the cost report, the Department will instruct Montana’s contracted intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.

Facilities will be required to file the cost report with Montana’s contracted intermediary and with the Department within 150 days of the facility’s fiscal year end.

Except as identified below, Medicare principles of reasonable cost reimbursement will be applied to cost settlement of outpatient hospital services that are paid on interim at outpatient hospital specific cost-to-charge ratio. Only cost-based outpatient services are cost settled.

The State of Montana uses CMS 2552-10 to identify outpatient costs. The outpatient costs are calculated using worksheet D, part V of the CMS 2552-10. The ancillary charges are recorded on column 3, line 202. The outpatient costs are recorded on column 6, line 202.

1. For each in-state PPS hospital which has an outpatient hospital service paid on the interim at the outpatient hospital specific cost-to-charge ratio, reasonable costs will be settled. The reasonable costs of outpatient hospital services will not include the cost of professional services, or the cost of general medical education; and will only include outpatient hospitals services covered by the Medicare Outpatient Prospective Payment System.

2. Effective January 1, 2018, Critical Access Hospital (CAH) final reimbursement shall be for reasonable costs of outpatient hospital services limited to 97.98% of allowable costs. 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. The State of Montana uses CMS 2552-10 to identify outpatient costs. The outpatient costs are calculated using worksheet D, part V of the CMS 2552-10. The ancillary charges are recorded on column 3, line 202. The outpatient costs are recorded on column 6, line 202.

E. UPPER PAYMENT LIMITS

The Department has structured the outpatient reimbursement methodology to ensure the Medicaid allowed amount does not exceed the hospital aggregate outpatient upper payment limit (UPL). The hospital outpatient upper payment limit will not include professional services or general medical education. For in-state PPS hospitals, the upper payment limit will only include outpatient hospital services covered by the Medicare OPPS.