Table of Contents

State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0014

This file contains the following documents in the order listed:

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

May 21, 2018

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

Dear Ms. Matthews:

We have approved the State Plan Amendment (SPA) submitted under transmittal number MT-18-0014. The amendment implements a reduction to the conversion factor for outpatient services and eliminates recognition of provider-based status in reimbursement for professional services provided in an outpatient setting.

Please be informed that this State Plan Amendment was approved today, with an effective date of March 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 indicated hospitals are content with their overall payments that include a hospital tax and 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.

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 information on specific lines where each of the State Plan service expenditures should be reported, please refer to Appendix A.

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,

[redacted]

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: 18-0014	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 03/01/18	

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 (7 months)** ($3,826,600) **FFY 19 (12 months)** ($5,825,476) **FFY 20 (5 months)** ($2,471,727)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B, Service 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 2 ,3, 5 and 6.	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 2, 3, 5, and 6.

10. SUBJECT OF AMENDMENT:
The purpose of the proposed state plan amendment is to take into consideration the reduction in spending by Montana Legislative special session in accordance with MCA 17-7-140. Effective, March 1, 2018, the conversion factor for outpatient services is reduced 10%, and provider based status is no longer recognized.

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]	16. RETURN TO: Montana Department of Public Health and Human Services Marie Matthews Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59620
13. TYPED NAME: Marie Matthews	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: 3-7-18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 7, 2018	18. DATE APPROVED: May 21, 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Richard C. Allen	22. TITLE: ARA, DMCHO
23. REMARKS:	

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 March 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 March 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 March 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.

C. MISCELLANEOUS SERVICES

1. PPS hospital therapy services, including physical therapy, occupational therapy and speech-language pathology, will be paid a Medicaid facility fee with a conversion factor appropriate for therapies. Refer to the Medicaid fee schedule for a list of these services located on the agency's website at http://medicaidprovider.mt.gov.

2. For PPS hospitals, immunizations not grouping to an APC will be paid a Medicaid fee. If the member is under 19 years old and the vaccine is provided under the Vaccines for Children Program, the payment to the hospital for the vaccine is zero.

3. Dental services not grouping to an APC will be reimbursed as specified in the Department's outpatient fee schedule.

4. Payment for Certified Registered Nurse Anesthetists (CRNA) will be paid to Critical Access Hospitals (CAH) at the hospital's specific outpatient cost-to-charge ratio. The percentage shall be the provider's outpatient cost-to-charge ratio 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.

5. Professional services are separately billable according to the rules governing CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) billing guidelines.

6. The Department requires that National Drug Codes (NDC) be submitted on all outpatient claims that include pharmaceuticals. Montana Medicaid will reimburse only those pharmaceuticals manufactured by companies that have a signed rebate agreement with CMS.
   a) Qualified providers that are participating in the 340B Drug Pricing Program are exempt from submitting National Drug Codes (NDC) on claim lines billed using pharmaceuticals purchased through the 340B program.

7. Montana Medicaid does not recognize provider-based status. Professional services provided in an outpatient hospital clinic bill the appropriate procedure code(s)in accordance with the reimbursement under Attachment 4.19B, Methods and Standards for Establishing Payment Rates for Service 5a, Physician Services.

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 March 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.