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State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0042

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

REGION VIII - DENVER

October 4, 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 reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-18-0042. This amendment restores rates to levels prior to the State's budget reduction.

Please be informed that this State Plan Amendment was approved today, with an effective date of July 1, 2018. 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.

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
Duane Preshinger
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: 18-0042	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 07/01/18	

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 – $1,650,138 3 months FFY 19 – $6,668,636 12 months FFY 20 – $5,136,537 9 months
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B, Service 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 1, 2, 3, 6 and 7.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19B, Service 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 1, 2, 3, 6 and 7.

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment - Effective July 1, 2018, this amendment restores the across the board Medicaid provider rates and fee schedules that were reduced by 2.99% effective January 1, 2018, due to budget shortfalls in State Fiscal year 2018. The proposed 2.99% rate reversal is the result of two Temporary Restraining Orders (TRO) that were filed as court orders in August 2018.

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: Mary E. Dalton	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: 9-13-18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 13, 2018	18. DATE APPROVED: October 4, 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Richard C. Allen	22. TITLE: ARA, DMCHO
23. REMARKS:	

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 July 1, 2018 for dates of services January 1, 2018 through June 30, 2018, interim reimbursement is based on the provider's specific outpatient cost-to-charge ratio (CCR), less 2.99%. For dates of service on or after July 1, 2018, the interim reimbursement is based on the hospital-specific Medicaid outpatient cost-to-charge ratio, not to exceed 100%. 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 July 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 July 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 July 1, 2018, for laboratory services, if there is a Medicare fee for the code, the system will price at 60% of the Medicare fee for non-sole community hospitals; and 62% of the Medicare fee for sole community hospitals. If the codes bundle to a lab panel or ATP panel, the system will also pay 60% or 62% 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 July 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.

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 July 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 July 1, 2018, Critical Access Hospital (CAH) final reimbursement shall be for reasonable costs of outpatient hospital services limited to 101% of allowable costs. For dates of services on or prior to December 31, 2017, final cost settlements for CAH facilities will be reimbursed at 101% of allowable costs. For dates of services on January 1, 2018 through June 30, 2018, final cost settlements for CAH facilities will be reimbursed at 97.98% of allowable costs. For dates of services on or after July 1, 2018, final cost settlements for CAH facilities will be reimbursed at 101% of allowable costs. For facilities where the cost reporting period spans multiple cost settlement percentages, the department will prorate the final cost settlement.

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 outpatient prospective payment system (OPPS).