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: 09-002

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
12/08/08

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 447.321

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $ No Impact
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 1-6 of 4.19B, Service 2a and 3.1-A page 10 and 3.1-B page 9. (DM)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages 1-8 of 4.19B, Service 2a

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Reimbursement

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Mary Dalton**

14. TITLE: Acting Director

15. DATE SUBMITTED: 12/30/08

16. RETURN TO:
Montana Dept. of Public Health and Human Services
Mary Dalton
Acting Director
Attn. Jo Thompson
PO Box 4210
Helena, MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/30/08

18. DATE APPROVED: 12/7/09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 12/8/08

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard C. Allen

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Critical Access Hospital(CAH)services.

/X/ Provided: / / No limitations /X/ With limitations

/ / Not provided.

*Description provided on attachment

Supplement to
Attachment 3.1A

Service 24g
CAH Hospital
Services

MONTANA

The following limitations apply to Critical Access Hospital (CAH) Services:

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.

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Critical Access Hospital(CAH)services.

/X/ Provided: / / No limitations /X/ With limitations

/ / Not provided.

*Description provided on attachment

Supplement to
Attachment 3.1B

Service 23g
CAH Hospital
Services

MONTANA

The following limitations apply to Critical Access Hospital (CAH) Services:

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.

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. The interim rate for outpatient services will be a percentage of usual and customary charges. The percentage shall be the provider's outpatient cost-to-charge ratio determined by the facilities Montana 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.

Except as 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 conversion factor 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.

(i) "Conversion factor" means an average base rate initially calculated by CMS and used to translate APC relative weights into dollar payment rates.

(b) This conversion factor 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.

(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) 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. On January 1st of each year, the Department publishes and makes effective the outpatient fee schedule as adopted from the Code of Federal Regulations (CFR) pertaining to the Outpatient Prospective Payment System (OPPS). The outpatient fee schedule is made final and published by the Centers for Medicare and Medicaid Services (CMS) in November of each year. All rates are published on the agency's website at www.mtmedicaid.org. Except as 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.

(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 lowest level 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, separately billable laboratory services, and separately billable drugs. The provider must furnish all of the necessary dialysis services, equipment, 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.

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.

2. For PPS hospitals, immunizations not grouping to an APC will he paid a Medicaid fee. If the recipient 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 using an all inclusive facility rate based on the average cost per visit for PPS facilities.

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. Montana Medicaid does not pay for the professional component under the Outpatient State Plan.

6. The Department requires that National Drug Codes (NDC) must be submitted on all outpatient claims that include physician administered drugs. Payment will be based on the applicable procedure code. Montana Medicaid will reimburse only those physician administered drugs manufactured by companies that have a signed rebate agreement with CMS.

7. Montana Medicaid does not allow self-attestation of provider based status. Reimbursement of the provider based entity facility component will be on a rate per service basis using the outpatient prospective payment system (OPPS) schedules or Medicare fee schedules except as follows:

(a) Provider based entity facility component billed under revenue code 510 will be reimbursed at 80% of the applicable rate.

(i) Provider based facilities must bill using revenue code 510 for evaluation and management services and procedural codes as per Medicare guidelines.

(b) 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.

(c) Provider based entities providing obstetric services must bill as a non-provider based provider.

(d) Vaccines for Children (VFC) services must be billed as a non-provider based provider.

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. On January 1st of each year, the Department publishes and makes effective the outpatient fee schedule as adopted from the Code of Federal Regulations (CFR) pertaining to the Outpatient Prospective Payment System (OPPS). The outpatient fee schedule is made final and published by the Centers for Medicare and Medicaid Services (CMS) in November of each year. All rates are published on the agency's website at www.mtmedicaid.org. 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.

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. Critical Access Hospital (CAH) reimbursement for reasonable costs of outpatient hospital services shall be limited to the lesser of 101% of allowable costs or the upper payment limit.

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).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Denver, CO 80202-4967

CENTERS for MEDICARE & MEDICAID SERVICES

Region VIII

December 7, 2009

Ms. Mary Dalton
Medicaid & Health Services Manager
Montana Department of Public Health & Human Services
111 North Sanders, Room 301
P.O. Box 4210
Helena, MT 59604

Re: Approval of State Plan Amendment (SPA) MT 09-002

Dear Ms. Dalton:

We have received Montana's State Plan Amendment 09-002. The intent of this SPA is to up-date the reimbursement pages for Outpatient Hospital rates to reflect actual state practices.

CMS has completed its review of this SPA. We would like to thank State staff for their cooperative efforts with CMS as we worked through a number of hurdles presented by the timing and topic of the SPA. Please be advised that the amendment is approved with an effective date of December 8, 2008.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Divisions of Medicaid and Children's Health

Cc: Duane Preshinger