DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

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August 22, 2011

Mr. Richard C. Allen
Associate Regional Administrator
Division of Medicaid and State Operations
Centers for Medicare and Medicaid Services, Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202

Dear Mr. Allen:

This letter accompanies the Title XIX State Plan Amendment, Transmittal No 11-034, pertaining to Optometrist Services reimbursement.

The purpose of this amendment is to update the rate change and date of the agency's rates in the State Plan. The update is necessary to reflect the change in fee schedule dates. Public notice was completed on May 26, 2011 when the Montana Administrative Register (MAR), Notice 37-541, was published.

Please contact Rena Steyaert, Medicaid Therapies Program Officer at 406-444-4066, rsteyaert@mt.gov or Duane Preshinger, Medicaid Systems Support Program Director at 406-444-4145, dpreshinger@mt.gov for additional information.

Sincerely,

Mary E. Dalton
State Medicaid Director

Cc: Duane Preshinger
Rena Steyaert

Encl: HCFA 179
4.19B Payment Methodology Questions
State Plan Amendment 4.19B Service 6.b, Optometrists' Services
ARRA Questions
Tribal Consultation
CMS Freezes or Reduction of Payment Questions 1.6.4

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: 11-034

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
09/01/2011

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:
N/A

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ 2,949
b. FFY 2012 $ 35,015

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page(s) 2 of 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 6.b
Optometrists' Services

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page(s) 2 of 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 6.b
Optometrists' Services

10. SUBJECT OF AMENDMENT:
Optometric payment fee schedule rate and date change.

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:

13. TYPED NAME: **Mary E. Dalton**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 8/22/2011

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

MONTANA

I. Reimbursement for Optometric Services shall be:

A. The lower of:

1. The provider's usual and customary charge for the service; or

2. Reimbursement provided in accordance with the methodology described in Number II.

II. The Department's fee schedule for Optometric Services is determined:

A. In accordance with the Resource Base Relative Value Scale (RBRVS) methodology, by multiplying Medicare's Relative Value Units (RVU), which is numeric, by the Montana Medicaid specific conversion factor, which is a dollar amount, to equal a fee. Specific to Montana Medicaid, there is an ability to multiply the fee times a policy adviser (either plus or minus) to affect the fee.

B. "Resource based relative value scale (RBRVS)" means the version of the Medicare resource based relative value scale contained in the physicians' Medicare Physician Fee Schedule adopted by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services published ~~November 25, 2009~~.January 11,2011

C. "Relative value unit (RVU)" means a numerical value assigned in the resource based relative value scale to each procedure code used to bill for services provided by a health care provider. The relative value unit assigned to a particular code expresses the relative effort and expense expended by a provider in providing one service as compared with another service.

D. The RVU's are adopted from the RBRVS. For the services for which the RBRVS does not specify RVU's, the department sets those RVU's as follows:

(1) The RVUs for a Medicaid covered service are calculated as follows:

i. If Medicare sets RVU's, the Medicare RVU's are applicable;

ii. If Medicare does not set RVU's but Medicaid sets RVUs, the Medicaid RVUs are set in the following manner:

MONTANA

(A) convert the existing dollar value of a fee to an RVU value;
(B) evaluate the RVU of similar services and adding an RVU value; or
(C) convert the average by report dollar value of a fee to an RVU value.

E. If there is not a Medicare RVU or Medicaid history data, reimbursement will be 'by report'. 'By report' means paying a percentage of billed charges. The percentage is derived by dividing the previous state fiscal year's total Medicaid reimbursement for services included in the RBRVS by the previous state fiscal year's total Medicaid billings.

F. The agency's rates were set as of ~~July 1, 2010~~ September 1, 2011 are effective for services on or after that date. All rates are published on the agency's website www.mtmedicaid.org. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

* A provider is an optometrist licensed in the State of Montana who is individually enrolled in the Montana Medicaid program.

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TN: 11-034
Optometric Services

For any SPA that freezes or reduces payments, CMS is requesting states address the standard access questions as follows:

• How did the State determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?

The reduction in payment was necessary to reduce the reimbursement rates to Medicaid providers by 2% beginning on September 1, 2011. These provider rate changes are based on a one-time-only provider rate increase that went into effect in Fiscal Year (FY) 2010, and was held constant in FY 2011. The 2010 provider rate increase was paid for with one-time-only funding appropriated by Montana's 61st Legislative session meeting in 2009. This one-time-only funding was not included in the budget base for FY 2012 and the funds were not appropriated by the current 62nd Legislative session.

Providers were notified during the state's Administrative Rule process in 2009 that the funds were one-time-only. No negative comments were received during the Administrative Rule public comment period in 2009.

In evaluating the reductions needed to remain within the legislative appropriation, the Department considered the alternatives of eliminating covered services and/or decreasing Medicaid eligibility. The Department is unable to decrease eligibility for services after March 23, 2010 and be in compliance with the Medicaid maintenance-of-effort (MOE) requirements of the Patient Protection and Affordable Care Act, PL 111-148, Title II, Sections 2001, et seq. Eliminating optional services was considered and rejected because of the impact on vulnerable Medicaid clients who would lose coverage for services. For these reasons, the Department pursued the provider rate decrease.

• What types of studies or surveys were conducted or used by the State to assure that access would not be negatively impacted (e.g. comparison with commercial access/reimbursement rates, comparison with Medicare rates, comparison with surrounding State Medicaid rates, comparison with national averages for Medicaid or Medicare, other).

Montana's rates for this program were compared to the bordering states of Idaho, North Dakota, South Dakota and Wyoming. The top five codes by amount paid in Montana were compared and it was found that Montana was within 93% of the surrounding states average reimbursement amount. The Department found that Optometric services in Montana averaged $57.80 for the top five paid codes and the average of the surrounding states was $62.09.

• How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?

Montana has a public notice requirement for any changes to the Administrative Rules. The proposed rate modifications were posted on the Montana Administrative Register Notice 37-539 for public viewing on May 26, 2011. The notice can be found at the following website: http://www.mtrules.org/gateway/ShowNoticeFile.asp?TID=3360

A Tribal consultation letter was sent to all Montana tribes on May 31, 2011 and the Medicaid Advisory Council was consulted regarding the proposed changes on June 9, 2011.

• Is the State modifying anything else in the State Plan which will counterbalance impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?

No

• How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels? Provide specific details about the measures to be used, how these measures were developed, data sources, and plans for reporting, tracking and monitoring. The State should also provide the specific benchmarks for each measure which would trigger State action to remedy indicated access problems.

The Department intends to monitor provider enrollment, disenrollment, and client utilization rates for the applicable provider type for 6 months (beginning with August 2011.)
Definitions/Development:

- Provider Enrollment: Monitor the number of providers currently enrolled in the program prior to the rate change.
- Provider Disenrollment: Monitor the number of providers disenrolled after the rate change
- Client utilization rates: Measures the percentage of total eligible clients accessing the specific provider type in any given month. Calculated by: total number of clients accessing service divided by total number of clients = % client utilization rate.

Data Source/Frequency/Reporting:

- Monthly DSS claims based data runs.
- Responsible Program Officers will monitor and report to Supervisor on a monthly basis. Any anomalies will be reported to Department leadership.

Benchmarks:

- 150 Enrolled Optometric providers.
- 0 disenrolled Optometric providers.
- 16.81% utilization rate as of June 1 2011.

• What action(s) does the State plan to implement after the rate modification(s) take place to counter any decrease to access if such a decrease is found to prevent sufficient access to care?

Should access become an issue the Department will initiate discussions with providers and their respective provider associations to discuss ways to improve or counter any loss of client access.

A Tribal consultation letter was sent to all Montana tribes on May 31, 2011 and the Medicaid Advisory Council was consulted regarding the proposed changes on June 9, 2011.

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The Department intends to monitor provider enrollment, disenrollment, and client utilization rates for the applicable provider type for 6 months (beginning with September 2011.)
Definitions/Development:

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CMS ARRA Questions

Please indicate whether, in relation to the coverage and reimbursement pages that include sections related to this State Plan Amendment, the State is in compliance with the terms of the American Recovery and Reinvestment Act (ARRA) concerning: Is this submittal likely to have a direct impact on Indians or Indian health programs (Indian Health Services, Tribal 638 Health Programs, and Urban Indian Organizations)?

1. **If this change is not likely to have a direct impact on Indians or Indian health programs, please explain why not.**

There will be no change in the coverage only the fee schedule date and rate of reimbursement for Optometrists' Services. This change is not expected to affect access or service provisions to any Medicaid clients. Regardless of the impact, Tribal consultation was initiated.

2. If this changes is likely to have a direct impact on Indians or Indian health programs please respond to the following questions:
a. How did the State consult with the federally-recognized tribes and Indian health programs prior to submission of this SPA or waiver request?

Tribal consultation letter was sent to Montana's Tribes on May 31, 2011.

b. If the tribes and Indian health programs were notified in writing, please provide a copy of the notification, the date it was sent and a list of the entities notified. In addition, please provide information about any concerns expressed by the tribes and/or Indian health providers and the outcome.

Attached

c. If the consultation with the tribes and Indians health providers occurred in a meeting, please provide a list of invitees, a list of attendees, the date the meeting took place and information about any concerns expressed by the tribes and/or Indian health providers and the outcome.

n/a

4.19B Payment Methodology Questions
TN # 11-034

CMS has identified five questions that are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Response: Yes, Optometrist providers retain all of the Medicaid payments including the Federal and State share.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: The State share is general fund dollars appropriated by the State legislature. Such appropriations are based on previous year's expenditures and targeted caseloads.

- The estimated total cost of this provider rate change for FFY 2011 is ($4,414) with a State share of ($1,465).

- The estimated total cost of this provider rate change for FFY 2012 is ($52,965) with a State share of ($17,950).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: N/A

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Response: N/A

5. Does any public provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response: No payments exceed the reasonable costs of providing services.