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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-12-028

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
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

NOV 2 3 2012

Ms. Mary E. Dalton
State Medicaid Director
Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: Montana 12-028

Dear Ms. Dalton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-028. Effective for services on or after September 1, 2012, this amendment (1) implements legislative funding for nursing facility reimbursement; (2) updates references to reflect the current fiscal year; (3) updates the current statewide median price; (4) incorporates the funding level for the direct care wage component of the rate; and, (5) provides for other minor clarifications.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 12-028 is approved effective September 1, 2012. The HCFA-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

Cindy Mann
Director, CMCS

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	1. TRANSMITTAL NUMBER: 12-028	2. STATE MONTANA
FOR: HEALTH CARE FINANCING ADMINISTRATION	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 ~~July~~ 1, 2012 September 1, 2012	

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:	7. FEDERAL BUDGET IMPACT:
42 CFR 447 (250-272)	a. FFY **2012** $1,310,589 b. FFY **2013** $3,931,766
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19 D **13 of 56** **15 of 56** **24 of 56** **32 of 56** **54 of 56**	**4.19 D** **13 of 56** **15 of 56** **24 of 56** **32 of 56** **54 of 56**

10. SUBJECT OF AMENDMENT:
NURSING FACILITY 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 STATE AGENCY**

12. SIGNATURE OF STATE AGENCY OFFICIAL: Mary E. Dalton	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**
13. TYPED NAME: **Mary E Dalton**	
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: 9/28/12	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: NOV 23 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2012	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

average case mix index and the statewide average Medicaid case mix index.

(i) The Medicaid average case mix index for each facility to be used in rate setting will be the simple average of each facility's four Medicaid case mix indices calculated for the periods of February 1 of the current year and November 1, August 1 and May 1 of the year immediately preceding the current year. The statewide average Medicaid case mix index will be the weighted average of each facility's four quarter average Medicaid case mix index to be used in rate setting.

(c) The statewide price for nursing facility services will be determined each year through a public process. Factors that could be considered in the establishment of this price include the cost of providing nursing facility services, Medicaid recipients access to nursing facility services, and the quality of nursing facility care.

(d) The total payment rate available for the period September 1, 2012 through June 30, 2013 will be the rate as computed in (2), plus any additional amount computed in ARM 37.40.311 and 37.40.361.

(3) Providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the Medicaid program in a newly constructed facility shall have a rate set at the statewide median price of $162.80 as computed on September 1, 2012. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred.

(4) For ICF/MR services provided by nursing facilities

department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized Medicaid recipients during the billing period.

(a) Authorized Medicaid recipients are those residents determined eligible for Medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37 40.110, 37.40.120, and 37.40.201, et seq.

(12) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or nonpayment, as specifically provided in these rules. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2006 MAR p. 1638, Eff. 7/1/06; AMD, 2007 MAR p. 1100, Eff. 8/10/07; AMD, 2008 MAR p. 1320, Eff. 7/1/08; AMD, 2009 MAR p. 1411, Eff. 8/14/09; AMD, 2010 MAR p. 1520, Eff. 7/1/10; AMD, 2011 MAR p. 1375, Eff. 7/29/11.)

37.40.308 RATE EFFECTIVE DATES (1) A provider's per diem rate effective for the rate period July 1, 2001 through June 30, 2002 and in subsequent rate years, shall be determined in accordance with ARM 37.40.307.

(2) Except as specifically provided in these rules, per diem rates and interim rates are set no more than once a year, effective July 1, and remain in effect at least through June 30 of the following year.

(a) Nothing in this subchapter shall be construed to require that the department apply any inflation adjustment, recalculate the Medicaid case mix index or the statewide price, or otherwise adjust or recalculate per diem rates or interim rates on July 1 of a rate year, unless the department adopts further rules or rule amendments providing specifically for a rate methodology for the rate year.

(3) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party" means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity;

(ii) ,A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3) (b) (i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3) (b) Ci) ; or

(iii) a sole proprietorship, partnership corporation or other entity in which a person, described in (3) (b) (i) or (ii) has a direct or indirect interest of 5% or more or a power, whetner or not legally enforceable to directly or indirectly influence or direct the actions -or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal medicare law, regulation or policy or related case law regarding changes in ownership under the medicare program are not applicable.

(5) As required in ARM 37.40.306, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the medicaid program in accordance with applicable requirements -

(6) Any change in provider, corporate or other business ownership structure or operation of the facility that results in a change in a change in the National Provider Identifier (NPI) will require a provider to seek a new medicaid provider enrollment. If the NPI is transferred with the facility, then only a provider file update is required to change the federal tax identification number and ownership information. A written request must be made to the department if the NPI is transferred with the facility.

(History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AND, 1994 MAR p. 1881, Eff. 7/8/94; AND, 1995 MAR p. 1227, Eff. 7/1/95; AND, 1997 MAR p. 76, Eff. 1/17/97; AND, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2011 MAR p. 1375, Eff. 7/29/11.)

facilities, including intermediate care facilities for the mentally retarded, whether or not located in the state of Montana

(10) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under ARM 37.40.307. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2007 MAR p. 1100, Eff. 8/10/07; AMD, 2011 MAR p. 1375, Eff. 7/29/11.)

Extended Rehabilitation Unit (ERU) or Traumatic Brain Injured Program (TBI)

Program Criteria

Program developed to meet needs of individuals who are not eligible for acute rehabilitation services but who are still unable to return to independent or home living. The program must provide individualized rehabilitation sustaining therapies and recreational opportunities.

All individuals appropriate for this program must be at Level II (Rancho Scale) or above and be alert to stimuli. The Rancho Scale is a cognitive functioning scale developed by the head injury treatment team at the Rancho Los Amigos Hospital and applies specifically to head injured people following injury.

Individuals referred and admitted to this unit shall demonstrate an ability to recognize, either on their own or with prompting when their behavior is inappropriate. People who demonstrate aggressive behaviors that are potentially dangerous to themselves or others are not appropriate for placement into this program. Those who are elopement risks or require locked units may not be appropriate. If these behaviors develop after admission into the

37.40.361 DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE REPORTING/ADDITIONAL PAYMENTS INCLUDING LUMP SUM PAYMENTS FOR DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE AND BENEFIT INCREASES (1) Effective for the period September 1, 2012 and for the six months thereafter, nursing facilities must report to the department actual hourly wage and benefit rates paid for all direct care and ancillary services workers or the lump sum payment amounts for all direct care and ancillary services workers that will receive the benefit of the increased funds. The reported data shall be used by the department for the purpose of comparing types and rates of payment for comparable services and tracking distribution of direct care wage funds to designated workers.

(2) The department will pay Medicaid certified nursing care facilities located in Montana that submit an approved request to the department a lump sum payment in addition to the amount paid as provided in ARM 37.40.307 and 37.40.311 to their computed Medicaid payment rate to be used only for wage and benefit increases or lump sum payments for direct care or ancillary services workers in nursing facilities.

(a) The department will determine the lump sum payments, twice a year commencing September 1, 2012, and again in six months from that date as a pro rata share of the appropriated $3,981,106 funds allocated for increases in direct care and ancillary services workers' wages and benefits or lump sum payments to direct care and ancillary services workers.

(b) To receive the direct care and/or ancillary services workers' lump sum payment, a nursing facility shall submit for approval a request form to the department stating how the direct care and ancillary services workers' lump sum payment will be spent in the facility to comply with all statutory requirements. The facility shall submit all of the information required on a form to be developed by the department in order to continue to receive subsequent lump sum payment amounts for the entire rate year. The form for wage and benefit increases will request information including but not limited to:

(i) the number by category of each direct care and ancillary services workers that will receive the benefit of the increased funds if these funds will be distributed in the form of a wage increase

(ii) the actual per hour rate of pay before benefits and before the direct care wage increase has been implemented for each worker that will receive the benefit of the increased funds;

(iii) the projected per hour rate of pay with benefits after the direct wage increase has been implemented;

(iv) the number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit; and

(v) the number of projected hours to be worked in the budget period.

(c) If these funds will be used for the purpose of providing lump sum payments (i.e. bonus, stipend or other payment types) to direct care and ancillary services workers in nursing care facilities the form will request information including, but not limited to:

(i) the number by category of each direct care and ancillary services worker that will receive the benefit of the increased funds,

(ii) the type and actual amount of lump sum payment to be provided for each worker that will receive the benefit of the lump sum funding;

(iii) the breakdown of the lump sum payment by the amount that represents benefits and the direct payment to workers by category of worker; and

(iv) the effective date of implementation of the lump sum benefit.

(d) A facility that does not submit a qualifying request for use of the funds distributed under (2), that includes all of the information requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care and ancillary services workers.

(3) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to the provisions of ARM 37.40.345, 37.40.346 and 37.85.414. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA, NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2006 MAR p. 1638, Eff. 7/1/06; AMD, 2007 MAR p. 1100, Eff. 8/10/07; AMD, 2009 MAR p. 1411, Eff. 8/14/09; AMD, 2010 MAR p. 1520, Eff. 7/1/10.)

37.5.310 ADMINISTRATIVE REVIEW AND FAIR HEARING PROCESS FOR MEDICAL ASSISTANCE PROVIDERS (1) The following administrative review and fair hearing process applies to all medical assistance providers that are aggrieved by an adverse action of the department, except medical assistance providers appealing eligibility determinations as a real party in interest.

(2) A medical assistance provider, other than a medical assistance provider appealing an eligibility determination as a real party in interest, aggrieved by an adverse action of the department may request an administrative review. The request must be in writing, must state in detail the provider's objections, and must include any substantiating documents and information which the provider wishes the department to consider in the administrative review. The request must be mailed or delivered to the Department of Public Health and Human Services, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 and should be addressed or directed to the division of the department that issued the contested determination. The request for administrative review must be received by the department within 30 days of mailing of the department's written determination.

(a) Within the 30 days a provider may request in writing an extension of up to 15 days for submission of a request for administrative review. The department may grant further extensions for good cause shown. Requests for further extensions must be in writing, must be received by the department within the