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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-14-018

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967



Region VIII

February 9, 2015

Mary Dalton, Medicaid & Health Services Manager
Montana Department of Health & Human Services
1400 Broadway
PO Box 202951
Helena, MT 59620

Re: SPA MT-14-018

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-14-018. This SPA amends the Outpatient Hospital Services reimbursement to include an approximate 9.7% rate increase; update the reference to the CMS form used to identify outpatient costs for cost reporting purposes; clarify that dental services not grouping to an ambulatory payment classification (APC) will be reimbursed as specified in the department's outpatient fee schedule; and remove the language that reimburses CPT codes 99281 and 99282 for emergency room visits based upon the lowest level clinic visit APC weight.

Please be informed that this State Plan Amendment was approved today with an effective date of July 1, 2014. We are enclosing the summary page and the amended plan page(s).


If you have any questions regarding this SPA please contact Cindy Smith at 303-844-7041.

Sincerely,

/s/

Richard C. Allen
Associate Regional Administrator
Division for Medicaid and Children's Health Operations

Cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

,TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 14-018	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 07/01/2014	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.321		7. FEDERAL BUDGET IMPACT: a. FFY 2014 \$ 378,808 (3 months) b. FFY 2015 \$1,495,232 (12 months) c. FFY 2016 \$1,121,424 (9 months)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Pages 1 through 7 of 7 of Attachment 4.19B, Outpatient Hospital Services, 2a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Pages 1 through 7 of 7 of Attachment 4.19B, Outpatient Hospital Services, 2a	
10. SUBJECT OF AMENDMENT: Amend Outpatient Hospital Services reimbursement to include an approximate 9.7% rate increase; update the reference to the CMS form used to identify outpatient costs for cost reporting purposes; clarify that dental services not grouping to an ambulatory payment classification (APC) will be reimbursed as specified in the department's outpatient fee schedule; and remove the language that reimburses CPT codes 99281 and 99282 for emergency room visits based upon the lowest level clinic visit APC weight.			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Single Agency Director Review	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Montana Dept of Public Health and Human Services Mary E. Dalton Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59604	
13. TYPED NAME: Mary E. Dalton		17. DATE RECEIVED: 06/30/15	
14. TITLE: State Medicaid Director		18. DATE APPROVED: 02/09/15	
15. DATE SUBMITTED: 6-30-14		FOR REGIONAL OFFICE USE ONLY	
PLAN APPROVED - ONE COPY ATTACHED		19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/15	
20. SIGNATURE OF REGIONAL OFFICIAL: /s/		21. TYPED NAME: Richard C. Allen	
22. TITLE: ARA, DMCHO		23. REMARKS:	

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Attachment 4.19B
Methods & Standards for
Establishing Payment Rates
Page 1
Outpatient Hospital Services
Service 2.a

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 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 OPPOS (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.

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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, 2014, 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.

(b) This Medicaid conversion factor effective for services provided on and after July 1, 2014, 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 OPPTS.

(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.

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(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. Rates were set as of July 1, 2014 and are effective for services on or after that date. All rates are published on the agency's website at www.mtmedicaid.org. Unless 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.

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3. Emergency Department Services for OPSS 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 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 OPSS 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. The provider must furnish all of the necessary dialysis services, equipment, laboratory services, drugs, 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. Refer to the Medicaid fee schedule for a list of these services located on the agency's website at www.mtmedicaid.org.

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2. For PPS hospitals, immunizations not grouping to an APC will be 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 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 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.

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(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.

(e) Montana Medicaid does not recognize out of state provider based status.

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 July 1, 2014 and are effective for services on or after that date. 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.

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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. Critical Access Hospital (CAH) final reimbursement shall be for reasonable costs of outpatient hospital services limited to 101% of allowable costs. 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).

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