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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-15-0007

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 AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

DEC 11 2015

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

Re: Montana 15-0007

Dear Ms. Dalton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-0007. Effective for services on or after July 1, 2015, 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) updates the current fiscal year 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 15-0007 is approved effective July 1, 2015. The HCFA-179 and the amended plan pages are attached.

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

Sincerely,

Kristin Fan
Director

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: **15-0007**

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
July 1, 2015

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 447 (250-272)

7. FEDERAL BUDGET IMPACT:
a. FFY **2015** ($ 731,577)
b. FFY **2016** ($2,194,730)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19 D
13 of 56
15 of 56
25 of 56
38 of 56
54 of 56 → 39 of 56 MEK 12-9-15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19 D
13 of 56
15 of 56
25 of 56
38 of 56
54 of 56 → 39 of 56 MEK

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: [redacted] 12-9-15 Mary Eve Kulawik for Mary Dalton

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

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 9-28-15

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: DEC 11 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMCo

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 July 1, 2015 through June 30, 2016 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 will have a rate set at the statewide median price of $172.70 as computed on July 1, 2015. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider will 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; AMD, 2012 MAR p. 1674, Eff. 8/24/12; AMD, 2013 MAR p. 1103, Eff. 7/1/13; AMD, 2014 MAR p. 1517, Eff. 7/11/14; AMD, 2015 MAR p. 824, Eff. 7/1/15.)

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

37.40.326 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) This rule specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/MR providers, which 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 or following a change in provider as defined in ARM 37.40.325.

(a) Effective July 1, 2001, and thereafter, the rate paid to new providers that acquire or otherwise assume the operations of an existing nursing facility, that was participating in the Medicaid program prior to the transaction, will be paid the price- based reimbursement rate in effect for the prior owner/operator of the facility before the transaction as if no change in provider had occurred. These rates will be adjusted at the start of each state fiscal year in accordance with (1)(b).

(b) Effective July 1, 2001, and thereafter, the rate paid to newly constructed facilities or to facilities participating in the Medicaid program for the first time will be the statewide average nursing facility rate under the price-based reimbursement system. The direct care component of the rate will not be adjusted for acuity, until such time as there are three or more quarters of Medicaid CMI information available at the start of a state fiscal year. Once the CMI information is available the price-based rate will include the acuity adjustment as provided for in ARM 37.40.307(2)(b). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 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. 1385, Eff. 7/1/93; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p.4-89; 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, 2014 MAR p. 1517, Eff. 7/11/14.)

Rules 27 through 29 reserved

37.40.330 SEPARATELY BILLABLE ITEMS (1) In addition to the amount payable under the-provisions of ARM 37.40.307(1) or (4), the department will reimburse nursing facilities located in the state of Montana for the following separately billable items. Refer to the department's nursing facility fee schedule for specific codes and refer to healthcare common procedure coding system (HCPCS) coding manuals for complete descriptions of codes:

(a) ostomy surgical tray;

medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana Medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary, XEROX, at P.O. Box 4936, Helena, MT 59604-4936.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana Medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state Medicaid agency establishing or stating the facility's Medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state Medicaid agency establishing or stating the Medicaid reimbursement payable for such items for the period the items were provided;

(d) a .properly completed level I screening form for the resident, as required by ARN 37.40.201, et seq.;

(i) To the extent required by ARN 37.40.201, et seq., a level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the resident's need for active treatment. A level I screening form may be obtained from the department.

(e) a copy of the preadmission-screening determination for the resident completed by the department or its designee;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, Medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for Medicaid during the period services were provided; and

(h) assurances that, during the period the billed services

were provided, the facility was not operating under sanctions imposed by Medicare or Medicaid which would preclude payment.

(5) Reimbursement to nursing facilities located outside the state of Montana for Medicare coinsurance days for dually eligible Medicaid and Medicare individuals shall be limited to the per diem rate established by the facility's state Medicaid agency, less the Medicaid recipient's patient contribution. (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; AI, 1992 MAR p. 1627, Eff. 7/31/92; AND, 1994 MAR p. 1881, Eff. 7/8/94;, 1998 MAR p. 1'749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489 ; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2015 MAR p. 824, Eff. 7/1/15.)

37.40:338 BED HOLD PAYMENTS (1) Except as provided in 6) through (9) for therapeutic home visits, payment will be made to a provider for holding a bed for a resident only if:

(a) the provider's facility is full and has a current waiting list of potential residents during each such bed day claimed for reimbursement;

(b) the resident- for whom the bed is held is temporarily receiving medical services outside the facility, except in a other nursing facility, and is expected to return to the provider;

(c) the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate long term care bed would otherwise become available; and

(d) the provider has received written approval from the department's senior and long term care division as provided in (4) (2) For purposes of (1) , a provider will be considered full if: (a) all Medicaid certified beds are occupied or being held for a recipient who is either temporarily receiving medical services outside the provider's facility or outside the facility on a therapeutic home visit; or

(b) as to gender, if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients.

(3) For purposes of (1) , the provider must maintain and, upon request, provide to the department or its agents documentation that the absence is expected to be temporary and of

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 July 1, 2015 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 will 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 July 1, 2015, and again in six months from that date as a pro rata share of the appropriated $5,483,582 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 must 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 must 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 will 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; AMD, 2012 MAR p. 1674, Eff. 8/24/12; AMD, 2013 MAR p. 1103, Eff. 7/1/13; AMD, 2014 MAR p. 1517, Eff. 7/11/14; AMD, 2015 MAR p. 824, Eff. 7/1/15 .)

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