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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-15-0020

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 15-0020

Dear Ms. Dalton:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0020. Effective for services on or after October 1, 2015, this amendment updates the reimbursement methodology for inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 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 15-0020 is approved effective October 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,

[redacted]

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: 15-0020

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
10/01/2015

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 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2015: $0
b. FFY 2016: $0
c. FFY 2017: $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, Service 1, Inpatient Hospital Services
Pages 1-17 of 17

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Service 1, Inpatient Hospital Services
Pages 1-17 of 17

10. SUBJECT OF AMENDMENT:
The purpose of this Inpatient State Plan Amendment is to update the state fiscal years in which Graduate Medical Education payments will be paid and add language which explains the process of unbundling Long Acting Reversible Contraceptives inserted at time of delivery in a Prospective Payment System Hospital.

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:
[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 9-27-15

16. RETURN TO:
Montana Department of Public Health and Human Services
Mary E. Dalton
Attn: Mary Eve Kulawik
PO Box 4210
Helena MT 59620

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: 10/1/2015

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE: Director, DMCO

23. REMARKS

FORM HCFA-179 (07-92)

REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

A. MONTANA MEDICAID PROSPECTIVE PAYMENT (DRG) REIMBURSEMENT

Except as specified in Subsection B, the Inpatient Prospective Payment Method applies to all inpatient stays in all acute care general, rehabilitation and mental health (psychiatric/substance abuse treatment) hospitals and units located in Montana or out-of-state.

1. Primacy of Medicaid Policy

Some features of the Medicaid Inpatient Prospective Payment Method are patterned after similar payment policies used by Medicare. When specific details of the payment method differ between Medicaid and Medicare, then the Medicaid policy prevails.

2. APR-DRG Reimbursement

For admissions dated October 1, 2008 and after, the Department will reimburse hospitals a per-stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained on the inpatient Medicaid claim such as diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG determines the reimbursement when the DRG Relative Weight is multiplied by the DRG Base Price.

The Medicaid grouper will be updated in July of each year or when updates are published.

Hospitals reimbursed using the Inpatient Prospective Payment Method are not subject to retrospective cost reimbursement.

3. DRG Relative Weights

For each DRG a relative weight factor is assigned. The relative weight is applied to determine the DRG Base Payment that will be paid for each admit-through-discharge case regardless of the specific services provided or the length of stay. The DRG relative weight is a weight assigned that reflects the typical resources consumed. DRG weights are reviewed and updated annually by the Department. The weights are adapted from national databases of millions of inpatient stays and are then "re-centered" so that the average Montana Medicaid stay in a base year has a weight of 1.00.

When the Department determines that adjustments to relative weights for specific DRGs are appropriate to meet Medicaid policy goals related to access to quality care, a "policy adjustor" will be explicitly applied to increase or decrease these relative weights. Policy adjustors are intended to be budget neutral, that is, they change payments for one type of service relative to other types without increasing or decreasing payments overall.

4. DRG Base Price

There are two different base prices for stays in acute care hospitals. These two base prices consist of the Montana average base rate and the base rate for Center of Excellence hospitals. The base price is a dollar amount that is reviewed by the Department each year. Changes in the DRG Base Price are subject to the public notice requirements of the Montana Code Annotated.

5. DRG Base Payment

For each stay, the DRG Base Payment equals the DRG Relative Weight multiplied by the DRG Base Price.

6. Cost Outlier Payments

It is recognized that there are occasional stays that are extraordinarily costly in relation to other stays within the same DRG because of the severity of the illness or complicating conditions. These variations are recognized by the Cost Outlier Payment which is an add-on payment for expenses that are not predictable by the diagnosis, procedures performed, and other statistical data captured by the DRG grouper.

Cost outlier stays are stays that exceed the cost outlier threshold for the DRG. To determine if a hospital stay exceeds the cost outlier threshold, the Montana Medicaid program excludes all services that are not medically necessary. Montana Medicaid then converts the charge information for medically necessary services into the estimated cost of the stay by applying the hospital specific cost-to-charge ratio (CCR). The estimated cost for medically necessary services is then compared to the cost outlier threshold for the appropriate DRG to determine if the stay qualifies for reimbursement as a cost outlier. Costs exceeding the threshold are multiplied by a marginal cost ratio to determine the Cost Outlier Payment.

7. Transfer Payment Adjustments

The transfer payment adjustment applies when a patient is transferred to another acute care hospital. It does not apply when a patient is discharged to a post-acute setting such as a skilled nursing facility. The receiving hospital is not impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

In the transfer payment adjustment, payment is calculated as if the member were not a transfer, then payment is adjusted. The DRG Base Payment is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day to reflect costs related to the admitting process.

If the transfer payment adjustment results in an amount greater than the amount without the adjustment, the transfer payment adjustment is disregarded. The cost outlier payment, if applicable, is then added to the DRG base payment, with the transfer adjustment made as needed.

The Transfer Payment Adjustment is not applicable to providers and services that are exempt from the Inpatient Prospective Payment Method. See Subsection B.

8. Prorated Payment Adjustment

When a member has Medicaid coverage for fewer days than the length of stay, the payment is prorated. The DRG Base Payment plus cost outlier payments, if applicable, is divided by the nationwide average length of stay for the assigned DRG to arrive at a per diem amount. The per diem amount is then multiplied by the number of days the member is eligible for Medicaid during the stay. If the prorated payment adjustment results in a payment amount greater than the amount without the adjustment, the prorated payment is disregarded.

The Prorated Payment Adjustment is not applicable to providers and services that are exempt from the Inpatient Prospective Payment Method. See Subsection B.

9. DRG Payment, Allowed Amount, and Reimbursement Amount

The DRG Payment equals the DRG Base Payment, plus the DRG Cost Outlier Payment, if applicable, with transfer and/or prorated adjustments made as needed. The allowed amount equals the DRG Payment plus applicable add-on payments for disproportionate share hospitals (DSH) as described elsewhere in this Attachment. The Reimbursement Amount equals the Allowed Amount minus deductions such as member cost-sharing, third-party liability, or patient responsibility (incurment).

10. Related Outpatient Services

Outpatient hospital services such as provider based entity hospital outpatient services, emergency room services, and diagnostic services to include clinical diagnostic laboratory tests that are provided by an entity owned or operated by the hospital either the day of or the day prior to the inpatient hospital admission must be bundled into the inpatient claims. These services will be reimbursed as part of the DRG.

Dialysis services and Long Acting Reversible Contraceptives (LARCs) are excluded from the bundling requirements.

11. Readmissions

Readmissions are subject to the provisions of Subsection E.

12. Interim Claims and Late Charges

Hospitals subject to the inpatient hospital prospective payment reimbursement method may interim bill every 30 days if the member has been a patient at least 30 days, is Medicaid eligible for the entire 30 days, and has received prior authorization. Interim claims are paid by a per diem amount multiplied by the number of covered Medicaid eligible days. Upon patient discharge, the hospital must credit all interim claim payments and bill a complete admit through a discharge claim.

The Department will not accept late charges (type of bill = 115). Instead, hospitals are instructed to adjust earlier claims if appropriate.

13. Payment for Capital

Capital cost is included in the DRG-based payment and will not be paid separately.

14. Prior Authorization

Out-of-state inpatient hospital claims are required to have prior authorization. Out-of-state inpatient hospital claims that are not prior authorized will be paid at a reduced percentage of the APR-DRG payment as described in ARM 37.86.2801.

i) Out-of-state Centers of Excellence inpatient hospital claims will be reimbursed according to the reimbursement methodology described in ARM 37.86.2947.

15. ELECTIVE DELIVERIES POLICY

All facilities enrolled in Montana Medicaid that provide obstetrical services must have an elective deliveries policy in place by July 1, 2014. Effective October 1, 2014 elective inductions or cesarean sections prior to 39 weeks and 0/7 days of gestation, and non-medically necessary cesarean sections at any gestation, will be subject to a reduced payment.

B. EXEMPT HOSPITALS, SERVICES, AND COSTS

1. Exempt Providers

The following providers are exempt from the Inpatient Prospective Payment Method described in Subsection A. In the interest of clarity, this list includes acute care hospitals as well as facilities that provide similar inpatient services:

i) Indian Health Service hospitals;
ii) The Montana State Hospital;
iii) Psychiatric residential treatment facilities (PRTFs) as defined in Service 16 of the Supplement to Attachments 3.1A and 3.1B of Montana's Medicaid State Plan. See Subsection H below;
iv) Critical access hospitals (CAHs);
v) Hospitals located in Montana counties that were classified by the U.S. Department of Agriculture as "rural" or "very rural" as of July 1, 1993. These hospitals are referred to as exempt hospitals.

2. Exempt Services and Costs

The following services are exempt from the Inpatient Prospective Payment Method described in Subsection A even when provided by hospitals that are otherwise subject to prospective payment.

i) Services where Medicare is the primary payer (crossover claims)
ii) Certified Registered Nurse Anesthetist costs as defined by Medicare. See subsection C.

C. REASONABLE COST REIMBURSEMENT

Hospitals, units and costs exempt from prospective payment will continue to use the Title XVIII retrospective reasonable cost principles for reimbursing Medicaid inpatient hospital services. 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, subject to the exceptions and limitations provided in the Department's Administrative Rules. Publication 15-1 is a manual published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, which provides guidelines and policies to implement Medicare regulations which set forth principals for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

Hospitals subject to retrospective reasonable cost reimbursement shall receive interim payments weekly or bi-weekly during the facility's fiscal year by submitting claims to the Department's fiscal intermediary. The interim payment rate will be based on a percentage of usual and customary (billed) charges to costs as determined by the facility's most recently settled Medicaid cost report. If a provider fails to submit financial information to compute the rate, the provider will be reimbursed at 50% of its usual and customary billed charges. Hospital providers are required to submit the CMS 2552-10 to the Medicare Fiscal Intermediary (FI) and the Department within five months of their fiscal year end. The FI either audits or desk reviews the cost report, and sends the Department the "as adjusted" cost report. Medicaid settlements are made from the "as adjusted" cost report.

For each hospital that is a CAH, or exempt hospital, reimbursement for reasonable costs of inpatient hospital services shall be limited to the lesser of 101% of allowable costs or the upper payment limit (UPL).

Services where Medicare is the primary payer (crossover claims) are not reimbursed using retrospective cost principles. Reimbursement for these services is the remaining coinsurance and deductible. Certified Registered Nurse Anesthetist costs as defined by Medicare are reimbursed using retrospective cost principles.

D. TRANSFERS

All transfers are subject to review for medical necessity of the initial as well as subsequent hospitalizations and the medical necessity of the transfer itself. Reimbursement cannot be made to a provider unless the service provided was medically necessary.

E. READMISSIONS

All readmissions are subject to review for medical necessity of the initial as well as the subsequent hospitalization and the medical necessity of the readmission itself. Reimbursement cannot be made to a provider unless the service provided was medically necessary. Readmissions may be reviewed on a retrospective basis to determine if additional payment for the case is warranted.

F. DISPROPORTIONATE SHARE PROVIDERS

Hospitals providing services to a disproportionate share of low-income or Medicaid eligible members shall receive an additional payment as computed below. The two following separate and distinct groups are identified for the calculation of DSH payments:

Routine DSH payments
Supplemental DSH payments

To be deemed eligible for a DSH payment adjustment, the hospital must meet the following criteria:

A) Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or a low income utilization rate that exceeds twenty percent (20%);

B) Medicaid inpatient utilization rate of at least one percent (1%);

C) The hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures; and

D) Section C does not apply to a hospital which:
   i) Predominantly has inpatient admissions for individuals under 18 years of age; or
   ii) Does not offer non-emergency obstetric services as of December 22, 1987.

The Medicaid inpatient utilization rate (expressed as a percentage) for a hospital shall be computed as a total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

1. Medicaid inpatient days means the hospital's number of inpatient days attributable to patients who were eligible for medical assistance under the approved Medicaid State Plan in a cost reporting period, whether the patients receive medical assistance on a fee-for-service basis or through a managed care program.

2. Inpatient days includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

The low-income utilization rate for a hospital shall be computed as the sum (expressed as a percentage) of the fraction and is calculated as follows:

1. Total Medicaid patient revenues includes fee for service and managed care programs paid to the hospital, plus the amount of cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of cash subsidies) in the same reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources) in a cost reporting period divided by the total number of the hospital's charges for inpatient services in the same period. Total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the State Plan), that is, reductions in charges given to other third party payer, such as Health Maintenance Organizations, Medicare, and private insurances.

The routine DSH payment will be an amount equal to the product of the hospital's Medicaid operating cost payment times the hospital's Medicaid DSH adjustment percentage developed under rules established by section 1886 (d)(5)(F)(iv) of the Social Security Act. Prospective Payment System (PPS) hospitals are paid routine DSH upon payment of the claim. CAHs are paid annually during the fourth quarter of the federal fiscal year (FFY).

If the routine DSH payments for a fiscal year are less than the final federal allotment for that fiscal year, the State will expend the remaining allotment using the supplemental DSH payment methodology as follows:

To be deemed eligible for a supplemental DSH payment, the hospital must have:

A) A Medicaid inpatient utilization rate of at least one percent (1%); and

B) At least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term obstetrician includes any physician or mid-level with staff privileges at the hospital to perform non-emergency obstetric procedures.

C) Section B does not apply to a hospital which:
   i) Predominantly has inpatient admissions for individuals under 18 years of age; or
   ii) Does not offer non-emergency obstetric services as of December 22, 1987.

The sum of all supplemental DSH payments will be equal to the remaining federal allotment after all routine DSH payments are made, plus the state financial participation. Each qualifying facility will receive a portion of the total available amount based on the number of Medicaid paid inpatient days provided as a percentage of the total number on Medicaid paid inpatient days provided by all of the facilities eligible for a supplemental DSH payment.

CAHs and other facilities paid outside of the PPS shall receive a uniform increased proportion of the total funding available for supplemental DSH payments. This increased proportion is intended to maintain access to hospital services in critical rural areas of Montana.

Hospitals that qualify for both routine and supplemental DSH payments will receive payments under both methodologies.

Hospitals must be located within the borders of the State of Montana to be eligible for routine or supplemental disproportionate share payments.

Supplemental disproportionate share payments will be made during the third quarter of the state fiscal year (SFY).

The total DSH payment made to the hospital shall not exceed the costs of furnishing hospital services by the hospital to individuals who either are eligible for medical assistance under the State Plan or have no health insurance (or other source of third party coverage), as established in Section 1923 of the Social Security Act and the Benefits Improvement and Protection Act of 2000 (BIPA).

G. AUDITS AND RECOVERY OF OVERPAYMENTS

The Department may perform audits or desk reviews pursuant to ARM 37.40.346. If at any time during an audit or desk review, the Department discovers evidence suggesting fraud or abuse by a provider, such evidence along with the last audit report regarding said provider, shall be referred to the State's Medicaid Fraud Unit.

The Department shall submit an independent certified audit to the Centers for Medicare and Medicaid Services (CMS) for each Medicaid State Plan rate year consistent with 42 CFR 455 Section(D). Should the Department determine there was an overpayment paid to a provider based upon the most recent audit or desk review, the Department will immediately recover the overpayment pursuant to ARM 37.86.2820. The amount of the overpayment will be redistributed to providers who did not exceed the hospital specific UPL during the period in which the DSH payments were determined. The payments will be distributed pursuant to ARM37.86.2925 and will be subject to hospital specific UPLs.

H. HOSPITAL BASED AND FREE STANDING INPATIENT PSYCHIATRIC SERVICES

1. Hospital based and free standing inpatient psychiatric services are reimbursed using the Inpatient Prospective Payment Method described in section A of this document.

2. The Department will reimburse in-state PRTFs an all-inclusive bundled per-diem interim rate as described in Attachment 4.19D, Service 16, PRTF.

3. All Montana providers of hospital based inpatient psychiatric services for individuals under age 21 shall be eligible to receive and annual continuity of payment (CCP) in addition to per-diem reimbursement. The CCPs will completely or partially reimburse providers for their otherwise un-reimbursed costs of providing care to Medicaid members. Total Medicaid payments to a provider of hospital based inpatient psychiatric services for individuals under age 21 will not exceed the Medicaid costs of that provider.

The amount of the CCP for each qualifying provider will be determined based upon the following formula:

CCP = [M/D] x P

Where:

1. CCP equals calculated continuity of care payment.
2. "M" equals the number of Medicaid days provided by the facility for which the CCP is being calculated.
3. "D" equals the total number of Medicaid days provided by all facilities eligible to receive a CCP.
4. "P" equals the total amount to be paid via the Continuity of Care Payment. The State's share of "P" will be the total amount of revenue generated by Montana's hospital utilization fee, less the amount expended as match for supplemental DSH payments.

The Medicaid days figures shall be from the Department's paid Medicaid claim data for the most recent calendar year that ended at least 12 months prior to the calculation of the CCPs.

CCPs will be paid during the third quarter of the SFY.

I. -HOSPITAL REIMBURSEMENT ADJUSTOR

All hospitals located in Montana that provide inpatient hospital services are eligible for a Hospital Reimbursement Adjustment (HRA) Payment. The payment consists of two separately calculated amounts.

In order to maintain access and quality in the most rural areas of Montana, CAHs shall receive both components of the HRA. All other hospitals shall receive only Part 1, as defined below in (1). For the purposes of determining HRA payment amounts, the following apply:

1. Part 1 of the HRA payment will be based upon Medicaid inpatient utilization, and will be computed as follows: HRA1=[M/D]xP. For the purposes of calculating Part 1 of the HRA, the following apply:

HRA1=(M/D)xP

Where:

(i) "HRA I" represents the calculated Part 1 HRA payment.
(ii) "M" equals the number of Medicaid inpatient days provided by the hospital for which the payment amount is being calculated.
(iii) "D" equals the total number of Medicaid inpatient days provided by all hospitals eligible to receive an HRA payment.
(iv) "P" equals the total amount to be paid via Part 1 of the HRA. The State's share of "P" will be the total amount of revenue generated by Montana's hospital utilization fee, less all of the following:
(A) the amount expended as match for supplemental DSH payments;
(B) the amount expended as match for continuity of care payments; and
(C) the amount expended as match for Part 2 of the HRA.

The Medicaid inpatient day numbers used to calculate Part 1 of the HRA must be from the Department's paid claims data from the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments.

2. Part 2 of the HRA payment will be based upon total Medicaid billed charges, and will be computed as follows: HRA2=[J/D]P. For the purposes of calculating Part 2 of the HRA, the following apply:

HRA2=(J/D)xP

Where:

(i) "HRA2" represents the calculated Part 2 HRA payment.

(ii) "J" equals amount of charges billed to Medicaid by the hospital for which the payment is being calculated.

(iii) "D" equals the total amount of charges billed to Medicaid by all hospitals eligible to receive Part 2 of the HRA payment.

(iv) "P" equals the total amount to be paid via Part 2 of the HRA. The State's share of "P" will be a minimal portion of the total revenue generated by Montana's hospital utilization fee, less all of the following:

(A) the amount expended as match for supplemental DSH Payments.
(B) the amount expended as match for continuity of care payments; and
(C) the amount expended as match for Part 1 of the HRA.

The total Medicaid billed charge amounts used to calculate part 2 of the HRA must be from the Department's paid claims data from the most recent calendar year that ended at least 12 months prior to the calculation of the HRA payments. The State will make Hospital Reimbursement Adjustment payments during the third quarter of the SFY. This reimbursement will be excluded from cost settlement.

J. GRADUATE MEDICAL EDUCATION (GME)

In addition to Medicaid payments, a GME payment is made to partially fund providers for their otherwise unreimbursed costs of providing care to Medicaid members as part of the primary care residency program to an eligible hospital located in Montana.

The State portion of the GME pool amount for SFY 2016 and SFY 2017 is $519,366 each year.

The Department will make an annual payment in August of each year to an eligible hospital. Payment will be calculated based upon the eligible hospital's inpatient Medicaid utilization per year. An eligible hospital's prior year as filed cost report will be used as a proxy for the following SFY's payment. Should an eligible hospital report no full time equivalents (FTE) participating in the GME program for any given program year or portion thereof, the eligible hospital will not receive payment for those time periods of non-participation. The GME payment regarding the primary care residency program shall be computed as follows:

(1) Step one shall be to divide the total GME FTE (GMEFTE) count for each eligible facility based upon the most recently filed cost report by the Total GMEFTE (TGMEFTE) for all eligible facilities to determine the Hospital Percentage of GME (HPGME);

$$\frac{\text{GMEFTE}}{\text{TGMEFTE}} = \text{HPGME}$$

(2) Step two shall be to divide the Hospital Specific Medicaid Inpatient Days (HSMID) by the total Hospital Specific Inpatient Days (HSID) for eligible hospitals to compute the Facility Specific Medicaid Hospital Day percentage (FSMHDP);

$$\frac{\text{HSMID}}{\text{HSID}} = \text{FSMHDP}$$

(3) Step three shall be to add together the FSMHDP for all eligible hospitals to determine a Total Medicaid Hospital Day Percentage (TMHDP);

$$\text{FSMHDP} + \text{FSMHDP} + \text{FSMHDP} + \text{FSMHDP} = \text{TMHDP}$$

(4) Step four shall be to divide each hospital's FSMHDP by the TMHDP to determine the Facility Specific Medicaid Utilization Percentage (FSMUP);

$$\frac{\text{FSMHDP}}{\text{TMHDP}} = \text{FSMUP}$$

(5) Step five shall be to divide the HSMID by the Total Medicaid Inpatient Days (TMID) of all eligible hospitals to compute the Facility Share of Medicaid Utilization (FSMU);

$$\frac{\text{HSMID}}{\text{TMID}} = \text{FSMU}$$

(6) Step six shall be to add the percentage of the FSMUP plus the FSMU plus the HPGME divided by three to acquire the Average Medicaid Utilization (AMU) specific to each eligible hospital; and

$$\frac{\text{FSMUP} + \text{FSMU} + \text{HPGME}}{3} = \text{AMU}$$

(7) Step seven shall be the allocation of funds to each eligible hospital based on the facility specific percentage of AMU as described in step (6).

The GME payment shall comply with the following criteria:

(i) If the eligible hospital's cost of hospital services do not exceed the total Montana Medicaid allowed payments for hospital care, the eligible hospital will receive a GME payment as calculated in section J. above;
(ii) As filed cost reports from eligible hospitals and information from the Medicaid paid claims database will be used for calculations; and
(iii) The GME payment must be for services derived from Medicaid paid claims.

(A) Dates of service must occur within the eligible hospital's fiscal year end and;

(B) The hospital's fiscal year must be the year immediately prior to the payment date.

(iv) At the end of the contract period, the Department will reconcile the total Medicaid payments including the Medicaid GME payments to ensure that the total of these payments do not exceed the Medicaid UPL for the fiscal year.

The following is an example of how the GME payment will be calculated based on four hospitals with eight FTE residents per facility:

	Hospital 1	Hospital 2	Hospital 3	Hospital 4	Totals
GME FTE Count Facility	8	8	8	8	32
Facility Percent of Residents	25.00%	25.00%	25.00%	25.00%	100.00%
Medicaid Inpatient days	9232	8195	3680	7872	
Medicaid Inpatient days in Formula	9232	8195	3680	7872	28979
Total hospital specific inpatient days	64269	53867	39725	26235	
Hospital Medicaid % of total days	14.36%	15.21%	9.26%	30.01%	68.85%
Facility Specific Medicaid Utilization Rate	21%	22%	13%	44%	
Medicaid Inpatient days	9232	8195	3680	7872	28979
Facility Share of Medicaid Utilization	31.86%	28.28%	12.70%	27.16%	100.00%
straight average of 3 percentages	25.91%	25.13%	17.05%	31.92%	100.00%
Allocation of Funds	$258,263	$250,469	$169,981	$ 318,160	$996,875

2. Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19(A) and 4.19(B):

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Montana Medicaid has adopted the baseline for other provider preventable conditions as identified by Medicare. The following reimbursement changes apply:

Payment will be denied for these conditions in any Health Care Setting as identified in Attachments 4.19A and 4.19B and any other settings where these events may occur. For any Montana Medicaid claim with dates of payment on or after August 1, 2011, that contains one of these diagnosis codes, these claims will be denied and will not be reimbursed. Reimbursement for PPS Hospitals regarding other provider preventable conditions is identified on page 4, number 15, of Attachment 4.19A.

_____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example - 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

K. APPEAL RIGHTS

Providers contesting the computation of interim payments or final settlement for coding errors resulting in incorrect DRG assignment; medical necessity determinations; outlier determinations; or, determinations of readmission and transfer shall have the opportunity for a fair hearing in accordance with the procedures set forth in ARM 37.5.310.

L. PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Montana Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

1. Health Care-Acquired Conditions

   The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A):

   __X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

   Montana Medicaid will adopt the baseline health care-acquired conditions as identified by Medicare. The following reimbursement changes will apply:

   PPS Hospitals
   For claims with dates of payment on or after August 1, 2011, when a health care-acquired condition occurs during hospitalization and the condition was not present on admission, claims shall be paid as though the diagnosis is not present.