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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-16-0015

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 01 2016

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

Re: Montana 16-0015

Dear Ms. Dalton:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-0015. Effective for services on or after July 1, 2016, this amendment (1) implements legislative funding for nursing facilities and intermediate care facilities for individuals with intellectual disabilities; (2) updates references to reflect the current fiscal year; (3) updates the current statewide median price; and, (4) maintains the spending level for the direct care wage component of the rate as well as "at risk" nursing facilities.

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 16-0015 is approved effective July 1, 2016. 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: **16-0015**	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, 2016**	

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 **2016** $429,893 b. FFY **2017** $1,289,678
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **4.19 D** **2 of 56 18 of 56 52 of 56** **3 of 56 25 of 56 54 of 56** **5 of 56 32 of 56** **12 of 56 36 of 56** **13 of 56 37 of 56** **14 of 56 42 of 56**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **4.19 D** **2 of 56 18 of 56 52 of 56** **3 of 56 25 of 56 54 of 56** **5 of 56 32 of 56** **12 of 56 36 of 56** **13 of 56 37 of 56** **14 of 56 42 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: [redacted]	16. RETURN TO: **Montana Dept. of Public Health and Human Services** **Mary E Dalton** **State Medicaid Director** **Attn: Mary Kulawik** **PO Box 4210** **Helena, MT 59604**
13. TYPED NAME: **Mary E Dalton**	
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: 9-7-16 Revised 11-30-16	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: DEC 01 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2016	20. SIGNATURE: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMCO

23. REMARKS:

INDEX TO NEW NURSING FACILITY MEDICAID RULE SECTIONS

37.4.,301 SCOPE, APPLICABILITY AND PURPOSE (1) This subchapter specifies requirements applicable to provision of and reimbursement for medicaid nursing facility services, including intermediate care facility services for individuals with intellectual disabilities. These rules are in addition to requirements generally applicable to medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) These rules are subject to the provisions of any conflicting federal statute, regulation or policy, whether now in existence or hereafter enacted or adopted.

(3) Reimbursement and other substantive nursing facility requirements are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption. (History: Sec. 53-2-201 and 53-6-113, MCA; .I, 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, 1998 MAR p. 1749, Eff 6726/98; TRANS & M, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AND, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.302 DEFINITIONS Unless the context requires otherwise in this subchapter, the following definitions apply:

(1) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with daily responsibility for operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be a person other than the titled administrator of the facility if such person has daily responsibility for operation of the nursing facility and is currently licensed by the state as a nursing home administrator.

(2) "Case mix index (CMI)" means an assigned weight or numeric score assigned to each RUG-Ill grouping which reflects the relative resources predicted to provide care to nursing facility residents.

(3) "Department" means the Montana department .of public health and human services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(4) "Department audit staff" and "audit staff" mean personnel directly employed by the department or any of the department's contracted audit personnel or organizations.

(17) "Rate year" means a 12-month period beginning July 1. For example, rate year 2006 means a period corresponding to the state fiscal year July 1, 2005 through June 30, 2006.

(18) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(19) "RUG-III" means resource utilization group, version III.

(20) "RUG-III grouper version" means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status using MDS assessment information for each resident. (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; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93, (14)(e) Eff. 10/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 76, Eff. 1/17/97; 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 MAA 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, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2005 MAR p. 1046, Eff. 7/1/05.)

Rule 03 reserved

37.40.304 NURSING FACILITY SERVICES (1) Nursing facility services are provided in accordance with 42 CFR, part 483, subpart B, or intermediate care facility services for individuals with intellectual disabilities provided in accordance with 42 CFR, part 483, subpart I. The department adopts and incorporates by reference 42 CFR, part 483, subparts B and I, that define the participation requirements for nursing facility and intermediate care facility for individuals with intellectual disabilities (ICF/IID) providers, copiesof which may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(2) The term "nursing facility services" includes the term "long term care facility services".

(3) Nursing facility services include, but are not limited to:

(a) a medically necessary room;

(b) dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet;

(c) nursing services;

(d) minor medical and surgical supplies; and

(e) the use of equipment and facilities.

483.12(a) (4), (5) and (6). The notice must be provided using the form prescribed by the department. In addition to the notice contents required by 42 CFR 483.12, the notice must inform the recipient of the recipient's right to a hearing, the method by which the recipient may obtain a hearing and that the recipient may represent herself or himself or may be represented by legal counsel, a relative, a friend or other spokesperson. Notice forms are available upon request from the department. Requests f or notice forms may be made to the Department bf Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-6-108, 53-6-111, 53-6-113 and 53-6-189, MCA; IMP,' Sec. 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-5-111, 53-6-113 and 53-5-168, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AND, 1992 MAR p. 1617, Eff. 7/31/92; AND, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AND, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AND, 2000 MAR p. 492, Eff. 2/11/00; AND, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/IID services, provided by nursing facilities located within the state of Montana, the Montana medicaid program will pay a provider, for each medicaid patient day, a per diem rate determined in accordance with this rule, minus the amount of the medicaid recipient's patient contribution.

(2) Effective July 1, 2001, and in subsequent rate years, nursing facilities will be reimbursed using a price-based reimbursement methodology. The rate for each facility will be determined using the operating component defined in (2) (a) and the direct resident care component defined in (2) (b):

(a) The operating component is the same per diem- for each nursing facility. It is set at 80% of the statewide price for nursing facility services.

(b) The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. It is adjusted for the acuity of the medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's medicaid

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, 2016 through June 30, 2017 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 $176.06 as computed on July 1, 2016. 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/IID services provided by nursing facilities

located within the state of Montana, the Montana medicaid program will pay a provider as provided in ARM 37.40.336.

(5) In addition to the per diem rate provided under (2) or the reimbursement allowed to an ICF/IID provider under (4), the Montana medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with ARM 37.40.330.

(6) For nursing facility services, including ICF/IID services, provided by nursing facilities located outside the state of Montana, the Montana medicaid program will pay a provider only as provided in ARM 37.40.337.

(7) The Montana medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.

(8) Reimbursement for medicare co-insurance days will be as follows:

(a) for dually eligible medicaid and medicare individuals, reimbursement is limited to the per diem rate, as determined under (1) or ARM 37.40.336, or the medicare co-insurance rate, whichever is lower, minus the medicaid recipient's patient contribution; and

(b) for individual whose medicare buy-in premium is being paid under th qualified medicare beneficiary (QMB) program under ARM 37.83.201 but are not otherwise medicaid eligible, payment will be made only under the QMB program at the medicare coinsurance rate.

(9) The department will not make any nursing facility per diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed which is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

(10) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(11) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The

MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS1 from SRS, 2000 MAR p.489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.315 STAFFING AND REPORTING REQUIREMENTS

(1) Providers must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

(a) Each provider must submit to the department within 10 days following the end of each calendar month a complete and accurate DPHHS-SLTC-01 5, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions.

(b) If a complete and accurate DPHHS-SLTC-015 is not received by the department within 10 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a). (History: Sec. 53-6-1 13, MCA; J.MEI Sec. 53-2-201, 53-6-101, 53-6-108, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 16 through 19 reserved

37.40.320 MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION (1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the centers for medicare and medicaid services (CMS) database as required by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the department of public health

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/IID 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;

facilities, including intermediate care facilities for individuals with intellectual disabilities, 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

AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 32 through 35 reserved

37.40.336 REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (1) For intermediate care facility services for individuals with intellectual disabilities provided in facilities located in the state of Montana, the Montana medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined retrospectively in accordance with ARM 37.40.345 and 37.40.346, divided by the total patient days of service during the rate year, minus the amount of the medicaid recipient's patient contribution, subject to the limits specified in (2) (a) and (b)

(2) Payments under (1) may not exceed the following limits:

(a) Final per diem payment rates for base years shall be as specified in (1), without application of any further limit. Base years are even-numbered state fiscal years, i.e., state fiscal years 1994, 1996 and subsequent even-numbered years.

(b) Final per diem rates in non-base years are limited to the final per diem rate for the immediately preceding base year indexed from June 30 of the base year to June 30 of the rate year. The index is the final medicare market basket index applicable to the non-base year. Non-base years are odd-numbered state fiscal years, i.e., state fiscal years 1993, 1995 and subsequent odd-numbered years.

(3) All ICF/IID providers must use a July 1 through June 30 fiscal year for accounting and cost reporting purposes.

(4) Prior to the billing of July services each rate year, the department will determine an interim payment rate for each provider. The provider's interim payment rate shall be determined based upon the department's estimate of actual allowable cost under ARM 37.40.345, divided by estimated patient days for the rate year. The department may consider, but shall not be bound by, the provider's cost estimates in estimating actual allowable costs. The provider's interim payment rate is an estimate only and shall not bind the department in any way in the final rate determination under (1) and (5)

(5) The provider's final rate as provided in (1) shall be determined based upon the provider's cost report for the rate

year filed in accordance with ARM 37.4Q.346, after desk review or audit by the departments audit staff. The difference between actual includable cost allocable to services to medicaid residents, as limited in (2), and the total amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures specified in ARN 37.40.347.

(6) Following the sale of an intermediate care facility for individuals with intellectual disabilities after April 5, 1989, the new providers property costs will be the lesser of historical costs or the rate used for all other intermediate care facilities, subject to the limitations in 42 USC 1396a(a) (13) (C) . (History: Sec. 53-5-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA.;. 1991 MAR p. 2050, Eff. 11/1/91; 1992 MAR p. 1617, Eff. 7/31/92; AND, 1993 MAR p. 1385, Eff. 7/1/93; AND, 1994 MAR p. 1881, Eff. 7/8/94; AND, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, .,<from SRS, 2000 MAR p. 489.)

37.40.337 REIMBURSEMENT TO OUT-OF-STATE FACILITIES

(1) The department will reimburse nursing facilities located outside the state of Montana for nursing facility services and any other reimbursable services or supplies provided to eligible Montana medicaid individuals at the medicaid rate and upon the basis established by the medicaid agency in the state in which the facility is located.

(2) The Montana medicaid program will pay for nursing facility services or related supplies provided to eligible Montana medicaid individuals in nursing facilities located outside the state of Montana only when one of the following conditions is met:

(a) because of a documented medical emergency, the resident's health would be endangered if he or she was to return to Montana for medical services;

(b) the services required are not provided in Montana;

(c) the required services and all related expenses are less costly than if the required services were provided in Montana;

(d) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(e) the department determines that it is general practice for recipients in the resident's particular locality to use

37.40.345 ALLOWABLE COSTS (1) This rule applies for purposes of determining allowable costs for cost reporting periods beginning on or after July 1, 1991. Allowable costs for cost reporting periods beginning prior to July 1, 1991 will be determined in accordance with rules for allowable costs then in effect.

(2) For purposes of reporting and determining allowable costs, the department hereby adopts and incorporates herein by reference the Provider Reimbursement Manual (PRM-15), published by the United States department of health and human services, social security administration, which provides guidelines and policies to implement medicare regulations and principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the PRM-15 may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 Sanders, Helena, MT 59604-4210. Applicability of the PRM-15 is subject to the exceptions and limitations specified in this rule.

(a) The term "allowable costs" means costs which are allowable under the provisions of this subchapter and which are considered in determining the costs of providing medicaid nursing facility services. The determination that a cost is an allowable cost does not require the department to reimburse the provider for that cost. Providers will be reimbursed only as specifically provided in these rules.

(3) For purposes of reporting costs as required in ARM 37.40.346, allowable costs will be determined in accordance with the PRM-15, subject to the exceptions and limitations provided in these rules, including but not limited to the following:

(a) Return on net invested equity is an allowable cost only for providers of intermediate care facility services for individuals with intellectual disabilities which provide services on a for-profit basis.

(b) Allowable property costs are limited as follows:

(i) The capitalized costs of movable equipment are not allowable in excess of the fair market value of the asset at the time of acquisition.

(ii) Property-related interest, whether actual interest or imputed interest for capitalized leases, is not allowable in excess of the interest rates available to commercial borrowers

other than the resident's patient contribution and any items billable to residents under ARM 37.40.331.

(3) This rule applies in addition to ARM 37.85.415. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMID, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.352 UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456 subpart F (1997), may evaluate the necessity of nursing facility care for each medicaid resident in an intermediate care facility for individuals with intellectual disabilities. 42 CFR 456 subpart F contains federal regulations which specify utilization review criteria for intermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997) . A copy of these regulations may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-142, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AND, 1995 ?IAR p. 1227, Eff. 7/1/95; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 53 through 59 reserved

37.40.360 LIEN AND ESTATE RECOVERY FUIIDS FOR ONE-TIME EXPENDITURES (REPEALED) (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, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; REP, 2003 MAR p. 1294, Eff. 7/1/03.)

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, 2016 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, 2016, 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