Table of Contents

State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0032

This file contains the following documents in the order listed:

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

December 6, 2018

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

Re: Montana 18-0032

Dear Ms. Matthews:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0032. Effective for services on or after July 1, 2018, this amendment (1) implements legislative funding for nursing facilities; (2) updates references to reflect the current fiscal year; (3) updates the current statewide median price; and, (4) increases the spending level for the direct care wage component of the rate.

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 18-0032 is approved effective July 1, 2018. 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: **18-0032**

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, 2018

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 **2018** **$2,854,434**
b. FFY **2019** **$12,005,958**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Skilled Nursing and Intermediate Care Services, 4.19 D
Page 8 of 35 **Page 32 of 35**
Page 9 of 35 **Page 33 of 35**
Page 10 of 35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Skilled Nursing and Intermediate Care Services, 4.19 D
Page 8 of 35 **Page 32 of 35**
Page 9 of 35 **Page 33 of 35**
Page 10 of 35

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]

13. TYPED NAME: **Marie Matthews**

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 9-13-18

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: DEC 06 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

(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, 2018 through June 30, 2019 will be the rate as computed in (2), plus any additional amount computed in Rate Adjustment for County Funded Rural Nursing Facilities and in Direct Care & Ancillary Services Workers' Wage Reporting.

(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 $202.46 as computed on July 1, 2018. Following a change in provider as defined in Change in Provider Defined, 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 Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

(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 Separately Billable Items.

(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 Reimbursement to Out-of-State Facilities.

(7) The Montana Medicaid program will not pay any provider for items billable to residents under the provisions of Items Billable to Residents.

(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 Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities, 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 the qualified Medicare beneficiary (QMB) program under the Eligibility Requirements for Qualified

Medicare Beneficiaries 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 Provider Participation and Termination Requirements 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 Bed Hold Payments(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 the General Medical Services. The department's fiscal agent will pay a provider on a weekly or 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 the Level of Care Determinations and in the Preadmission Screening for Skilled Nursing and Intermediate Care Services.

(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.

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 withNursing Facility Reimbursement.

(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 subchapter, until the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year.

RATE ADJUSTMENT FOR COUNTY FUNDED RURAL NURSING FACILITIES (1) For each state fiscal year, the department will provide a mechanism for a one time, lump sum payment to nonstate government owned or operated facilities for Medicaid services according to the methodology specified in this rule. These payments will be for the purpose of maintaining access and viability for a class of "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county.

(2) A nursing facility is eligible to participate in this lump sum payment distribution if it is a nonstate government owned or operated facility that has provided Medicaid services in the current state fiscal year.

(a) The department will calculate the amount of lump sum distribution that will be allowed for each county affiliated provider so that the total per day amount does not exceed the computed Medicare upper payment limit for these providers. Distribution of these lump sum payments will be based on the Medicaid utilization at each participating facility for the period July 1 of the previous year through June 30 of the current year.

(b) In order to qualify for this lump sum adjustment, each county on behalf of its nonstate government owned or operated facility must enter into a written agreement to transfer local county funds to be used as matching funds by the department. This transfer option is voluntary, but those counties that agree to participate must abide by the terms of the written agreement.

(3) On or after July 1 of each year, the department will provide for a one time, lump sum distribution of funding to nursing facilities not participating in the funding for "at risk" facilities for the provision of Medicaid services.

(4) The department will calculate the maximum amount of the lump sum payments that will be allowed for each participating nonstate government owned or operated facility, as well as the additional payments for other nursing facilities not participating in the funding for "at risk" facilities for the provision of Medicaid services in accordance with state and federal laws, as well as applicable Medicare upper payment limit thresholds. This payment will be computed as a per day add-on based upon the funding available. Distribution will be in the form of lump sum payments and will be based on the Medicaid utilization at each participating facility for the period July 1 of the preceding year through June 30 of the current year.

(5) There may be no pre-arranged formal or informal agreements with the nursing facility to return or redirect any portion of the lump sum nursing facility payment to the county in order to fund other Medicaid services or non-Medicaid services.

(a) Payments or credits for normal operating expenses and costs are not considered a return or redirection of a Medicaid payment.

(6) "Normal operating expenses" and "costs" include, but are not limited to:
(a) taxes, including health care provider related taxes;

(b) mill levies;

(c) fees;

(d) payment of facility construction bonds or loans;

(e) health insurance costs, unemployment insurance, workers compensation and other employee benefits;

coverage or program. If the department finds that Medicaid has made payments in such an instance, retroactive collections may be made from the provider in accordance with Cost Settlement Procedures.

(a) This rule does not apply to payment sources which by law are made secondary to Medicaid.

(2) The payments allowed under Nursing Facility Reimbursement constitute full payment for nursing facility services and separately billable items provided to a resident. A provider may not charge, bill or collect any amount from a Medicaid recipient,
other than the resident's patient contribution and any items billable to residents underItems Billable to Residents.

(3) This rule applies in addition toStatistical Sampling Audits.

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 (1997) contains federal regulations which specify utilization review criteria for inermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997).

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 each state fiscal year 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 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 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 Nursing Facility Reimbursement and Rate Adjustment for County Funded Rural Nursing Facilities 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 of the state fiscal year, and again in six months from that date as a pro rata share of the appropriated $10,929,216 funds allocated by nursing facility Medicaid bed days 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 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 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 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. If any providers do not participate in the direct care wage funding the department will revise the funding for the participating providers based on the appropriated funding amount and the allocated Medicaid days.

(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 Allowable Costs, Cost Reporting, Desk Review & Audit andMaintenance of Records and Auditing.

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