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State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0041

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 4, 2018

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

Re: Montana 18-0041

Dear Ms. Matthews:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0041. Effective for services on or after July 1, 2018, this amendment provides for a 2.99 percent increase 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 18-0041 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: 18-0041	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 07/01/18	

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 42 CFR 447.250 1902(a)(30)(A) of the Social Security Act	7. FEDERAL BUDGET IMPACT: FFY 18 $1,255,839 3 months FFY 19 $5,078,746 12 months FFY 20 $3,918,148 9 months
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A, Service 1, Inpatient Hospital Services Pages 1, 6 and 7.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19A, Service 1, Inpatient Hospital Services Pages 1, 6 and 7.

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment - Effective July 1, 2018, this amendment restores the across the board Medicaid provider rates and fee schedules that were reduced by 2.99% effective January 1, 2018, due to budget shortfalls in State Fiscal year 2018. The proposed 2.99% rate reversal is the result of two Temporary Restraining Orders (TRO) that were filed as court orders in August 2018.

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]	16. RETURN TO: Montana Department of Public Health and Human Services Marie Matthews Attn: Mary Eve Kulawik PO Box 4210 Helena MT 59620
13. TYPED NAME: Marie Matthews	
14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: 9-13-18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: DEC 04 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)

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, 2016 and after, the Department will reimburse hospitals the lesser of a per-stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs) or billed charges. 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 APR-DRG relative weights values, average national length of stay (ALOS), outlier thresholds, and APR-DRG grouper are contained in the APR-DRG Calculator effective July 1, 2018. The APR-DRG calculator can be referenced on the state's website: https://medicaidprovider.mt.gov/.

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 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.

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. Effective July 1, 2018, for dates of services January 1, 2018 through June 30, 2018, interim reimbursement is based on the provider's specific inpatient cost-to-charge ratio (CCR), less 2.99%. For dates of service on or after July 1, 2018, the interim reimbursement is based on the provider's specific inpatient cost-to-charge ratio, not to exceed 100%. The inpatient CCR is determined by Montana Medicaid's contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recently settled Medicare 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 exempt hospital, reimbursement for reasonable costs of inpatient hospital services shall be limited to 101% of allowable costs or the upper payment limit (UPL). Effective July 1, 2018, Critical Access Hospitals (CAH) will be reimbursed 101% of allowable costs for inpatient hospital services. For dates of services on or prior to December 31, 2017, final cost settlements for CAH facilities will be reimbursed at 101% of allowable costs. For dates of services on January 1, 2018 through June 30, 2018, final cost settlements for CAH facilities will be reimbursed at 97.98% of allowable costs. For dates of services on or after July 1, 2018, final cost settlements for CAH facilities will be reimbursed at 101% of allowable costs. For facilities where the cost reporting period spans multiple cost settlement percentages, the department will prorate the final cost settlement.

For 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.

To be deemed eligible for a routine 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.