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State/Territory Name: Montana

State Plan Amendment (SPA) #: 18-0062

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294

CENTERS FOR MEDICARE & MEDICAID SERVICES

REGION VIII - DENVER

December 27, 2018

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

Dear Ms. Matthews:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-18-0062. This amendment reverses the targeted reduction to MT's outpatient hospital conversion factor from this year's prior State budget reduction.

Please be informed that this State Plan Amendment was approved today, with an effective date of January 1, 2019. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Barbara Prehmus at (303) 844-7472.

Sincerely,

[redacted]

Curtis Volesky
Acting Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Sheila Hogan, Department Director
Duane Preshinger
Mary Eve Kulawik

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: 18-0062

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
01/01/2019

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 440.20
1902(a)(30)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

FFY 19 – $ 9,210,923 9 months
FFY 20 – $ 12,860,471 12 months
FFY 21 – $ 3,316,756 3 months

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B, Service 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 2, 3, and 6.

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19B, Service 2A, Methods & Standards for Establishing Payment Rate; Outpatient Hospital Services, Pages 2, 3, and 6.

10. SUBJECT OF AMENDMENT:
The purpose of this State Plan Amendment is to increase the outpatient conversion factor from $50.98 to $56.64.

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: Marie Matthews

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 12-19-18

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 19, 2018

18. DATE APPROVED: December 27, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2019

20. S[redacted] OFFICIAL:

21. TYPED NAME: Curtis Volesky

22. TITLE: Acting ARA, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

Out-of-state hospitals are those hospitals that are located beyond 100 miles of the border of the state of Montana.

Unless otherwise specified, the following outpatient hospital services for in-state PPS, border and out-of-state facilities will be reimbursed under a prospective payment methodology for each service as follows:

1. Outpatient Prospective Payment System, Ambulatory Payment Classification (APC) Groups

Outpatient hospital services that are not provided by Critical Access Hospitals (CAH) will be reimbursed on a predetermined rate-per-service basis. These services are classified according to a list of APC groups published annually in the Code of Federal Regulation (CFR). APC group reimbursement is based on the CPT or HCPCS code associated with the service and may be an all-inclusive bundled payment per service. These bundled services may include some or all of the following services: nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment, and other outpatient hospital services. The Department follows Medicare's grouping of services by APC as published annually in the CFR. The Department will update Medicare's changes quarterly.

a) The Department uses a Medicaid conversion factor effective for services provided on and after January 1, 2019, to establish a rate that is less than the rate established by Medicare's conversion factor. This rate will periodically be re-evaluated by the Department. All rates are published on the agency's website at http://medicaidprovider.mt.gov. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

b) This Medicaid conversion factor effective for services provided on and after January 1, 2019, is the same for all APC groups and for all facilities. The APC fee equals the Medicare specific weight for the APC times the Medicaid conversion factor. These rates are updated quarterly when the Medicare update is published. All rates are published on the agency's website at http://medicaidprovider.mt.gov. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

c) The total claim reimbursement will be the lower of the provider's claim charge or the reimbursement as calculated using OPPS.

d) If two or more surgical procedures are performed on the same patient at the same hospital on the same day, the most expensive procedure will pay at 100% of that APC; and the other procedures will pay at 50% of their APC, if appropriate.

e) Procedures started on a patient but discontinued before completion will be paid at 50% of that APC.

f) A separate payment will be made for observation care using criteria established by Medicare with the exception of obstetric complications. Observation care that does not meet Medicare's criteria will be considered bundled into the APC for other services.

(i) When billing observation services, the appropriate procedure codes must be used and the units field on the claim must reflect the number of hours provided. Observation services must be a direct admit or have a high level clinic visit, high level critical care, or high level ER visit to qualify. The service must be at least eight hours in length.

(ii) Obstetric observation must have a qualifying diagnosis and must be at least one hour in length of service.

g) Medicare has set guidelines for procedures it has determined should be performed in an inpatient setting only. The Department follows Medicare guidelines for procedures defined as "inpatient only".

2. Outpatient Payment Methodology Paid Under OPPS

Outpatient services will be reimbursed as follows:

a) For each outpatient service or procedure, the fee is 100% of the Ambulatory Payment Classification (APC) rate. Some codes price by APC, but bundle so they pay at zero.

b) Where no APC rate has been assigned, outpatient services will be paid by the applicable Medicare fee.

(i) Effective July 1, 2018, for laboratory services, if there is a Medicare fee for the code, the system will price at 60% of the Medicare fee for non-sole community hospitals; and 62% of the Medicare fee for sole community hospitals. If the codes bundle to a lab panel or ATP panel, the system will also pay 60% or 62% of the bundled fee, depending on the hospital status.

c) If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates were set as of January 1, 2019, and are effective for services on or after that date. All rates are published on the agency's website at http://medicaidprovider.mt.gov. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

9. If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates were set as of January 1, 2019, and are effective for services on or after that date. All rates are published on the agency's website at http://medicaidprovider.mt.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

D. COST REPORTING AND COST SETTLEMENTS

All in-state PPS Hospitals and Critical Access Hospitals will be required to submit a Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records that will enable the facility to fully complete the cost report. Upon receipt of the cost report, the Department will instruct Montana's contracted intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.

Facilities will be required to file the cost report with Montana's contracted intermediary and with the Department within 150 days of the facility's fiscal year end.

Except as identified below, Medicare principles of reasonable cost reimbursement will be applied to cost settlement of outpatient hospital services that are paid on interim at outpatient hospital specific cost-to-charge ratio. Only cost-based outpatient services are cost settled.