Table of Contents

State/Territory Name: MT

State Plan Amendment (SPA) #: 21-0014

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

November 23, 2021

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

Re: Montana 21-0014

Dear Ms. Matthews,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0014. Effective for services on or after July 1, 2021, this amendment updates the reimbursement methodology for nursing facility services for State Fiscal Year 2022.

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 21-0014 is approved effective July 1, 2021. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at christine.storey@cms.hhs.gov or (303) 844-7044.

Sincerely

For
Rory Howe
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: **21-0014**	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, 2021**	

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 **2021** **$ 66,363** b. FFY **2022** **$ 265,451**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Skilled Nursing and Intermediate Care Services, 4.19 D** **Pages 7-8 of 35**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Skilled Nursing and Intermediate Care Services, 4.19 D** **Pages 7-8 of 35**

10. SUBJECT OF AMENDMENT:
This amendment to the state plan provides for changes to the Medicaid nursing facility rules to:

1. implement legislative mandate funding for nursing facility reimbursement for state fiscal year 2022;
2. insert the reference to the current fiscal year; and
3. Insert the current flat rate compensation of $208.68 for fiscal year 2022.

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:	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**
13. TYPED NAME: **Marie Matthews**	
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: 9/24/2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 24, 2021	18. DATE APPROVED: November 23, 2021
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Rory Howe	22. TITLE: Director, Financial Management Group

23. REMARKS:

imposition of any remedy or combination of remedies provided by state or federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

(3) A provider must provide the department with 30 days advance written notice of termination of participation in the Medicaid program. Notice will not be effective prior to 30 calendar days following actual receipt of the notice by the department. Notice must be mailed or delivered to 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.

(a) For purposes of (3), termination includes a cessation of provision of services to Medicaid residents, termination of the providers business, a change in the entity administering or managing the facility or a change in provider as defined in Change in Provider Defined.

(b) In the event that discharge or transfer planning is necessary, the provider remains responsible to provide for such planning in an orderly fashion and to care for its residents until appropriate transfers or discharges are effected, even though transfer or discharge may not have been completed prior to the facility's planned date of termination from the Medicaid program.

(c) Providers terminating participation in the Medicaid program must prepare and file, in accordance with applicable cost reporting rules, a close out cost report covering the period from the end of the provider's previous fiscal year through the date of termination from the program. New providers assuming operation of a facility from a terminating provider must enroll in the Medicaid program in accordance with applicable rules.

(4) A provider must notify a resident or the resident's representative of a transfer or discharge as required by 42 CFR 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 for notice forms may be made to 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.

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, 2020 and in subsequent rate years, the reimbursement rate for each nursing facility will be determined using the flat rate component specified in (2) (a) and the quality component specified in (2) (b).

(a) The flat rate component is the same per diem rate for each nursing facility and will be determined each year through a public process. Factors that could be considered in the establishment of this flat rate component include cost of providing nursing facility services and Medicaid recipient access to nursing facility services. The flat rate component for state fiscal year (SFY) 2022 is $208.68.

(b) The quality component of each nursing facility's rate is based on the 5-star rating system for nursing facility services calculated by the Center for Medicare and Medicaid Services (CMS). It is set for each facility based on their average 5-star rating for staffing and quality. Facilities with an average rating of 3 to 5 stars will receive a quality component payment. The funding for the quality component payment will be divided by the total estimated Medicaid bed days to determine the quality component per Medicaid bed day. The quality component per bed day is then adjusted based on each facility's 5-star average of staffing and quality component scores. A facility with a 5-star average of staffing and quality component scores will receive 100%, 4-star average will receive 75%, 3-star average will receive 50%, and 1-2 star average facilities will receive 0% of the quality component payment. Funds unused by the first allocation round will be reallocated based on the facility's percentage of unused allocation against the available funds.

(c) The total payment rate available for the period July 1, 2021 through June 30, 2022, 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' Rate 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 as computed on July 1, 2021. 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