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State/Territory Name: MT

State Plan Amendment (SPA) MT: 22-0033

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

February 9, 2023

Michael Randol
Montana Medicaid and Health Services Executive Director/State Medicaid Director
Montana Department of Public Health & Human Services
Attn: Mary Eve Kulawik
P.O. Box 4210
Helena, MT 59604

RE: **Montana State Plan Amendment (SPA) Transmittal Number 22-0033**

Dear Director Randol:

We have reviewed the proposed Montana State Plan Amendment (SPA) to Attachment 4.19-B of your state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 18, 2022. This plan amendment proposes to adopt Version 39.1 of the 3M All Patient Refined Diagnosis Related Groups (APR-DRG) grouper and reflects changes to DRG relative weights, average length of stays, and adds and/or deletes select DRGs.

Based upon the information provided by the State, we have approved the amendment with an effective date of October 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica (Josh) Smith via 214-767-6453 or lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER **22 - 0033**	2. STATE **Montana**
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT ✓ **XIX** XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **10/01/2022**	
5. FEDERAL STATUTE/REGULATION CITATION ~~**Section 1905(a)(1)**~~ **Section 1905(a)(2)(A)**	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. ~~**FFY 2022 $ 0**~~ **a. FFY 2023 $ 358,397** b. ~~**FFY 2023 $ 0**~~ **b. FFY 2024 $ 360,044**	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Attachment 4.19B, Service 1, Outpatient Hospital Services, Pages 1-8 of 8.**	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **Attachment 4.19B, Service 1, Outpatient Hospital Services, Pages 1-8 of 8.**	

9. SUBJECT OF AMENDMENT

DPHHS proposes to adopt Version 39.1 of the 3M All Patient Refined Diagnosis Related Groups (APR-DRG) grouper. This grouper update includes changes to DRG relative weights, average length of stays, and adds and/or deletes some DRGs. The department proposes to increase the base rate for 'General Hospitals' to $5,390 and the base rate for 'Centers of Excellence' to $8,030. These changes to APR-DRG are projected to provide for an increase of $511,712 for SFY 2023.

10. 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:
X Single Agency Review

11. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	15. RETURN TO: **Montana Department of Public Health and Human Services** **Mike Randol** **Attn: Mary Eve Kulawik** **PO Box 4210** **Helena MT 59620**
12. TYPED NAME: **Mike Randol**	
13. TITLE **Medicaid & Health Services Executive Director/State Medicaid Director**	
14. DATE SUBMITTED 11-18-2022	

FOR CMS USE ONLY

16. DATE RECEIVED	17. DATE APPROVED
11/18/2022	February 9, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL
10/01/22	[redacted]
20. TYPED NAME OF APPROVING OFFICIAL Todd McMillion	21. TITLE OF APPROVING OFFICIAL Director, Division of Reimbursement Review

22. REMARKS

2/06/23 - P&I - pen & ink adjustment to Box 5 to reflect correct citation.
2/06/23 - P&I - pen & ink adjustment to Box 6 to reflect correct budget impact.

FORM CMS-179 (09/24)

REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

A. COST BASED RETROSPECTIVE REIMBURSEMENT

1. Interim Reimbursement

Facilities defined as Critical Access Hospitals (CAH) will be reimbursed on a cost-based retrospective basis.

Cost of hospital services will be determined for inpatient and outpatient care separately. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15-1, and is subject to the exceptions and limitations provided in the Department's Administrative Rules. CMS Publication 15-1 is a manual published by the United States Department of Health and Human Services, Center for Medicare and Medicaid Services, which provides guidelines and policies to implement Medicare regulations and establish principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

Critical Access Hospital (CAH) facilities will be reimbursed on an interim basis during the facility's fiscal year. Effective July 1, 2018 for dates of services January 1, 2018 through June 30, 2018, interim reimbursement is based on the provider's specific outpatient 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 hospital-specific Medicaid outpatient cost-to-charge ratio, not to exceed 100%. The outpatient CCR is determined by Montana Medicaid's contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicaid cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report which is necessary to determine the outpatient cost to charge ratio, the provider's interim rate will be 50% of its usual and customary charges.

B. PROSPECTIVE REIMBURSEMENT

In-state PPS (Prospective Payment System) hospitals are paid under the OPPS (Outpatient Prospective Payment System) for outpatient claims. Such hospitals may be classified as sole community hospitals or non-sole community hospitals.

Border hospitals are those hospitals that are located within 100 miles of the border of the state of Montana.

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 October 1, 2022, 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 October 1, 2022, 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.

If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates were set as of October 1, 2022, 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.

a) If Medicaid does not have an established fee and the code is allowed by Medicaid, outpatient hospital specific cost-to-charge ratio will be used to determine payment.

b)

(i) The provider's outpatient cost-to-charge ratio is determined by Montana's contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicaid cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the outpatient cost-to-charge ratio, the provider's rate will be the average statewide cost-to-charge ratio for PPS hospitals.

3. Emergency Department Services for OPPS Hospitals

Emergency department services provided by hospitals that are not Critical Access Hospitals (CAH) will be reimbursed based on the APC methodology with the exception of ER visits using CPT codes 99281 and 99282, which will be reimbursed based upon the clinic visit APC weight.

Professional services are separately billable according to the applicable rules governing medical billing. In addition to the APC rate specified for each emergency department visit, Medicaid will reimburse providers separately for OPPS covered laboratory, imaging, and other diagnostic services provided during emergency visits.

4. Dialysis Services

Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413, subpart H. The facilities composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services. The provider must furnish all of the necessary dialysis services, equipment, laboratory services, drugs, and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, CMS Publication 15-1.

For purposes of specifying the services covered by the composite rate and the services that are separately billable, the department adopts and incorporates by reference CMS Publication 15-1.

C. MISCELLANEOUS SERVICES

1. PPS hospital therapy services, including physical therapy, occupational therapy and speech-language pathology, will be paid a Medicaid facility fee with a conversion factor appropriate for therapies. Refer to the Medicaid fee schedule for a list of these services located on the agency's website at http://medicaidprovider.mt.gov.

2. For PPS hospitals, immunizations not grouping to an APC will be paid a Medicaid fee. If the member is under 19 years old and the vaccine is provided under the Vaccines for Children Program, the payment to the hospital for the vaccine is zero.

3. Dental services not grouping to an APC will be reimbursed as specified in the Department's outpatient fee schedule.

4. Payment for Certified Registered Nurse Anesthetists (CRNA) will be paid to Critical Access Hospitals (CAH) at the hospital's specific outpatient cost-to-charge ratio. The percentage shall be the provider's outpatient cost-to-charge ratio determined by Montana Medicaid's contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicaid cost report.

5. Professional services are separately billable according to the rules governing CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) billing guidelines.

6. The Department requires that National Drug Codes (NDC) be submitted on all outpatient claims that include pharmaceuticals. Montana Medicaid will reimburse only those pharmaceuticals manufactured by companies that have a signed rebate agreement with CMS.
   a) Qualified providers that are participating in the 340B Drug Pricing Program are exempt from submitting National Drug Codes (NDC) on claim lines billed using pharmaceuticals purchased through the 340B program.

7. Montana Medicaid does not recognize provider-based status. Professional services provided in an outpatient hospital clinic bill the appropriate procedure code(s)in accordance with the reimbursement under Attachment 4.19B, Methods and Standards for Establishing Payment Rates for Service 5a, Physician Services.

8. Partial hospitalization services will be reimbursed using the lower of the following two rates:
   a) The provider's usual and customary claim charges for the service; or
   b) The department's Mental Health Fee Schedule. This is a bundled rate for acute full-day programs and sub-acute half-day programs.

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 October 1, 2022, 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.

The State of Montana uses CMS 2552-10 to identify outpatient costs. The outpatient costs are calculated using worksheet D, part V of the CMS 2552-10. The ancillary charges are recorded on column 3, line 202. The outpatient costs are recorded on column 6, line 202.

1. For each in-state PPS hospital which has an outpatient hospital service paid on the interim at the outpatient hospital specific cost-to-charge ratio, reasonable costs will be settled. The reasonable costs of outpatient hospital services will not include the cost of professional services, or the cost of general medical education; and will only include outpatient hospitals services covered by the Medicare Outpatient Prospective Payment System.

2. Effective July 1, 2018, Critical Access Hospital (CAH) final reimbursement shall be for reasonable costs of outpatient hospital services limited to 101% of allowable costs. 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.

   The State of Montana uses CMS 2552-10 to identify outpatient costs. The outpatient costs are calculated using worksheet D, part V of the CMS 2552-10. The ancillary charges are recorded on column 3, line 202. The outpatient costs are recorded on column 6, line 202.

E. UPPER PAYMENT LIMITS

The Department has structured the outpatient reimbursement methodology to ensure the Medicaid allowed amount does not exceed the hospital aggregate outpatient upper payment limit (UPL). The hospital outpatient upper payment limit will not include professional services or general medical education. For in-state PPS hospitals, the upper payment limit will only include outpatient hospital services covered by the Medicare outpatient prospective payment system (OPPS).

F. Outpatient Hospital Utilization Fee

Effective January 1, 2020, hospitals located in Montana who provide outpatient hospital services are eligible for an outpatient Hospital Reimbursement Adjustment (HRA) Payment. In order to maintain access and quality in the most rural areas of Montana, CAHs shall receive the HRA Payment. The Montana State Hospital or a hospital or facility operated by the state, a political subdivision of the state, the United States, or an Indian Tribe or any facility authorized under the Indian Health Care Improvement Act are not eligible for an outpatient HRA payment.

The outpatient HRA payment will be based upon total Medicaid outpatient charges and will be computed as follows: $HRA = \frac{J}{D} \times P$.

For the purposes of calculating the hospital specific outpatient HRA, the following apply:

Where:

(i) "HRA" represents the calculated hospital specific outpatient HRA payment.

ii) "J" equals the total outpatient hospital charges billed to Medicaid by the hospital for which the payment is calculated.

(iii) "D" equals the total outpatient hospital charges billed to Medicaid by all hospitals eligible to receive of the HRA payment.

(iv) "P" equals the distributable revenue generated by the outpatient hospital utilization fee.

Effective January 1, 2020, the total Medicaid billed charge amounts used to calculate the HRA must be from the Department's paid claims data in the most recent calendar year. The State will make HRA in an annual lump-sum payment in the fourth quarter of the State's fiscal year and is limited by the outpatient upper payment limit (UPL). This reimbursement will be excluded from cost settlement.