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State/Territory Name: MT

State Plan Amendment (SPA) MT: 25-0010

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Companion Letter
- 3) CMS 179 Form/Summary Form (with 179-like data)
- 4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604



Financial Management Group

April 10, 2026

Rebecca de Camara
Montana Department of Public Health & Human Services State Medicaid Director
Attn: Carla Rime
P.O. Box 4210
Helena, MT 59604

RE: TN 25-0010

Dear Acting Director de Camara:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Montana state plan amendment (SPA) to Attachment 4.19-B MT 25-0010 which was submitted to CMS on September 29, 2025. This state plan updates the fee schedule methodology for outpatient hospital services.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. 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 Blake Holt at 303-844-6218 or via email at blake.holt@cms.hhs.gov.

Sincerely,

A solid black rectangular box redacting the signature of Todd McMillion.

Todd McMillion
Director
Division of Reimbursement Review

Enclosures


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 25-0010	2. STATE Montana
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <p style="text-align: right;">✓ XIX XXI</p>	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 07/01/2025	
5. FEDERAL STATUTE/REGULATION CITATION Section 1905(a)(1) (2)(a)	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY 2025 \$ 712,923 b. FFY 2026 \$ 2,857,705	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19B, Service 1, Outpatient Hospital Services, Pages 1-8 <u>2, 3, 6</u> 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 <u>2, 3, 6</u> of 8.	

9. SUBJECT OF AMENDMENT

Effective July 1, 2025, the department proposes to update the Outpatient hospital services fee schedules *and* increase the conversion factor for Outpatient services to \$62.54 *and to update the Medicaid statewide average Outpatient cost-to-charge ratio to 48.59%.*

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:
 Single Agency Review

11. SIGNATURE OF STATE AGENCY OFFICIAL


12. TYPED NAME: **Rebecca de Camara**

13. TITLE **Medicaid & Health Services Executive Director/State Medicaid Director**

14. DATE SUBMITTED
9/29/2025

15. RETURN TO:
Montana Department of Public Health and Human Services
Rebecca de Camara
Attn: Carla Rime
PO Box 4210
Helena MT 59604

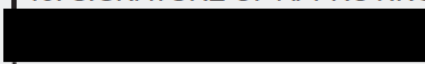
FOR CMS USE ONLY

16. DATE RECEIVED
 September 29, 2025

17. DATE APPROVED
 April 10, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
 July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL


20. TYPED NAME OF APPROVING OFFICIAL
 Todd McMillion

21. TITLE OF APPROVING OFFICIAL
 Director, Division of Reimbursement Review

22. REMARKS
 3/4/26: State concurs with pen-and-ink change to Box 1.
 3/19/26: State concurs with pen-and-ink changes to Boxes 5,7, 8 and 9.

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 July 1, 2025, 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/enduserproviders>, after accepting terms of service. 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 July 1, 2025, 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/enduserproviders>, after accepting terms of service. 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 OPSS.
- 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 OPSS

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 July 1, 2025, and are effective for services on or after that date. All rates are published on the agency's website at <http://medicaidprovider.mt.gov/enduserproviders>, after accepting terms of service. Unless otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

MONTANA

Attachment 4.19B
Methods & Standards for
Establishing Payment Rates
Page 6
Outpatient Hospital Services
Service 2.a

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 July 1, 2025, and are effective for services on or after that date. All rates are published on the agency's website at <http://medicaidprovider.mt.gov/enduserproviders>, after accepting terms of service. 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.