

## **Table of Contents**

**State/Territory Name: Montana**

**State Plan Amendment (SPA) #: 20-0018**

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD 21244-1850



---

**Financial Management Group**

December 21, 2020

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

Re: Montana 20-0018

Dear Ms. Matthews,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 20-0018. Effective for services on or after July 1, 2020, this amendment updates the reimbursement methodology for nursing facility services for state fiscal year 2021.

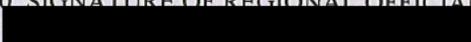
We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 20-0018 is approved effective July 1, 2020. The CMS-179 (HCFA-179) and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

  
For

Rory Howe  
Acting Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>20-0018</b>	2. STATE <b>MONTANA</b>
		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 <b>July 1, 2020</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR 447 (250-272)</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>2020</b> \$ <b>982,050</b> b. FFY <b>2021</b> \$ <b>3,928,200</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Skilled Nursing and Intermediate Care Services, 4.19 D</b> Page 7 of 35                      Page 8 of 35 Page 15 of 35                      Page 17 of 35 Page 18 of 35                      Page 19 of 35		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Skilled Nursing and Intermediate Care Services, 4.19 D</b> Page 7 of 35                      Page 8 of 35 Page 15 of 35                      Page 17 of 35 Page 18 of 35                      Page 19 of 35	
10. SUBJECT OF AMENDMENT:  <b>NURSING FACILITY REIMBURSEMENT</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>SINGLE STATE AGENCY</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>Montana Dept. of Public Health and Human Services</b> <b>Marie Matthews</b> <b>State Medicaid Director</b> <b>Attn: Mary Eve Kulawik</b> <b>PO Box 4210</b> <b>Helena, MT 59604</b>	
13. TYPED NAME: <b>Marie Matthews</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED: <b>9-29-2020</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>12/21/20</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>7/1/20</b>		20. SIGNATURE OF REGIONAL OFFICIAL:  For	
21. TYPED NAME: <b>Rory Howe</b>		22. TITLE: <b>Acting Director, FMG</b>	
23. REMARKS:			

**Attachment 4.19 D**

**Reimbursement for Skilled Nursing and Intermediate Care Services**

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) 2021 is \$208.06.

Reimbursement for Skilled Nursing and Intermediate Care Services

(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, 2020 through June 30, 2021 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 of \$211.42 as computed on July 1, 2020. 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

**Attachment 4.19 D**

**Reimbursement for Skilled Nursing and Intermediate Care Services**

(iii) a sole proprietorship, partnership corporation or other entity in which a person, described in (3) (b) (i) or (ii) has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal Medicare law, regulation or policy or related case law regarding changes in ownership under the Medicare program are not applicable.

(5) As required in Provider Participation and Termination Requirements, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the Medicaid program in accordance with applicable requirements.

(6) Any change in provider, corporate or other business ownership structure or operation of the facility that results in a change in the National Provider Identifier (NPI) will require a provider to seek a new Medicaid provider enrollment. If the NPI is transferred with the facility, and this results in a change in the federal tax identification number, the provider will be required to seek a new Medicaid provider enrollment.

INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS

(1) This rule specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/IID providers, which 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 or following a change in provider as defined in Change in Provider Defined.

(a) Effective July 1, 2001 , and thereafter, the rate paid to new providers that acquire or otherwise assume the operations of an existing nursing facility, that was participating in the Medicaid program prior to the transaction, will be paid the price-based reimbursement rate in effect for the prior owner/operator of the facility before the transaction as if no change in provider had occurred. These rates will be adjusted at the start of each state fiscal year in accordance with (1)(b).

(b) Effective July 1, 2020, and thereafter, the rate paid to newly constructed facilities or to facilities participating in the Medicaid program for the first time will be the flat rate component specified under Nursing Facility Reimbursement (2)(a). combined with the quality component specified in Nursing Facility Reimbursement (2)(b).

**SEPARATELY BILLABLE ITEMS**

(1) In addition to the amount payable under the-provisions of Nursing Facility Reimbursement (1) or (4), the department will reimburse nursing facilities located in the state of Montana for the following separately billable items. Refer to the department's nursing facility fee schedule for specific codes (fee schedule link is at; <http://medicaidprovider.mt.gov/Portals/68/docs/feeschedules/2017/fsapproved/q2approved/fsprov0327ancillary2014rev06272017.pdf> and the effective date is June 27, 2017) and refer to healthcare common procedure coding system (HCPCS) coding manuals for complete descriptions of codes:

**Attachment 4.19 D**

**Reimbursement for Skilled Nursing and Intermediate Care Services**

(at) nutrition administration kits;

(au) feeding supply kits;

(av) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for residents who, because of chronic illness or trauma, cannot be sustained through oral feeding. Payment for these solutions will be allowed only where the department determines they are medically necessary and appropriate, and authorizes payment before the items are provided to the resident;

(aw) routine nursing supplies used in extraordinary amounts and prior authorized by the department;

(ax) oxygen concentrators and portable oxygen units (cart, E tank and regulators), if prior authorized by the department.

(i) The department will prior authorize oxygen concentrators and portable oxygen units (cart, E tank and regulators) only if:

(A) The provider submits to the department documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice.

(B) The provider maintains a certificate of medical necessity indicating the P02 level or oxygen saturation level. This certificate of medical necessity must meet or exceed Medicare criteria and must be signed and dated by the patient's physician. If this certificate is not available on request of the department or during audit, the department may collect the corresponding payment from the provider as an overpayment in accordance with Settlement Procedures.

(ii) The provider must attach to its billing claim a copy of the prior authorization form.

(iii) The department's maximum monthly payment rate for oxygen concentrators and portable oxygen units (cart, E tank and regulators) will be the invoice cost of the unit divided by its estimated useful life as determined by the department. The provider is responsible for maintenance costs and operation of the equipment and will not be reimbursed for such costs by the department. Such costs are considered to be covered by the provider's per diem rate.

(2) The department may, in its discretion, pay as a separately billable item, a per diem nursing services increment for services provided to a ventilator dependent resident, trach dependent resident, behavior related needs resident, wound care resident, bariatric care resident, and residents with traumatic brain injury (TBI) diagnoses if the department determines that extraordinary staffing by the facility is medically necessary based upon the resident's needs.

(a) Payment of a per diem nursing services increment under (2) for services provided to a ventilator dependent resident shall be available only if, prior to the provision of services, the increment has been authorized in writing by the department's senior and long term care division. Approvals will be effective for one month intervals and reapproval must be obtained monthly.

(b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of five consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and non-licensed.

**Attachment 4.19**

**Reimbursement for Skilled Nursing and Intermediate Care Services**

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average Medicaid case mix index (CMI) used for rate setting determined in accordance with Minimum Data Set Submission, Treatment of Delays in Submission, Incomplete Assessments and Case Mix Index Calculation from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS) information for the resident in order to determine the difference in case mix for this resident from the average case mix for all Medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average Medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and five consecutive day nursing time documentation review.

(3) The department will reimburse for all Montana Medicaid covered services delivered via telemedicine/telehealth originating site fees as long as such services are medically necessary and clinically appropriate for delivery via telemedicine/telehealth, comply with the guidelines set forth in the applicable Montana Medicaid provider manual, and are not a service specifically required to be face-to-face.

(4) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(a) If the items listed in (1)(a) through (1)(ax) are also covered by the Medicare program and provided to a Medicaid recipient who is also a Medicare recipient, reimbursement will be limited to the lower of the Medicare prevailing charge or the amount allowed under (3). Such items may not be billed to the Medicaid program for days of service for which Medicare Part A coverage is in effect.

(b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by a physician.

(5) Physical, occupational, and speech therapies which are not nursing facility services may be billed separately by the licensed therapist providing the service, subject to department rules applicable to physical therapy, occupational therapy, and speech therapy services.

(a) Maintenance therapy and rehabilitation services within the definition of nursing facility services in Definitions are reimbursed under the per diem rate and may not be billed separately by either the therapist or the provider.

(b) If the therapist is employed by or under contract with the provider, the provider must bill for services which are not nursing facility services under a separate therapy provider number.

(6) Durable medical equipment and medical supplies which are not nursing facility services and which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care, may be billed separately by the medical supplier in accordance with department rules applicable to such services.

(7) All prescribed medication may be billed separately by the pharmacy providing the medication, subject to department rules applicable to outpatient drugs. The nursing facility will bill Medicare directly for reimbursement of Medicare Part B covered drugs and vaccines and their administration when they are provided to an eligible Medicare Part B recipient. Medicaid reimbursement is not available for Medicare Part B covered drugs and vaccines and related administration costs for residents that are eligible for Medicare Part B.

**Reimbursement for Skilled Nursing and Intermediate Care Services**

(8) Nonemergency routine transportation for activities other than those described in Definitions (11), may be billed separately in accordance with department rules applicable to such services. Emergency transportation may be billed separately by an ambulance service in accordance with department rules applicable to such services.

(9) The provider of any other medical services or supplies, which are not nursing facility services, provided to a nursing facility resident may be billed by the provider of such services or supplies to the extent allowed under and subject to the provisions of applicable department rules.

(10) The provisions of (3) through (7) apply to all nursing facilities, including intermediate care facilities for individuals with intellectual disabilities, whether or not located in the state of Montana.

(11) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under Nursing Facility Reimbursement.

Extended Rehabilitation Unit (ERU) or Traumatic Brain Injured Program (TBI)

Program Criteria

Program developed to meet needs of individuals who are not eligible for acute rehabilitation services but who are still unable to return to independent or home living. The program must provide individualized rehabilitation sustaining therapies and recreational opportunities.

All individuals appropriate for this program must be at Level II (Rancho Scale) or above and be alert to stimuli. The Rancho Scale is a cognitive functioning scale developed by the head injury treatment team at the Rancho Los Amigos Hospital and applies specifically to head injured people following injury.

Individuals referred and admitted to this unit shall demonstrate an ability to recognize, either on their own or with prompting when their behavior is inappropriate. People who demonstrate aggressive behaviors that are potentially dangerous to themselves or others are not appropriate for placement into this program. Those who are elopement risks or require locked units may not be appropriate. If these behaviors develop after admission into the unit the facility reserves the right to discharge to a more appropriate setting or initiate acute intervention.

Services to be Provided:

This facility must provide a continuum of rehabilitation sustaining therapies and activities for post acute TBI survivors to provide quality of life in the least restrictive environment, provide opportunities for TBI survivors to achieve a higher level of independence, offer a peer group to individuals with newly acquired disabilities and supportive services as