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State/Territory Name: Montana

State Plan Amendment (SPA) #: 22-0022

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

Financial Management Group

November 21, 2022

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

Re: Montana 22-0022

Dear Mr. Randol,

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 22-0022. Effective for services on or after July 1, 2022, this amendment updates the reimbursement methodology for nursing facility services for State Fiscal Year 2023.

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 22-0022 is approved effective July 1, 2022. 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,

[redacted]

Director

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 **22-0022**	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 **July 1, 2022**	
5. FEDERAL STATUTE/REGULATION CITATION **42 CFR 447 (250-272)**	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY 2022 $ 85,410 b. FFY 2023 $ 341,640	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Skilled Nursing and Intermediate Care Services, 4.19 D** **Pages 1 through 35**	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)* **Skilled Nursing and Intermediate Care Services, 4.19 D** **Pages 1 through 35**	

9. SUBJECT OF AMENDMENT

NURSING FACILITY REIMBURSEMENT

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 STATE AGENCY**
11. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]	15. RETURN TO **Montana Dept. of Public Health and Human Services** **Mike Randol** **State Medicaid Director** **Attn: Mary Kulawik** **PO Box 4210** **Helena, MT 59604**
12. TYPED NAME **Mike Randol**	
13. TITLE **Medicaid and Health Services Executive Director/ State Medicaid Director**	
14. DATE SUBMITTED 8-29-2022	

FOR CMS USE ONLY

16. DATE RECEIVED August 29, 2022	17. DATE APPROVED November 21, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2022	19. SIGNATURE OF APPROVING OFFICIAL [redacted]
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe	21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group

22. REMARKS

SCOPE, APPLICABILITY AND PURPOSE

(1) This subchapter specifies requirements applicable to provision of and reimbursement for Medicaid nursing facility services, including intermediate care facility services for the individuals with intellectual disabilities. These rules are in addition to requirements generally applicable to Medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) These rules are subject to the provisions of any conflicting federal statute, regulation or policy, whether now in existence or hereafter enacted or adopted.

(3) Reimbursement and other substantive nursing facility requirements are subject to the laws, regulations, rules and policies then in effect. Procedural and other non-substantive provisions of these rules are effective upon adoption.

DEFINITIONS Unless the context requires otherwise in this subchapter, the following definitions apply:

(1) “Administrator” means the person licensed by the state, including an owner, salaried employee, or other provider, with daily responsibility for operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be a person other than the titled administrator of the facility if such person has daily responsibility for operation of the nursing facility and is currently licensed by the state as a nursing home administrator.

(2) “Case mix index (CMI)” means an assigned weight or numeric score assigned to each RUG-III grouping which reflects the relative resources predicted to provide care to nursing facility residents.

(3) “Department” means the Montana department of Public Health and Human Services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review. (4) “Department audit staff” and “audit staff” mean personnel directly employed by the department or any of the department’s contracted audit personnel or organizations.

(5) “Estimated economic life” means the estimated remaining period during which property is expected to be economically usable by one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

(6) “Fiscal year” and “fiscal reporting period” both mean the provider’s internal revenue tax year.

(7) “Maintenance therapy and rehabilitation services” mean repetitive services required to maintain functions which do not involve complex and sophisticated therapy procedures or the judgment and skill of a qualified therapist and without the expectation of significant progress.

(8) “Medicaid recipient” means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(9) “Minimum data set (MDS)” means the assessment form approved by the centers for Medicare and Medicaid services (CMS)and designated by the department to satisfy conditions of participation in the Medicaid and Medicare programs.

(10) “Minimum data set RUG-III quarterly assessment form” means the three page quarterly, optional version for RUG-III 1997 update.

(11) “Nonemergency routine transportation” means transportation for routine activities, such as outings scheduled by the facility, nonemergency visits to physicians, dentists, optometrists or other medical providers. This definition includes such transportation when it is provided within 20 miles of the facility.

(12) “Nursing facility fee schedule” means the list of separately billable ancillary services provided in Separately Billed Items.

(13) “Nursing facility services” means nursing facility services as provided in Nursing Facility Services and in Nursing Facility Services: Reimbursable Services.

(14) “Patient contribution” means the total of all of a resident’s income from any source available to pay the cost of care, less the resident’s personal needs allowance. The patient contribution includes a resident’s incurment determined in accordance with applicable eligibility rules.

(15) “Patient day” means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a resident who takes a temporary leave from a provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

(16) “Provider” means any person, agency, corporation, partnership or other entity that, under a written agreement with the department, furnishes nursing facility services to Medicaid recipients.

(17) “Rate year” means a 12-month period beginning July 1. For example, rate year 2006 means a period corresponding to the state fiscal year July 1, 2005 through June 30, 2006.

(18) “Resident” means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(19) “RUG-III” means resource utilization group, version III.

(20) “RUG-III grouper version” means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status using MDS assessment information for each resident.

NURSING FACILITY SERVICES

(1) Nursing facility services are provided in accordance with 42 CFR, part 483, subpart B, or intermediate care facility services for individuals with intellectual disabilities provided in accordance with 42 CFR, part 483, subpart I. The department adopts and incorporates by reference 42 CFR, part 483, subparts B and I, that define the participation requirements for nursing facility and intermediate care facility for individuals with intellectual disabilities (ICF/IID) providers, copies of which may be obtained from 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.

(2) The term “nursing facility services” includes the term “long term care facility services”.

(3) Nursing facility services include, but are not limited to:

(a) a medically necessary room;

(b) dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet;
(c) nursing services;
(d) minor medical and surgical supplies; and
(e) the use of equipment and facilities.
(4) Payment for the service listed in Nursing Facility Services and in Nursing Facility Services: Reimbursable Services are included in the per diem rate determined by the department under Nursing Facility Reimbursement or Reimbursement for Intermediate Care Facilities for Individuals with Intellectual Disabilities and no additional reimbursement is provided for such services.

NURSING FACILITY SERVICES: REIMBURSABLE SERVICES
(1) Nursing facility services include but are not limited to the following or any similar items:
(a) all general nursing services, including but not limited to administration of oxygen and medications, handfeeding, incontinence care, tray service, nursing rehabilitation services, enemas, and routine pressure sore/decubitis treatment;
(b) services necessary to provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life;
(c) services required to attain or maintain the highest practicable physical, mental, and psychosocial well being of each Medicaid recipient who is a resident in the facility;
(d) items furnished routinely to all residents without charge, such as resident gowns, water pitchers, basins and bed pans;
(e) items routinely provided to residents including but not limited to:
(i) antibacterial/bacteriostatic solutions, including betadine,
hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution;
(ii) cotton;
(iii) denture cups;
(iv) deodorizers (room-type);
(v) distilled water;
(vi) enema equipment and/or solutions;
(vii) facial tissues and paper toweling;
(viii) finger cots;
(ix) first aid supplies;
(x) foot soaks;
(xi) gloves (sterile and unsterile);
(xii) hot water bottles;
(xiii) hypodermic needles (disposable and nondisposable);
(xiv) ice bags;
(xv) incontinence pads;
(xvi) linens for bed and bathing;
(xvii) lotions (for general skin care);
(xviii) medication-dispensing cups and envelopes;
(xix) ointments for general protective skin care;

(xx) ointments (antibacterial);
(xxi) personal hygiene items and services, including but not limited to:
(A) bathing items and services, including but not limited to towels, washcloths and soap;
(B) hair care and hygiene items, including but not limited to shampoo, brush and comb;
(C) incontinence care and supplies appropriate for the resident's individual medical needs;
(D) miscellaneous items and services, including but not limited to cotton balls and swabs, deodorant, hospital gowns, sanitary napkins and related supplies, and tissues;
(E) nail care and hygiene items;
(F) shaving items, including but not limited to razors and shaving creme;
(G) skin care and hygiene items, including but not limited to bath soap, moisturizing lotion, and disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; and
(H) tooth and denture care items and services, including but not limited to toothpaste, toothbrush, floss, denture cleaner and adhesive;
(xxii) safety pins;
(xxiii) sterile water and normal saline for irrigating;
(xxiv) sheepskins and other fleece-type pads;
(xxv) soaps (hand or bacteriostatic);
(xxvi) supplies necessary to maintain infection control, including those required for isolation-type services;
(xxvii) surgical dressings;
(xxviii) surgical tape;
(xxix) over-the-counter drugs (or their equivalents), including but not limited to:
(A) acetaminophen (regular and extra-strength);
(B) aspirin (regular and extra-strength);
(C) cough syrups;
(D) specific therapeutic classes D4B (antacids), D6S (laxatives and cathartics) and Q3S (laxatives, local/rectal) including but not limited to:
(I) milk of magnesia;
(II) mineral oil;
(III) suppositories for evacuation (dulcolax and glycerine);
(IV) maalox; and
(V) mylanta;
(E) nasal decongestants and antihistamines;
(xxx) straw/tubes for drinking;
(xxxi) suture removal kits;
(xxxii) swabs (including alcohol swab);
(xxxiii) syringes (disposable or nondisposable hypodermic; insulin; irrigating);
(xxxiv) thermometers, clinical;
(xxxv) tongue blades;
(xxxvi) water pitchers;
(xxxvii) waste bags;
(xxxviii) wound-cleansing beads or paste;

(f) items used by individual residents which are reusable and expected to be available, including but not limited to:
(i) bathtub accessories (seat, stool, rail);
(ii) beds, mattresses, and bedside furniture;
(iii) bed boards, foot boards, cradles;
(iv) bedside equipment, including bedpans, urinals, emesis basins, water pitchers, serving trays;
(v) bedside safety rails;
(vi) blood-glucose testing equipment;
(vii) blood pressure equipment, including stethoscope;
(viii) canes, crutches;
(ix) cervical collars;
(x) commode chairs;
(xi) enteral feeding pumps;
(xii) geriatric chairs;
(xiii) heat lamps, including infrared lamps;
(xiv) humidifiers;
(xv) isolation cart;
(xvi) IV poles;
(xvii) mattress (foam-type and water);
(xviii) patient lift apparatus;
(xix) physical examination equipment;
(xx) postural drainage board;
(xxi) room (private or double occupancy as provided in items Billable to Residents);
(xxii) raised toilet seat;
(xxiii) sitz baths;
(xxiv) suction machines;
(xxv) tourniquets;
(xxvi) traction equipment;
(xxvii) trapeze bars;
(xxviii) vaporizers, steam-type;
(xxix) walkers (regular and wheeled);
(xxx) wheelchairs (standard); and
(xxxi) whirlpool bath;
(g) laundry services whether provided by the facility or by a hired firm, except for residents' personal clothing which is dry cleaned outside of the facility; and
(h) nonemergency routine transportation as defined in Definitions(11).

PROVIDER PARTICIPATION AND TERMINATION REQUIREMENTS

(1) Nursing facility service providers, as a condition of participation in the Montana Medicaid program must meet the following requirements:
(a) comply with and agree to be bound by all laws, rules, regulations and policies generally applicable to Medicaid providers, including but not limited to the provisions of the General Medicaid Services;

(b) maintain a current license issued by the department of Public Health and Human Services under Montana law for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain a current license under the laws of the state in which the facility is located for the category and level of nursing facility care being provided;

(c) maintain a current certification for Montana Medicaid issued by the department of Public Health and Human Services under applicable state and federal laws, rules, regulations and policies for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain current Medicaid certification in the state in which the facility is located for the category and level of nursing facility care being provided;

(d) maintain a current agreement with the department to provide the level of care for which payment is being made, or, if the facility is located outside the state of Montana, comply with the provisions of Reimbursement to Out-of-State Facilities;

(e) operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules or policies may require;

(f) for providers maintaining resident trust accounts, insure that any funds maintained in such accounts are used only for those purposes for which the resident, legal guardian, or personal representative of the resident has given written authorization. The provider must maintain personal funds in excess of $50 in an interest bearing account and must credit all interest earned to the resident's account. Resident's personal funds in amounts up to $50 must be maintained in such a manner that the resident has convenient access to such funds within a reasonable time upon request. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

(g) A provider holding personal funds of a deceased nursing facility resident who received Medicaid benefits at any time shall, within 30 days following the resident's death, pay those funds as provided by law and regulation.

(h) maintain admission policies which do not discriminate on the basis of diagnosis or handicap, and which meet the requirements of all federal and state laws prohibiting discrimination against the handicapped, including persons infected with acquired immunity deficiency syndrome/human immunodeficiency virus (AIDS/HIV);

(i) comply with the Level of Care Determinations and the Preadmission Screening for Skilled Nursing and Intermediate Care Services;

(j) comply with all applicable federal and state laws, rules, regulations and policies regarding nursing facilities at the times and in the manner required therein, including but not limited to 42 USC 1396r(b) (5) and 1396r(c) (1994 supp.) and implementing regulations, which contain federal requirements relating to nursing home reform.

(2) A provider which fails to meet any of the requirements of this rule may be denied Medicaid payments, refused further participation in the Medicaid program or otherwise sanctioned or made subject to appropriate department action, according to applicable laws, rules, regulations or policies.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal Medicaid participation requirements. Department sanctions or actions may include

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) 2023 is $209.34.

(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, 2022 through June 30, 2023 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. Copies of the department's current nursing facility reimbursement rates per facility are posted at https://medicaidprovider.mt.gov/26#1875810541, or may be obtained from the Department of Public Health and Human Services, Senior & long-Term Care Division, P.O. Box 4210, Helena, MT 59604-4210.

(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, 2022. 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 Medicare Beneficiaries but are not otherwise Medicaid eligible, payment will be made only under the QMB program at the Medicare coinsurance rate.

(9) The department will not make any nursing facility per diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed which is licensed and certified as provided in Provider Participation and Termination Requirements as a nursing facility or skilled nursing facility bed.

(10) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of Bed Hold Payments (1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(11) Providers must bill for all services and supplies in accordance with the provisions of the General Medical Services. The department's fiscal agent will pay a provider on a weekly or monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized Medicaid recipients during the billing period.

(a) Authorized Medicaid recipients are those residents determined eligible for Medicaid and authorized for nursing facility services as a result of the screening process described in the Level of Care Determinations and in the Preadmission Screening for Skilled Nursing and Intermediate Care Services.

(12) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or nonpayment, as specifically provided in these rules.

RATE EFFECTIVE DATES

(1) A provider's per diem rate effective for the rate period July 1, 2001 through June 30, 2002 and in subsequent rate years, shall be determined in accordance with Nursing Facility Reimbursement.

(2) Except as specifically provided in these rules, per diem rates and interim rates are set no more than once a year, effective July 1, and remain in effect at least through June 30 of the following year.

(a) Nothing in this subchapter shall be construed to require that the department apply any inflation adjustment, recalculate the Medicaid case mix index or the statewide price, or otherwise adjust or recalculate per diem rates or interim rates on July 1 of a rate year, unless the department adopts further rules or rule amendments providing specifically for a rate methodology for the rate year.

(3) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this subchapter, until the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year.

RATE ADJUSTMENT FOR COUNTY FUNDED RURAL NURSING FACILITIES

(1) For each state fiscal year, the department will provide a mechanism for a one time, lump sum payment to nonstate government owned or operated facilities for Medicaid services according to the methodology specified in this rule. These payments will be for the purpose of maintaining access and viability for a class of “at risk” county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county.

(2) A nursing facility is eligible to participate in this lump sum payment distribution if it is a nonstate government owned or operated facility that has provided Medicaid services in the current state fiscal year.

(a) The department will calculate the amount of lump sum distribution that will be allowed for each county affiliated provider so that the total per day amount does not exceed the computed Medicare upper payment limit for these providers. Distribution of these lump sum payments will be based on the Medicaid utilization at each participating facility for the period July 1 of the previous year through June 30 of the current year.

(b) In order to qualify for this lump sum adjustment, each county on behalf of its nonstate government owned or operated facility must enter into a written agreement to transfer local county funds to be used as matching funds by the department. This transfer option is voluntary, but those counties that agree to participate must abide by the terms of the written agreement.

(3) On or after July 1 of each year, the department will provide for a one time, lump sum distribution of funding to nursing facilities not participating in the funding for “at risk” facilities for the provision of Medicaid services.

(4) The department will calculate the maximum amount of the lump sum payments that will be allowed for each participating nonstate government owned or operated facility, as well as the additional payments for other nursing facilities not participating in the funding for “at risk” facilities for the provision of Medicaid services in accordance with state and federal laws, as well as applicable Medicare upper payment limit thresholds. This payment will be computed as a per day add-on based upon the funding available. Distribution will be in the form of lump sum payments and will be based on the Medicaid utilization at each participating facility for the period July 1 of the preceding year through June 30 of the current year.

(5) There may be no pre-arranged formal or informal agreements with the nursing facility to return or redirect any portion of the lump sum nursing facility payment to the county in order to fund other Medicaid services or non-Medicaid services.

(a) Payments or credits for normal operating expenses and costs are not considered a return or redirection of a Medicaid payment.

(6) “Normal operating expenses” and “costs” include, but are not limited to:

(a) taxes, including health care provider related taxes;

(b) mill levies;

(c) fees;

(d) payment of facility construction bonds or loans;

(e) health insurance costs, unemployment insurance, workers compensation and other employee benefits;

(f) payments in lieu of rent based on depreciation cost of county buildings occupied by nursing facility;
(g) mortgage or rent payments;
(h) payment of building insurance;
(i) other business relationships with county governments unrelated to Medicaid in which there is no connection to Medicaid payments; and
(j) legitimate services provided by the county to the nursing facility, such as building maintenance, legal services, accounting and advertising.
(7) Charges for services must be reasonable and the services must be documented.
(a) Documentation supporting charges are subject to the audit and record retention provisions in Maintenance of Records and Auditing.

STAFFING AND REPORTING REQUIREMENTS
(1) Providers must provide staffing at levels which are adequate to meet federal law, regulations and requirements.
(a) Each provider must submit to the department within 10 days following the end of each calendar month a complete and accurate DPHHS-SLTC--015, “Monthly Nursing Home Staffing Report” prepared in accordance with all applicable department rules and instructions.
(b) If a complete and accurate DPHHS-SLTC-015 is not received by the department within 10 days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a).

MINIMUM DATA SET SUBMISSION, TREATMENT OF DELAYS IN SUBMISSION, INCOMPLETE ASSESSMENTS, AND CASE MIX INDEX CALCULATION
(1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) database as required by federal participation requirements, laws and regulations.
(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.
(3) Retention of assessments on the database will follow the records retention policy of the department of public health and human services. Back up tapes of each rate setting period will be maintained for a period of five years.
(4) Assessments not containing sufficient in-range data to perform a resource utilization group-III (RUG-III) algorithm will not be included in the case mix calculation during the transition period.
(5) All current assessments in the database older than six months will be excluded from the case mix index calculation.
(6) For purposes of calculating rates, the department will use the RUG-III, 34 category, index maximizer model, version 5.12. The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

(7) For purposes of calculating rates, case mix weights will be developed for each of the 34 RUG-III groupings. The department will compute a Montana specific Medicaid case mix utilizing average nursing times from the 1995 and the 1997 CMS case mix time study. The average minutes per day per resident will be adjusted by Montana specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information.

(8) For purposes of calculating rates, the department shall assign each resident a RUG-III group calculated on the most current non-delinquent assessment available on the first day of the second month of each quarter as amended during the correction period. The RUG-III group will be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the department shall determine a simple facility average case mix index, carried to four decimal places, based on all resident case mix indices. For each quarter, the department shall calculate a Medicaid average case mix index, carried to four decimal places, based on all residents for whom Medicaid is reported as the per diem payor source any time during the 30 days prior to their current assessment.

(9) Facilities will be required to comply with the data submission requirements specified in this rule and in Correction of Erroneous or Missing Data. The department will utilize Medicaid case mix data in the computation of rates for the period July 1, 2001 through June 30, 2002 and for rate years thereafter.

CORRECTION OF ERRONEOUS OR MISSING DATA

(1) The department will prepare and distribute resident listings to facilities by the 15th day of the third month of each quarter (cut off date). The listings will identify current assessments for residents in the nursing facility on the first day of the second month of each quarter as reflected in the database maintained by the department. The listings will identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source. Resident listings shall be signed and returned to the department by the 15th day of the first month of the following calendar quarter. Facilities who do not return this corrected resident listing by the due date will use the database information on file in their case mix calculation.

(2) If data reported on the resident listings is in error or if there is missing data, facilities will have until the 15th day of the first month of each calendar quarter to correct data submissions.

(a) Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by the department of Public Health and Human Services (DPHHS) are corrected by transmitting the appropriate assessments or tracking documents to DPHHS in accordance with CMS requirements.

(b) Errors in key field items are corrected following the CMS key field specifications through DPHHS.

(c) Errors on the current payor source should be noted on the resident listings prior to signing and returning to DPHHS.

(3) The department may also use Medicaid paid claim data to determine the Medicaid residents in each facility when determining the Medicaid average case mix index for each facility.

OBRA NURSE AIDE TESTING AND TRAINING COST REPORTING

(1) Omnibus Budget Reconciliation Act of 1987 (OBRA) costs will be reimbursed under the per diem rate determined under Nursing Facility Reimbursement. No further reimbursement will be provided outside the per diem rate.

(2) Each provider must document and submit to the department on a quarterly basis information on the nurse aide certification training and competency evaluation (testing) costs, including but not limited to the costs of training for nurse aides and the costs of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing). The required information must be submitted quarterly on the nurse aide certification/training and competency evaluation (testing) survey reporting form provided by the department and must include the total dollars incurred in each of the categories of facility personnel, supplies and equipment, subcontracted services and testing fees. The reporting form must include a brief description of the items included in each of the four categories.

(a) Acceptable documentation will be any documentation that adequately supports the costs claimed on the reporting form and includes all records and documentation as defined in Cost Reporting, Desk Review & Audit, such as invoices, contracts, canceled checks and time cards. This documentation is subject to desk review and audit in accordance with Cost Reporting, Desk Review & Audit. This documentation must be maintained by the facility for six years, three months from the date the form is filed with the department or until any dispute or litigation regarding the costs supported by such documentation is finally resolved, whichever is later.

(b) If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments. in accordance with Cost Reporting, Desk Review & Audit (4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.

(3) Medicaid nursing facility reimbursement for the costs associated with training and competency evaluation programs for nurse aides employed in Medicare and Medicaid nursing facilities, as required under OBPA, shall be as follows:

(a) Nurse aide certification training and competency evaluation (testing) costs documented in accordance with (2) and allowable under Allowable Costs will be reimbursed to the extent provided under the per diem rate determined under Nursing Facility Reimbursement. No additional reimbursement will be provided for such costs.

(4) For purposes of reporting under (2), nurse aide tests are those tests which:

(a) demonstrate competency through testing methods which address each course requirement and include successful, completion of both a written or oral examination and a demonstration of the skills required to perform the tasks required of a nurse aide;

(b) are performed at either a nursing facility which is currently in compliance with Medicaid nursing facility participation requirements or at a regional testing site at regularly scheduled testing times;

(c) are administered to nurse aides actually employed by the facility; and

(d) do not exceed a third attempt by the individual nurse aide to successfully complete the portion of the test for which costs are reported. The written/oral examination and the skills demonstration may be taken separately if the nurse aide passed only one portion of the test in a previous exam.

(5) Competency evaluation' (testing) costs reported by a provider shall include the testing entity's basic fee charged to the facility and other costs associated with competency testing, to the extent allowable under Allowable Costs.

CHANGE IN PROVIDER DEFINED

(1) Except as provided in (2), a change in provider will be deemed to have occurred if the events described in any one of the following (1) (a) through (d) occurs:

(a) For sole proprietorship providers, a change in provider occurs where the entire sole proprietorship is sold to an unrelated party and a selling proprietor does not retain a right of control over the business

(b) For partnership providers, a change in provider occurs where:

(i) a new partner acquires an interest in the partnership greater than 50%;

(ii) the new partner not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest; and

(iii) the current or former partners from whom the new partner acquires an interest do not retain a right of control over the partnership arising from the transferred interest.

(c) For corporation providers, a change in provider occurs where stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated party.

(d) For all providers, a change in provider occurs where an unrelated party acquires:

(i) the provider's title or interest in the nursing facility or a leasehold interest in the nursing facility; and

(ii) the right to control and manage the business of the nursing facility.

(2) Regardless of the provisions of (1) through (1) (d), a change in provider will not be deemed to have occurred if the circumstances indicate that:

(a) a related party will acquire, retain or actually exercise substantial influence over the new entity; or

(b) the occurrence or transaction is undertaken primarily for the purpose of triggering a change in provider under this rule.

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party' means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who 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;

(ii) A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3) (b) (i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3) (b) (i); or

(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:

(a) ostomy surgical tray;
(b) ostomy face plate;
(c) ostomy skin barriers;
(d) ostomy filter;
(e) ostomy bags (pouches);
(f) ostomy belt;
(g) adhesive;
(h) adhesive remover;
(1) ostomy irrigation set and supplies;
U) ostomy lubricant;
(k) ostomy rings;
(I) ostomy irrigation supply, cone/catheter, including brush;
(m) catheter care kit;
(n) urine test or reagent strips or tablets;
(0) blood tubing, arterial or venous;
(p) blood glucose test strips for dialysis;
(q) blood glucose test or reagent strips for home blood glucose monitor;
(r) implantable access catheter (venous, arterial, epidural, subarachnoid, peritoneal, etc.) external access;
(s) gastrostomy/jejunostomy tube, any material, any type;
(t) oropharyngeal suction catheter;
(u) implanted pleural catheter;
(v) external urethral clamp or compression device;
(w) urinary catheters;
(x) urinary insertion trays (sets);
(y) urinary collection bags;
(z) tracheostomy care kit for established tracheostomy;
(aa) tracheostomy, inner cannula (replacement only);
(ab) oxygen contents, portable, liquid;
(ac) oxygen contents, portable, gas;
(ad) oxygen contents, stationary, liquid;
(ae) oxygen contents, stationary, gas;
(af) cannula, nasal;
(ag) oxygen tubing;
(ah) regulator;
(ai) mouth piece;
(aj) stand/rack;
(ak) face tent;
(al) humidifier;
(am) breathing circuits;
(an) respiratory suction pump, home model, portable or stationary;
(ao) nebulizer, with compressor;
(ap) feeding syringe;
(aq) nasal interface (mask or cannula type) used with positive airway device;

(ar) stomach tube - Levine type;
(as) nasogastric tubing (with or without stylet);
(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.

(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.

(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 they learn to adapt and create a positive environment in which behavior intervention and retraining are a part of all programming.

All admissions into the unit will meet nursing facility level of care and will meet the requirements for level I and II criteria for PASARR. Minimum data set requirements and timelines will apply to all admissions into this unit.

Interim rates will be established on July 1, of the rate year from budget information submitted by the provider and an evaluation of the costs of providing care to the individuals in the respective unit. The rate established on July 1, will include all nursing facility services as specified in Nursing Facility Reimbursement and all ancillary services specified in Separately Billable Items including all feeding solutions, as well as, increased staffing appropriate for the residents in the unit and any costs for physical therapy, speech therapy, occupational therapy, social worker services, psychological services. All of the above indicated costs must be provided within the interim daily rate established for the facility by employees of the facility or under contract with outside providers. The outside providers of these services may not bill Medicaid for the provision of these services for any residents occupying a bed in this unit.

Services billable directly to Medicaid when provided for residents in this unit and not included in the computation of the daily rate will be dental, pharmacy, physician visits, optometric, podiatry, lab and x-ray and durable medical equipment limited to wheelchairs, adaptations, specialized equipment and repairs.

Reimbursement

This unit must operate as a distinct unit separate from the rest of the nursing facility. Reimbursement levels will be established effective July 1, using an interim payment rate that will be subject to final settlement upon the submission of a cost report of at least six months of operation. Upon submission of a final cost report all costs, must meet the allocability criteria and reasonableness established in Allowable Costs, Cost Reporting, Desk Review & Audit, and Cost Reporting Procedures.

Settlement of costs will be within a lower limit and an upper limit established as follows:

If the unit provides the required services for less than the interim rate times 95 percent, the lower limit, the facility will be allowed to maintain all amounts between the lower limit and the actual settled cost per day for provision of the services through the settlement process.

If the unit provides the required services for an allowable cost per day between the interim rate times 95 percent and the interim rate time 105 percent the facility will receive their actual allowable cost per day through the settlement process.

If the unit provides the required services for an allowable cost per day in excess of the interim rate times 105 percent, the upper limit, they will receive 100 percent of their cost up to the upper limit through settlement and any allowable costs in excess of the upper limit will be settled at 75 percent of the incurred costs through the settlement process.

Maximum occupancy in the unit will be 19 residents. The facility will be required to maintain 90 percent occupancy for reimbursement purposes in this unit. If the unit operates at less than 90 percent an assumed 90 percent occupancy will be utilized in the final rate settlement process for this facility.

ITEMS BILLABLE TO RESIDENTS

(1) The department will not pay a provider for any of the following items or services provided by a nursing facility to a resident. The provider may charge these items or services to the nursing facility resident:
(a) gifts purchased by residents;
(b) social events and entertainment outside the scope of the provider's activities program;
(c) cosmetics and grooming items and services in excess of those for which payment is made by Medicare or Medicaid;
(d) personal comfort items, including tobacco products and accessories, notions, novelties, and confections;
(e) personal dry cleaning;
(f) beauty shop services;
(g) television, radio and private telephone rental;
(h) less-than-effective drugs (exclusive of stock items)
(i) vitamins, multivitamins, vitamin supplements and calcium supplements;
(j) personal reading materials;
(k) personal clothing;
(l) flowers and plants;
(m) privately hired nurses or aides;
(n) specially prepared or alternative food requested instead of food generally prepared by facility; and
(o) the difference between the cost of items usually reimbursed under the per diem rate and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers);
(2) Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.

(a) A provider must provide a medically necessary private room at no additional charge and may not bill the recipient any additional charge for the medically necessary private room.
(b) A provider may bill a resident for the extra cost of a private room if the private room is not medically necessary and is requested by the resident. The provider must clearly inform the resident that additional payment is strictly voluntary.

REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

(1) For intermediate care facility services for individuals with intellectual disabilities provided in facilities located in the state of Montana, the Montana Medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined retrospectively in accordance with Allowable Cost and Cost Reporting, Desk Review & Review, divided by the total patient days of service during the rate year, minus the amount of the Medicaid recipient's patient contribution, subject to the limits specified in (2) (a) and (b)

(2) Payments under (1) may not exceed the following limits:

(a) Final per diem payment rates for base years shall be as specified in (1), without application of any further limit. Base years are even numbered state fiscal years, i.e., state fiscal years 1994, 1996 and subsequent even-numbered years.

(b) Final per diem rates in non-base years are limited to the final per diem rate for the immediately preceding base year indexed from June 30 of the base year to June 30 of the rate year. The index is the final Medicare market basket index applicable to the non-base year. Non-base years are odd-numbered state fiscal years, i.e., state fiscal years 1993, 1995 and subsequent odd-numbered years.

(3) All ICF/IID providers must use a July 1 through June 30 fiscal year for accounting and cost reporting purposes.

(4) Prior to the billing of July services each rate year, the department will determine an interim payment rate for each provider. The provider's interim payment rate shall be determined based upon the department's estimate of actual allowable cost under Allowable Costs, divided by estimated patient days for the rate year. The department may consider, but shall not be bound by, the provider's cost estimates in estimating actual allowable costs. The provider's interim payment rate is an estimate only and shall not bind the department in any way in the final rate determination under (1) and (5)

(5) The provider's final rate as provided in (1) shall be determined based upon the provider's cost report for the rate year filed in accordance with Cost Reporting, Desk Review & Audit, after desk review or audit by the departments audit staff. The difference between actual includable cost allocable to services to Medicaid residents, as limited in (2), and the total amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures specified in Cost Settlement Procedures.

(6) Following the sale of an intermediate care facility for individuals with intellectual disabilities after April 5, 1989, the new providers property costs will be the lesser of historical costs (facility's last fiscal year's cost report) or the rate used for all other intermediate care facilities, subject to the limitations in 42 USC 1396a(a) (13) (C).

REIMBURSEMENT TO OUT-OF-STATE FACILITIES

(1) The department will reimburse nursing facilities located outside the state of Montana for nursing facility services and any other reimbursable services or supplies provided to eligible Montana Medicaid individuals at the Medicaid rate and upon the basis established by the Medicaid agency in the state in which the facility is located.

(2) The Montana Medicaid program will pay for nursing facility services or related supplies provided to eligible Montana Medicaid individuals in nursing facilities located outside the state of Montana only when one of the following conditions is met:

(a) because of a documented medical emergency, the resident's health would be endangered if he or she was to return to Montana for medical services;

(b) the services required are not provided in Montana;

(c) the required services and all related expenses are less costly than if the required services were provided in Montana;

(d) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(e) the department determines that it is general practice for recipients in the resident's particular locality to use medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana Medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana Medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state Medicaid agency establishing or stating the facility's Medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state Medicaid agency establishing or stating the Medicaid reimbursement payable for such items for the period the items were provided;

(d) a properly completed level I screening form for the resident, as required by Preadmission Screening, et seq.;

(i) To the extent required by Preadmission Screening, et seq., a level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the resident's need for active treatment. A level I screening form may be obtained from the department.

(e) a copy of the preadmission screening determination for the resident completed by the department or its designee;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, Medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for Medicaid during the period services were provided; and

(h) assurances that, during the period the billed services were provided, the facility was not operating under sanctions imposed by Medicare or Medicaid which would preclude payment.

(5) Reimbursement to nursing facilities located outside the state of Montana for Medicare coinsurance days for dually eligible Medicaid and Medicare individuals shall be limited to the per diem rate established by the facility's state Medicaid agency, less the Medicaid recipient's patient contribution.

BED HOLD PAYMENTS

(1) Except as provided in 6) through (9) for therapeutic home visits, payment will be made to a provider for holding a bed for a resident only if:

(a) the provider's facility is full and has a current waiting list of potential residents during each such bed day claimed for reimbursement;

(b) the resident for whom the bed is held is temporarily receiving medical services outside the facility, except in another nursing facility, and is expected to return to the provider;

(c) the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate long term care bed would otherwise become available; and

(d) the provider has received written approval from the department's Senior and Long Term Care Division as provided in (4) (2) For purposes of (1), a provider will be considered full if: (a) all Medicaid certified beds are occupied or being held for a recipient who is either temporarily receiving medical services outside the provider's facility or outside the facility on a therapeutic home visit; or

(b) as to gender, if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients.

(3) For purposes of (1), the provider must maintain and, upon request, provide to the department or its agents documentation that the absence is expected to be temporary and of the anticipated duration of the absence. Temporary absences which are of indefinite duration must be documented at least weekly by the provider to assure that the absence is indeed temporary.

(4) A provider's request for the department's written approval of bed hold days as required in (1) must be submitted to the department's Senior and Long Term Care Division on the form provided by the department within 90 days after the first day of the requested bed hold period. The request must include a copy of the waiting list applicable to each bed hold day claimed for reimbursement.

(5) Where the condition of (1) through (4) are met, providers are required to hold a bed and may not fill the bed until these conditions are no longer met. The bed may not be filled unless prior approval is obtained from the department's Senior and Long Term Care Division. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill Medicaid for the bed hold day until all conditions of billing are met and may not bill the resident under any circumstances.

(6) Payment will be made to a provider for holding a bed for a resident during a therapeutic home visit only if:
(a) the recipient's plan of care provides for therapeutic home visits;
(b) the recipient is temporarily absent on a therapeutic home visit; and
(c) the resident is absent from the provider's facility for no more than 72 consecutive hours per absence, unless the department determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence. If a resident leaves the facility unexpectedly, on a weekend or a non-business day for a visit longer than 72 hours a provider must call in to the department on the next business day to receive prior authorization for the visit. If a resident is unexpectedly delayed while out on a therapeutic home visit, a provider must call the department and receive prior authorization if that delay will result in the visit exceeding 72 hours or obtain an extension for a visit that was previously approved by the department in excess of 72 hours.
(7) The department may allow therapeutic home visits for trial placement in the Home and Community Services (Medicaid waiver) program.
(8) No more than 24 days per resident in each rate year (July 1 through June 30) will be allowed for therapeutic home visits.
(9) The provider must submit to the department's Senior and Long Term Care Division a request for a therapeutic home visit bed hold, on the appropriate form provided by the department, within 90 days of the first day a resident leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the department's Senior and Long Term Care Division.
(10) Approvals or authorizations of bed hold days obtained from county offices will not be valid or effective for purposes of this rule.

MEDICARE HOSPICE BENEFIT - REIMBURSEMENT

(1) In accordance with section 9435(b) of the Omnibus Budget Reconciliation Act of 1986, Public Law 99-509, the department may not pay a nursing facility provider for services provided to an eligible Medicaid/Medicare individual who has elected the Medicare hospice benefit.
(a) This rule applies where the hospice provider and the nursing facility provider have made a written agreement under which the hospice provider agrees to provide professional management of the individual's hospice care and the nursing facility provider agrees to provide room and board to the individual.
(b) When this rule applies, the department will pay the hospice provider in accordance with the department's rules governing Medicaid reimbursement to hospice providers.

ALLOWABLE COSTS

(1) This rule applies for purposes of determining allowable costs for cost reporting periods beginning on or after July 1, 1991. Allowable costs for cost reporting periods beginning prior to July 1, 1991 will be determined in accordance with rules for allowable costs then in effect.

(2) For purposes of reporting and determining allowable costs, the department hereby adopts and incorporates herein by reference the Provider Reimbursement Manual (PRM-15), published by the United States Department of Health and Human Services, Social Security Administration, which provides guidelines and policies to implement Medicare regulations and principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. Applicability of the PRM-15 is subject to the exceptions and limitations specified in this rule.

(a) The term “allowable costs” means costs which are allowable under the provisions of this subchapter and which are considered in determining the costs of providing Medicaid nursing facility services. The determination that a cost is an allowable cost does not require the department to reimburse the provider for that cost. Providers will be reimbursed only as specifically provided in these rules.

(3) For purposes of reporting costs as required in Cost Reporting, Desk Review & Audit, allowable costs will be determined in accordance with the PRM-15, subject to the exceptions and limitations provided in these rules, including but not limited to the following:

(a) Return on net invested equity is an allowable cost only for providers of intermediate care facility services for individuals with intellectual disabilities which provide services on a for-profit basis.

(b) Allowable property costs are limited as follows:

(i) The capitalized costs of movable equipment are not allowable in excess of the fair market value of the asset at the time of acquisition.

(ii) Property-related interest, whether actual interest or imputed interest for capitalized leases, is not allowable in excess of the interest rates available to commercial borrowers from established lending institutions at the date of asset acquisition or at the inception of the lease.

(iii) Leases must be capitalized according to generally accepted accounting principles.

(iv) Depreciation of real property and movable equipment must be in accordance with American hospital association guidelines. Depreciation of real property and movable equipment based upon accelerated cost recovery guidelines is not an allowable cost.

(v) In accordance with sections 1861 (v) (1) (0) and 1902 (a) (13) of the Social Security Act, allowable property costs shall not be increased on the basis of a change in ownership which takes, place on or after July 18, 1984. Section 1861(v) (1) (0) and section 1902 (a) (13) of the Social Security Act are hereby adopted and incorporated herein by reference. The cited statutes are federal statutes governing allowability of certain facility property costs for purposes of Medicare and Medicaid program reimbursement.

(c) Administrator compensation is allowable only as determined according to the PRN-15 provisions relating to owner compensation, and as specifically limited in this rule.

(i) For purposes of reporting and determining allowable administrator compensation, administrator compensation includes:

(A) all salary paid to the administrator for managerial, administrative, professional or other services;

(B) all employee benefits except employer contributions required by state or federal law for FICA, workers’ compensation insurance (WCI), federal unemployment insurance (FUL), and state Unemployment insurance (SUL)

(C) all deferred compensation either accrued or paid;

(D) the value of all supplies, services, special merchandise, and other valuable items paid or provided for the personal use or benefit of the administrator;
(E) wages of any provider employee to the extent such employee works in the home of the administrator;
(F) the value of use of an automobile owned by the provider business to the extent used by the administrator for uses not related to patient care;
(G) personal life, health, or disability insurance premiums paid by the provider on the administrator's behalf;
(H) the rental value of any portion of the facility occupied by the administrator as a personal residence;
(I) the value of any other remuneration, compensation, fringe or other benefits whether paid, accrued, or contingent.
(d) Allowable costs include employee benefits as follows:
addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death, if uniformly applicable to all employees. A item is an employee benefit only if it directly benefits an individual employee and does not directly benefit the owner, provider or related parties.
(ii) Employee benefits include all employer contributions
which are required by state or federal law, including FICA, WCI, FUI, SUI.
(iii) Costs of recreational activities or facilities, available to employees as a group, including but not limited to condominiums, swimming pools, weight rooms and gymnasiums, are not allowable.
(iv) For purposes of this rule, an employee is one from whose salary or wages the employer is required to withhold FICA. Stockholders who are related parties to the corporate providers, officers of a corporate provider, and sole proprietors and partners owning or operating a facility are not employees even if FICA is withheld for them.
(v) Accrued vacation and sick leave are employee benefits if the facility has in effect a written policy uniformly applicable to all employees within a given class of employees, and are allowable to the extent they are reasonable in amount.
(e) Bad debts, charitable contributions and courtesy allowances are deductions from revenue and are not allowable costs.
(f) Revenues received for services or items provided to employees and guests are recoveries of cost and must be deducted from the allowable cost of the related items.
(g) Dues, membership fees and subscriptions to organizations unrelated to the provider's provision of nursing facility services are not allowable costs.
(h) Charges for services of a chaplain are not an allowable cost.
(i) Subject to (4), fees for management or professional services (e.g., management, legal, accounting or consulting services) are allowable to the extent they are identified to specific services and the hourly rate charged is reasonable in amount. In lieu of compensation on the basis of an hourly rate allowable costs may include compensation for professional services on the basis of a reasonable retainer agreement which specifies in detail the services to be performed. Documentation that such services were in fact performed must be maintained

by the provide. If the provider elects compensation under a retainer agreement, allowable costs for services specified under the agreement are limited to the agreed retainer fee.

(j) Travel costs and vehicle operating expenses related to resident care are allowable to the extent such costs are reasonable and adequately documented.

(i) Vehicle operating costs will be allocated between business and personal use based on actual mileage logs and percentage derived from a sample mileage log and pre-approved by the department, or any other method pre-approved by the department.

(ii) For vehicles used primarily by an administrator, any portion of vehicle costs allocated to personal use shall be included as administrator compensation and subject to the limits specified in (3) (c).

(iii) Allowable costs include automobile depreciation calculated on a straight-line basis, subject to salvage value, with a minimum of a three-year useful life. The total of automobile depreciation and interest, or comparable lease costs will not be allowable in excess of $7,500 per year.

(iv) Public transportation costs will be allowable only at tourist or other available commercial rate (not first class).

(k) Allowable costs for purchases, leases or other transactions between related parties are subject to the following limitation:

(i) Allowable cost of services, facilities and supplies furnished to a provider by a related party or parties shall not exceed the lower of costs to the related party or the price of comparable services, facilities or supplies obtained from an unrelated party. A provider must identify such related parties and costs in the annual cost report.

(4) Costs, including attorney's fees, in connection with court or administrative proceedings are allowable only to the extent that the provider prevails in the proceeding. Where such proceedings are related to specific reimbursement amounts, the proportion of costs which are allowable shall be the percentage of costs incurred which equals the percentage derived by dividing the total cost or reimbursement on which the provider prevails by the total cost or reimbursement at issue.

COST REPORTING, DESK REVIEW AND AUDIT

(1) Providers must use generally accepted accounting principles to record and report costs. The provider must, in preparing the cost report required under this rule, adjust such costs in accordance with Allowable Costs to determine allowable costs.

(2) Providers must use the accrual method of accounting, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(3) Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain the provider's costs of the various services provided. In preparing cost reports, all providers must use the methods of cost finding described at 42 CFR 413.24 (1997), which the department hereby adopts and incorporates herein by reference. 42 CFR 413.24 is a federal regulation setting forth methods for allocating costs. Notwithstanding the above, distinctions between skilled nursing and nursing facility care need not be made in cost finding.

(4) All providers must report allowable costs based upon the provider's fiscal year and using the financial and statistical report forms designated and/or provided by the department. Reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for correction.

(a) A provider must file its cost report:

(i) within 150 days after the end of its designated fiscal year:

(ii) within 150 days after the effective date of a change in provider as defined in Change in Provider Defined; or

(iii) for changes in providers occurring on or after July 1, 1993, within 150 days after six months participation in the Medicaid program for providers with an interim rate established under Interim Per Diem Rates for Newly Constructed Facilities and New Providers. Subsequent cost reports are to be filed in accordance with (4)(a)(i) above and subsequent cost reports shall not duplicate previous cost reporting periods.

(b) The report forms required by the department include certain Medicare cost report forms and related instructions, including but not limited to certain portions of the most recent version of the CMS-2540 or CMS-2552 cost report forms, as more specifically identified in the department's cost report instructions. The department also requires providers to complete and submit certain Medicaid forms, including but not limited to the most recent version of the Medicaid expense statement, form DPHHS-MA-008A.

(i) In preparing worksheet A on the CMS-2540 or CMS-2552 cost report form, providers must report costs in the worksheet A category that correspond to the category in which the cost is reportable on the Medicaid expense statement, as designated in the department's cost report instructions.

(ii) For purposes of the Medicaid cost report required under this rule, all Medicare and Medicaid cost report forms must be prepared in accordance with applicable cost report instructions. Medicare cost report instructions shall apply to Medicare cost report forms to the extent consistent with Medicaid requirements, but the Medicaid requirements specified in these rules and the department's Medicaid cost reporting instructions shall control in the event of a conflict with Medicare instructions.

(c) If a provider files an incomplete cost report or reported costs are inconsistent, the department may return the cost report to the facility for completion or correction, and may withhold payment as provided in (4)(d).

(d) If a provider does not file its cost report within 150 days of the end of its fiscal year, or if a provider files an incomplete cost report, the department may withhold from payment to the provider an amount equal to 10% of the provider's total reimbursement for the month following the due date of the report or the filing of the incomplete report. If the report is overdue or incomplete a second month, the department may withhold 20% of the provider's total reimbursement for the following month. For each succeeding month for which the report is, overdue or incomplete, the department may withhold the provider's entire Medicaid payment for the following month. If the provider fails to file a complete and accurate cost report within six months after the due date, the department may recover all amounts paid to the provider by the department for the fiscal period covered by the cost report. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

(e) The department may grant a provider one 30-day extension for filing the cost report if the provider's written request for the extension is received by the department prior to expiration of the filing deadline and if, based upon the explanation in the request, the department determines that the delay is unavoidable.

(f) Cost reports must be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider, or an authorized officer of a corporate provider. The person executing the reports must sign, under penalties of false swearing, upon an affirmation that he has examined the report, including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared in accordance with applicable laws, regulations, rules, policies and departmental instructions.

(5) A provider must maintain records of financial and statistical information which support cost reports for six years, three months after the date a cost report is filed, the date the cost report is due, or the date upon which a disputed cost report is finally settled, whichever is later.

(a) Each provider must maintain, as a minimum, a chart of accounts, a general ledger and the following supporting ledgers and journals: revenue, accounts receivable, cash receipts, accounts payable, cash disbursements, payroll, general journal, resident census records identifying the level of care of all residents individually, all records pertaining to private pay residents and resident trust funds.

(b) To support allowable costs, the provider must make available for audit at the facility all business records of any related party, including any parent or subsidiary firm, which relate to the provider under audit. To support allowable costs, the provider must make available at the facility for audit any owner's or related party's personal financial records relating to the facility. Any costs not so supported will not be allowable.

(c) Cost information and documentation developed by the provider must be complete, accurate and in sufficient detail to support payments made for services rendered to recipients and recorded in such a manner to provide a record which is auditable through the application of reasonable audit procedure. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, checks, invoices, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. The provider must make and maintain contemporaneous records to support labor costs incurred. Documentation created after the fact will not be sufficient to support such costs.

(d) The provider must make all of the above records and documents available at the facility at all reasonable times after reasonable notice for inspection, review or audit by the department or its agents, the federal department of Health and Human Services, the Montana legislative auditor, and other appropriate governmental agencies. Upon refusal of the provider to make available and allow access to the above records and documents, the department may recover, as provided in Cost Settlement Procedures, all payments made by the department during the provider's fiscal year to which such records relate.

(6) Department audit staff may perform a desk review of cost statements or reports and may conduct on site audits of provider records. Such audits will be conducted in accordance with audit procedures developed by the department.

(a) Department audit staff may determine adjustments to cost reports or reported costs through desk review or audit of cost reports. Department audit staff may conduct a desk review of a cost report to verify, to the extent possible, that the provider has provided a complete and accurate report.

(b) Department audit staff may conduct on site audits of a provider's records, information and documentation to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards.

(c) The department shall notify the provider of any adverse determination resulting from a desk review or audit of a cost report and the basis for such determination. Failure of the department to complete a desk review or audit within any particular time shall not entitle the provider to retain any overpayment discovered at any time.

(d) The department, in accordance with the provisions of Cost Settlement Procedures, may collect any overpayment and will reimburse a provider for any underpayment identified through desk review or audit.

(7) A provider aggrieved by an adverse department action may request administrative review and a fair hearing as provided in Administrative Review & Fair Hearing Process for Medical Assistance Providers.

COST SETTLEMENT PROCEDURES

(1) The department will notify the provider of any overpayment discovered. The provider may contact the department to seek an agreement providing for repayment of the full overpayment within 60 days of mailing of the overpayment notice.

(2) Unless, within 30 days of mailing of overpayment notice to the provider, the provider enters into an agreement with the department which provides for full repayment within 60 days of mailing of the overpayment notice, the department will immediately commence offsetting from rate payments so as to complete full recovery as soon as possible.

(3) The department may recover the full overpayment amount regardless of whether the provider disputes the department's determination of the overpayment in whole or in part. A request for administrative review or fair hearing does not entitle a provider to delay repayment of any overpayment determined by the department

(4) The department will notify the provider of any underpayment discovered. In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of the amount of the underpayment

(5) Court or administrative proceedings for collection of overpayment or underpayment must be commenced within five years following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time.

(6) The amount of any overpayment constitutes a debt due the department as of the date the department mails notice of overpayment to the provider. The department may recover the overpayment from any person, party, transferee, or fiduciary who has benefited from either the payment or from a transfer of assets.

THIRD PARTY PAYMENTS AND PAYMENT IN FULL

(1) Regardless of any other provision of these rules, a provider may not bill the Medicaid program for any patient day, item, service or other amount which could have been or could be paid by any other payer, including but not limited to a private or governmental insurer, or Medicare, regardless of whether the facility participates in such coverage or program. If the department finds that Medicaid has made payments in such an instance, retroactive collections may be made from the provider in accordance with Cost Settlement Procedures.

(a) This rule does not apply to payment sources which by law are made secondary to Medicaid.

(2) The payments allowed under Nursing Facility Reimbursement constitute full payment for nursing facility services and separately billable items provided to a resident. A provider may not charge, bill or collect any amount from a Medicaid recipient,
other than the resident's patient contribution and any items billable to residents under Items Billable to Residents.

(3) This rule applies in addition to Statistical Sampling Audits.

UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456 subpart F (1997), may evaluate the necessity of nursing facility care for each Medicaid resident in an intermediate care facility for individuals with intellectual disabilities. 42 CFR 456 subpart F (1997) contains federal regulations which specify utilization review criteria for intermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997).

DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE REPORTING/ADDITIONAL PAYMENTS INCLUDING LUMP SUM PAYMENTS FOR DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE AND BENEFIT INCREASES

1) Effective for each state fiscal year and for the six months thereafter, nursing facilities must report to the department actual hourly wage and benefit rates paid for all direct care and ancillary services workers or the lump sum payment amounts for all direct care and ancillary services workers that will receive the benefit of the funds. The reported data will be used by the department for the purpose of comparing types and rates of payment for comparable services and tracking distribution of direct care wage funds to designated workers.

(2) The department will pay Medicaid certified nursing facilities located in Montana that submit an approved request to the department a lump sum payment in addition to the amount paid as provided in Nursing Facility Reimbursement and Rate Adjustment for County Funded Rural Nursing Facilities to their computed Medicaid payment rate to be used only for wage and benefit increases or lump sum payments for direct care or ancillary services workers in nursing facilities.

(a) The department will determine the lump sum payments, twice a year commencing July 1 of the state fiscal year, and again in six months from that date as a pro rata share of the appropriated $10,929,216 funds allocated by nursing facility Medicaid bed days for increases in direct care and ancillary services workers' wages and benefits or lump sum payments to direct care and ancillary services workers.
(b) To receive the direct care and/or ancillary services workers' lump sum payment, a nursing facility must submit for approval a request form to the department stating how the direct care and ancillary services workers' lump sum payment will be spent in the facility to comply with all statutory requirements. The facility must submit all of the information required on a form to be developed by the department in order to continue to receive subsequent lump sum payment amounts for the entire rate year. The form for wage and benefit increases will request information including but not limited to:
(i) the number by category of each direct care and ancillary services workers that will receive the benefit of the funds if these funds will be distributed in the form of a wage increase
(ii) the actual per hour rate of pay before benefits and before the direct care wage increase has been implemented for each worker that will receive the benefit of the funds;
(iii) the projected per hour rate of pay with benefits after the direct wage increase has been implemented;
(iv) the number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit; and
(v) the number of projected hours to be worked in the budget period.

(c) If these funds will be used for the purpose of providing lump sum payments (i.e. bonus, stipend or other payment types) to direct care and ancillary services workers in nursing care facilities the form will request information including, but not limited to:
(i) the number by category of each direct care and ancillary services worker that will receive the benefit of the funds;
(ii) the type and actual amount of lump sum payment to be provided for each worker that will receive the benefit of the lump sum funding;
(iii) the breakdown of the lump sum payment by the amount that represents benefits and the direct payment to workers by category of worker; and
(iv) the effective date of implementation of the lump sum benefit.
(d) A facility that does not submit a qualifying request for use of the funds distributed under (2), that includes all of the information requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount will not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care and ancillary services workers. If any providers do not participate in the direct care wage funding the department will revise the funding for the participating providers based on the appropriated funding amount and the allocated Medicaid days.
(3) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record

requirements, including, but not limited to, the provisions of Allowable Costs, Cost Reporting, Desk Review & Audit and Maintenance of Records and Auditing.

ADMINISTRATIVE REVIEW AND FAIR HEARING PROCESS FOR MEDICAL ASSISTANCE PROVIDERS

(1) The following administrative review and fair hearing process applies to all medical assistance providers that are aggrieved by an adverse action of the department, except medical assistance providers appealing eligibility determinations as a real party in interest.

(2) A medical assistance provider, other than a medical assistance provider appealing an eligibility determination as a real party in interest, aggrieved by an adverse action of the department may request an administrative review. The request must be in writing, must state in detail the provider's objections, and must include any substantiating documents and information which the provider wishes the department to consider in the administrative review. The request must be mailed or delivered to the Department of Public Health and Human Services, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 and should be addressed or directed to the division of the department that issued the contested determination. The request for administrative review must be received by the department within 30 days of mailing of the department's written determination.

(a) Within the 30 days a provider may request in writing an extension of up to 15 days for submission of a request for administrative review. The department may grant further extensions for good cause shown. Requests for further extensions must be in writing, must be received by the department within the period of any previous extension, and must demonstrate good cause for the extension.

(b) The provider may also request a conference as part of the administrative review. If the provider requests an administrative review conference, the conference must be held at a time scheduled by the department as provided in –Administrative Review. If a provider requests a conference as part of the administrative review, any substantiating materials the provider wishes the department to consider as part of the review may be submitted no later than the time of the conference. The conference may be conducted by the department or its designee and shall be based on the department’s records and determination and the provider’s written objections and substantiating materials, if any.

(c) No later than 60 days following receipt of the written objections and substantiating materials, if any, or the conference, whichever is later, the department must mail a written determination concerning the provider’s objections and substantiating materials and the position the department takes concerning the determination.

(d) A provider must exhaust in a timely manner the administrative review process provided in this rule before requesting a fair hearing. A provider that has not exhausted the administrative review process, including a provider that fails to timely, request an administrative review, is not entitled to a fair hearing before the department or the board.

(3) In the event the provider is aggrieved by an adverse department administrative review determination, the following fair hearing procedures will apply. In addition to the authority granted in Dismissal of Hearing, the hearings officer may dismiss a fair hearing request if a provider fails to meet any of the requirements of (3) (a) through (3) (e)

(a) The written request for a fair hearing must be mailed or delivered to the Department of Public Health and Human Services, Quality Assurance Division, Office of Fair Hearings, P.O. Box 202953, Helena, MT 59620-2953.

(b) The request must be signed by the provider or his designee.

(c) The fair hearing request must be received not later than the 30th calendar day following the date of mailing of the department's written administrative review determination.

(d) The fair hearing request must contain a short and plain statement of each reason the provider contends the department's administrative review determination fails to comply with applicable law, regulations, rules or policies.

(e) The provider must serve a copy of the hearing request upon the department's division that issued the contested determination within 3 working days of filing the request. Service by mail is permitted.

(f) The hearings officer will conduct the fair hearing in accordance with the applicable provisions of this subchapter at Helena, Montana. The hearing shall be in person except that the hearing may be conducted by telephone as mutually agreed by the parties.

(g) The hearings officer will render a written proposed decision within 90 calendar days of final submission of the matter to him.

(4) In the event the provider or, department is aggrieved by a hearings officer's proposed decision the provider or department may request review by the board of public assistance as provided in Notice of Appeal and Review of Proposal for Decision.

(5) The provisions of this rule apply in addition to the other applicable provisions of this subchapter, except that the provisions of this rule shall control in the event of a conflict with the other provisions of this subchapter.