DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-037

2. STATE: Montana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.321

7. FEDERAL BUDGET IMPACT:
a. SFY 12 No Impact
b.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, Service 2a, Pages 1-7
Attachment 3.1-B, Service 2a, ~~Pages 2-2a~~ Pg 9 DM
Attachment 3.1-A, Service 2a, ~~Pages 1-1a~~ Pg 10 DM

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B, Service 2a, Pages 1-6
Attachment 3.1-B, Service 2a, ~~Page 2~~ pg 9 DM
Attachment 3.1-A, Service 2a, Page 1 pg 10 DM

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Reimbursement.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Single Agency Director Review

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Diane Rechenmacher for Mary Dalton

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 6-30-2011

16. RETURN TO:
Montana Dept of Public Health and Human Services
Mary E. Dalton
Attn: Jo Thompson
PO Box 4210
Helena MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/30/11

18. DATE APPROVED: 9/27/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: RICHARD C. ALLEN

22. TITLE: ARA, DNCHO

23. REMARKS:

FORM HCFA-179 (07-92)

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Critical Access Hospital(CAH)services.

/X/ Provided: / / No limitations /X/ With limitations

/ / Not provided.

Description provided on attachment

25a. Freestanding Birthing Center Services. Licensed or otherwise state-approved Freestanding Birthing Centers.

/X/ Provided: / /No Limitations /X/ With Limitations*
(i) Licensed or otherwise state-recognized covered professionals providing services in the Freestanding Birthing Center

Provided: / / No Limitations /X/ With Limitations (please describe below)
/ /Not applicable (there are no licensed or state approved Freestanding Birth Centers)

Please describe any limitations:
A. For physicians, those limits provided for under Supplement to Attachment 3.1A for Service 5a Physician Services;
B. For mid-level practitioners, those limits provided for under Supplement to Attachment 3.1A for Service 6d Other Practitioner Services

Please check all that apply:
/X/ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
/X/ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*
/ / (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

For mid-level practitioners, those limits provided under Supplement to Attachment 3.1A for Service 6d Other Practitioner Services. Mid-level Practitioner to physician assistant, advanced practice nurse (certified nurse midwife, certified registered nurse anesthetist, nurse practitioner)

State/Territory: MONTANA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
g. Critical Access Hospital (CAH) services.
/X/ Provided: / / No limitations /X/ With limitations

/ / Not provided.

24a. Freestanding Birthing Center Services. Licensed or Otherwise State-Approved Freestanding Birthing Centers.
/x/Provided: / /No limitations /x/With limitations*
(i) Licensed or Otherwise State-Recognized covered professionals Providing services in the Freestanding Birth Center
Provided: / /No limitations /x/With limitations (please describe Below)
/ /Not applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:
A. For physicians, those limits provided for under Supplement to Attachment 3.1A for Service 5a Physician Services;
B. For mid-level practitioners, those limits provided under Supplement to Attachment 3.1A for Service 6d Other Practitioner Services.

Please check all that apply:
/x/ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
/x/ (b) other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birthing center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*
/ / (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*
*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:
For mid-level practitioners, those limits under Supplement to Attachment 3.1A for Service 6d Other Practitioner Services. Mid-level Practitioner to physician assistant, advanced practice nurse (certified nurse midwife, certified registered nurse anesthetist, nurse practitioner)
*Description provided on attachment

REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

A. COST BASED RETROSPECTIVE REIMBURSEMENT

1. Interim Reimbursement

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

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

Critical Access Hospital (CAH) facilities will be reimbursed on an interim basis during the facility's fiscal year. The interim rate for outpatient services will be a percentage of usual and customary charges. The percentage shall be the provider's outpatient cost-to-charge ratio determined by the facilities Montana contracted intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicaid cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report which is necessary to determine the outpatient cost to charge ratio, the provider's interim rate will be 50% of its usual and customary charges.

B. PROSPECTIVE REIMBURSEMENT

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

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

Out-of-state hospitals are those hospitals that are located beyond 100 miles of the border of the state of Montana.

Except as otherwise specified, the following outpatient hospital services for in-state PPS, border and out-of-state facilities will be reimbursed under a prospective payment methodology for each service as follows:

1. Outpatient Prospective Payment System, Ambulatory Payment Classification (APC) Groups

Outpatient hospital services that are not provided by Critical Access Hospitals (CAH) will be reimbursed on a predetermined rate-per-service basis. These services are classified according to a list of APC groups published annually in the Code of Federal Regulation (CFR). APC group reimbursement is based on the CPT or HCPCS code associated with the service and may be an all-inclusive bundled payment per service. These bundled services may include some or all of the following services: nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment, and other outpatient hospital services. The Department follows Medicare's grouping of services by APC as published annually in the CFR. The Department will update Medicare's changes quarterly.

(a) The Department uses a conversion factor to establish a rate that is less than the rate established by Medicare's conversion factor. This rate will periodically be re-evaluated by the Department.

(i) "Conversion factor" means an average base rate initially calculated by CMS and used to translate APC relative weights into dollar payment rates.

(b) This conversion factor is the same for all APC groups and for all facilities. The APC fee equals the Medicare specific weight for the APC times the Medicaid conversion factor. These rates are updated quarterly when the Medicare update is published.

(c) The total claim reimbursement will be the lower of the provider's claim charge or the reimbursement as calculated using OPPS.

(d) If two or more surgical procedures are performed on the same patient at the same hospital on the same day, the most expensive procedure will pay at 100% of that APC; and the other procedures will pay at 50% of their APC, if appropriate.

(e) Procedures started on a patient but discontinued before completion will be paid at 50% of that APC.

(f) A separate payment will be made for observation care using criteria established by Medicare with the exception of obstetric complications. Observation care that does not meet Medicare's criteria will be considered bundled into the APC for other services.

(i) When billing observation services, the appropriate procedure codes must be used and the units field on the claim must reflect the number of hours provided. Observation services must be a direct admit or have a high level clinic visit, high level critical care, or high level ER visit to qualify. The service must be at least eight hours in length.

(ii) Obstetric observation must have a qualifying diagnosis and must be at least one hour in length of service.

(g) Medicare has set guidelines for procedures it has determined should be performed in an inpatient setting only. The Department follows Medicare guidelines for procedures defined as "inpatient only".

2. Outpatient Payment Methodology Paid Under OPPS

Outpatient services will be reimbursed as follows:

(a) For each outpatient service or procedure, the fee is 100% of the Ambulatory Payment Classification (APC) rate. Some codes price by APC, but bundle so they pay at zero.

(b) Where no APC rate has been assigned, outpatient services will be paid by the applicable Medicare fee.

(i) For laboratory services, if there is a Medicare fee for the code, the system will price at 60% of the Medicare fee for non-sole community hospitals; and 62% of the Medicare fee for sole community hospitals. If the codes bundle to a lab panel or ATP panel, the system will also pay 60% or 62% of the bundled fee, depending on the hospital status.

(c) If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates for SFY 2011 were set as of July 1, 2010 and are effective for services on or after that date. All rates are published on the agency's website at www.mtmedicaid.org. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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

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

3. Emergency Department Services for OPPS Hospitals

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

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

4. Dialysis Services

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

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

5. Freestanding Birthing Centers

Birthing Center services will be reimbursed using the Outpatient Prospective Payment System (OPPS). Facility services are reimbursed on a predetermined rate-per-service basis based on the CPT codes. These services are classified according to a list of APC groups published annually in the Code of Federal Regulations (CFR). Professional services are reimbursed according to Attachment 3.1A for Service 5a Physician Services and 6d Other Practitioner Services.

C. MISCELLANEOUS SERVICES

1. PPS hospital therapy services, including physical therapy, occupational therapy and speech-language pathology, will be paid a Medicaid facility fee with a conversion factor appropriate for therapies.

(a) Specific speech-language pathology services will be paid a Medicaid office fee using the conversion factor appropriate for therapies.
Refer to the Medicaid fee schedule for a list of these services located on the agency's website at www.mtmedicaid.org.

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

3. Dental services not grouping to an APC will be reimbursed using an all inclusive facility rate based on the average cost per visit for PPS facilities.

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

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

6. The Department requires that National Drug Codes (NDC) must be submitted on all outpatient claims that include pharmaceuticals. Montana Medicaid will reimburse only those pharmaceuticals manufactured by companies that have a signed rebate agreement with CMS.

(a)Qualified providers that are participating in the 340B Drug Pricing Program are exempt from submitting National Drug Codes (NDC) on claim lines billed using pharmaceuticals purchased through the 340B program.

7. Montana Medicaid does not allow self-attestation of provider based status. Reimbursement of the provider based entity facility component will be on a rate per service basis using the outpatient prospective payment system (OPPS) schedules or Medicare fee schedules except as follows:

(a) Provider based entity facility component billed under revenue code 510 will be reimbursed at 80% of the applicable rate.

(i) Provider based facilities must bill using revenue code 510 for evaluation and management services and procedural codes as per Medicare guidelines.

(b) The facility component of provider based services that are provided in a Critical Access Hospital (CAH) will be interim reimbursed a hospital specific outpatient cost to charge ratio.

(c) Provider based entities providing obstetric services must bill as a non-provider based provider.

(d) Vaccines for Children (VFC) services must be billed as a non-provider based provider.

8. Partial hospitalization services will be reimbursed using the lower of the following two rates:

(a) The provider's usual and customary claim charges for the service; or

(b) The department's Mental Health Fee Schedule. This is a bundled rate for acute full-day programs and sub-acute half-day programs.

9. If there is no Medicare fee established for the service, payment will be made using the applicable Medicaid fee. Rates for SFY 2011 were set as of July 1, 2010 and are effective for services on or after that date. All rates are published on the agency's website at www.mtmedicaid.org. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

D. COST REPORTING AND COST SETTLEMENTS

All in-state PPS Hospitals and Critical Access Hospitals will be required to submit a Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records that will enable the facility to fully complete the cost report. Upon receipt of the cost report, the Department will instruct Montana's contracted intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.

Facilities will be required to file the cost report with Montana's contracted intermediary and with the Department within 150 days of the facility's fiscal year end.

Except as identified below, Medicare principles of reasonable cost reimbursement will be applied to cost settlement of outpatient hospital services that are paid on interim at outpatient hospital specific cost-to-charge ratio. Only cost-based outpatient services are cost settled.

The State of Montana uses CMS 2552-96 to identify outpatient costs. The outpatient costs are calculated using worksheet D, part V of the CMS 2552-96. The ancillary charges are recorded on column 5, line 104. The outpatient costs are recorded on column 9, line 104.

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

2. Critical Access Hospital (CAH) reimbursement for reasonable costs of outpatient hospital services shall be limited to the lesser of 101% of allowable costs or the upper payment limit.

The State of Montana uses CMS 2552-96 to identify outpatient costs. The outpatient costs are calculated using worksheet D, part V of the CMS 2552-96. The ancillary charges are recorded on column 5, line 104. The outpatient costs are recorded on column 9, line 104.

E. UPPER PAYMENT LIMITS

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