BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.40.830, 37.85.104, 37.85.105, 37.86.610, 37.86.705, 37.86.805, 37.86.1101, 37.86.1105, 37.86.1406, 37.86.1807, 37.86.2005, 37.86.2605, 37.86.2803, 37.86.2806, 37.86.2905, 37.86.2912, 37.86.3007, 37.86.3109, 37.86.3205, and 37.87.1226 pertaining to updating the effective dates of non-Medicaid and Medicaid fee schedules to October 1, 2017.	)))))))))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Concerned Persons

1. On July 27, 2017, at 8:30 a.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on July 19, 2017, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

3. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

37.40.830 HOSPICE, REIMBURSEMENT (1) through (11) remain the same.

(12) The hospice fee schedules are effective ~~October 1, 2016~~ October 1, 2017. Copies of the department's current fee schedules are posted at http://medicaidprovider.mt.gov and may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1401 East Lockey, P.O. Box 202951, Helena, MT 59602-2951.

AUTH: 53-6-113, MCA
IMP: 53-6-101, MCA

37.85.104 EFFECTIVE DATES OF PROVIDER FEE SCHEDULES FOR MONTANA NON-MEDICAID SERVICES (1) The department adopts and incorporates by reference the fee schedule for the following programs within the Addictive and Mental Disorders Division and Developmental Services Division on the dates stated:

(a) Mental health services plan provider reimbursement, as provided in ARM 37.89.125, is effective ~~July 1, 2016~~ October 1, 2017.

(b) 72-hour presumptive eligibility for adult-crisis stabilization services reimbursement for services, as provided in ARM 37.89.523, is effective ~~July 1, 2016~~ October 1, 2017.

(c) Youth respite care services, as provided in ARM 37.87.2203, is effective ~~January 1, 2017~~ October 1, 2017.

(d) Substance use disorder services provider reimbursement, as provided in ARM 37.27.908, is effective ~~July 1, 2016~~ October 1, 2017.

(2) Copies of the department's current fee schedules are posted at http://medicaidprovider.mt.gov and may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1401 East Lockey, P.O. Box 202951, Helena, MT 59620-2951. A description of the method for setting the reimbursement rate and the administrative rules applicable to the covered service are published in the chapter or subchapter of this title regarding that service.

AUTH: 53-2-201, 53-6-101, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, MCA

37.85.105 EFFECTIVE DATES, CONVERSION FACTORS, POLICY ADJUSTERS, AND COST-TO-CHARGE RATIOS OF MONTANA MEDICAID PROVIDER FEE SCHEDULES (1) remains the same.

(2) The department adopts and incorporates by reference, the resource-based relative value scale (RBRVS) reimbursement methodology for specific providers as described in ARM 37.85.212 on the date stated.

(a) Resource-based relative value scale (RBRVS) means the version of the Medicare resource-based relative value scale contained in the Medicare Physician Fee Schedule adopted by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services and published at ~~80 Federal Register 220, page 70886 (November 16, 2015) effective January 1, 2016~~ 81 Federal Register 220, page 80170 (November 15, 2016) effective January 1, 2017 which is adopted and incorporated by reference. Procedure codes created after January 1, 2017 will be reimbursed using the relative value units from the Medicare Physician Fee Schedule in place at the time the procedure code is created.

(b) Fee schedules are effective ~~January 1, 2017~~ October 1, 2017. The conversion factor for physician services is ~~$37.89~~ $36.23. The conversion factor for allied services is ~~$25.38~~ $24.17. The conversion factor for mental health services is ~~$24.90~~ $23.95. The conversion factor for anesthesia services is ~~$29.76~~ $28.73.

(c) remains the same.

(d) The payment-to-charge ratio is effective ~~July 1, 2016~~ October 1, 2017 and is ~~47%~~ 45.37% of the provider's usual and customary charges.

(e) through (h) remain the same.

(i) Reimbursement for physician-administered drugs described ~~at~~ in ARM 37.86.105 is determined ~~at~~ in 42 CFR 414.904 (2016). The department adopts 102.32% of the Average Sale Price (ASP), effective October 1, 2017.

(j) Reimbursement for vaccines described at ARM 37.86.105 is effective October 1, 2017.

(3) The department adopts and incorporates by reference, the fee schedule for the following programs within the Health Resources Division, on the date stated.

(a) The inpatient hospital services fee schedule and inpatient hospital base fee schedule rates including:

(i) the APR-DRG fee schedule for inpatient hospitals as provided in ARM 37.86.2907, effective ~~October 1, 2016~~ October 1, 2017; and

(ii) the Montana Medicaid APR-DRG relative weight values, average national length of stay (ALOS), outlier thresholds, and APR grouper version ~~33~~ 34 are contained in the APR-DRG Table of Weights and Thresholds effective ~~October 1, 2016~~ October 1, 2017. The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective ~~October 1, 2016~~ October 1, 2017.

(b) The outpatient hospital services fee schedules including:

(i) the Outpatient Prospective Payment System (OPPS) fee schedule as published by the Centers for Medicare and Medicaid Services (CMS) in ~~80 Federal Register 219, page 70298, November 13, 2015, effective July 1, 2016~~ 81 Federal Register 219, page 79562, effective January 1, 2017, and reviewed annually by CMS as required in 42 CFR 419.5 (2016) as updated by the department;

(ii) the conversion factor for outpatient services on or after ~~July 1, 2015~~ October 1, 2017 is ~~$56.64~~ $54.67;

(iii) the Medicaid statewide average outpatient cost-to-charge ratio is ~~45.2%~~ 39.91%; and

(iv) the bundled composite rate of ~~$252.00~~ $243.26 for services provided in an outpatient maintenance dialysis clinic effective on or after ~~July 1, 2014~~ October 1, 2017.

(c) The hearing aid services fee schedule, as provided in ARM 37.86.805, is effective ~~January 1, 2017~~ October 1, 2017.

(d) The Relative Values for Dentists, as provided in ARM 37.86.1004, reference published in ~~2016~~ 2017 resulting in a dental conversion factor of ~~$33.78~~ $32.61 and fee schedule is effective ~~July 1, 2016~~ October 1, 2017.

(e) remains the same.

(f) The outpatient drugs reimbursement, dispensing fees range as provided in ARM 37.86.1105(3)(b) is effective ~~July 1, 2016~~ October 1, 2017:

(i) for pharmacies with prescription volume between 0 and 39,999, the minimum is ~~$2.00~~ $3.41 and the maximum is ~~$15.00~~ $14.48;

(ii) for pharmacies with prescription volume between 40,000 and 69,999, the minimum is ~~$2.00~~ $3.41 and the maximum is ~~$13.00~~ $12.55; or

(iii) for pharmacies with prescription volume greater than 70,000, the minimum is ~~$2.00~~ $3.41 and the maximum is ~~$11.00~~ $10.62.

(g) remains the same.

(h) The outpatient drugs reimbursement, vaccine administration fee as provided in ARM 37.86.1105(6), will be ~~$21.32~~ $20.58 for the first vaccine and ~~$13.00~~ $12.55 for each additional administered vaccine, effective ~~July 1, 2016~~ October 1, 2017.

~~(i) The out-of-state providers will be assigned a $3.50 dispensing fee.~~

(j) remains the same, but is renumbered (i).

~~(k)~~ (j) The home infusion therapy services fee schedule, as provided in ARM 37.86.1506, is effective ~~July 1, 2016~~ October 1, 2017.

~~(l)~~ (k) Montana Medicaid adopts and incorporates by reference the Region D Supplier Manual, effective ~~January 1, 2017~~ October 1, 2017, which outlines the Medicare coverage criteria for Medicare covered durable medical equipment, local coverage determinations (LCDs), and national coverage determinations (NCDs) as provided in ARM 37.86.1802, effective ~~January 1, 2017~~ October 1, 2017. The prosthetic devices, durable medical equipment, and medical supplies fee schedule, as provided in ARM 37.86.1807, is effective ~~July 1, 2015~~ October 1, 2017.

~~(m)~~ (l) Fee schedules for private duty nursing, nutrition, children's special health services, and orientation and mobility specialists as provided in ARM 37.86.2207(2), are effective ~~July 1, 2016~~ October 1, 2017.

(n) and (o) remain the same, but are renumbered (m) and (n).

~~(p)~~ (o) The ambulance services fee schedule, as provided in ARM 37.86.2605, is effective ~~July 1, 2016~~ October 1, 2017.

~~(q)~~ (p) The audiology fee schedule, as provided in ARM 37.86.705, is effective ~~July 1, 2016~~ October 1, 2017.

~~(r)~~ (q) The therapy fee schedules for occupational therapists, physical therapists, and speech therapists, as provided in ARM ~~37.85.610~~ 37.86.610, are effective ~~January 1, 2017~~ October 1, 2017.

~~(s)~~ (r) The optometric fee schedule provided in ARM 37.86.2005, is effective ~~January 1, 2017~~ October 1, 2017.

~~(t)~~ (s) The chiropractic fee schedule, as provided in ARM 37.85.212(2), is effective ~~July 1, 2016~~ October 1, 2017.

~~(u)~~ (t) The lab and imaging fee schedule, as provided in ARM 37.85.212(2) and 37.86.3007, is effective ~~January 1, 2017~~ October 1, 2017.

~~(v)~~ (u) The Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) fee schedule for ~~education health~~ add-on services, as provided in ARM 37.86.4412, is effective ~~January 1, 2017~~ October 1, 2017.

~~(w)~~ (v) The Targeted Case Management for Children and Youth with Special Health Care Needs fee schedule, as provided in ARM 37.86.3910, is effective ~~July 1, 2016~~ October 1, 2017.

~~(x)~~ (w) The Targeted Case Management for High Risk Pregnant Women fee schedule, as provided in ARM 37.86.3415, is effective ~~July 1, 2016~~ October 1, 2017.

(x) The mobile imaging fee schedule, as provided in ARM 37.85.212, is effective October 1, 2017.

(y) The licensed direct entry midwife fee schedule, as provided in ARM 37.85.212, is effective October 1, 2017.

(4) The department adopts and incorporates by reference, the fee schedule for the following programs within the Senior and Long Term Care Division on the date stated:

(a) Home and community-based services for elderly and physically disabled persons fee schedule, as provided in ARM 37.40.1421, is effective ~~January 1, 2017~~ October 1, 2017.

(b) Home health services fee schedule, as provided in ARM 37.40.705, is effective ~~July 1, 2016~~ October 1, 2017.

(c) Personal assistance services fee schedule, as provided in ARM 37.40.1135, is effective ~~July 1, 2016~~ October 1, 2017.

(d) Self-directed personal assistance services fee schedule, as provided in ARM 37.40.1135, is effective ~~July 1, 2016~~ October 1, 2017.

(e) Community first choice services fee schedule, as provided in ARM 37.40.1026, is effective ~~July 1, 2016~~ October 1, 2017.

(5) The department adopts and incorporates by reference, the fee schedule for the following programs within the Addictive and Mental Disorders Division on the date stated:

~~(a) Case management services for adults with severe disabling mental illness reimbursement, as provided in ARM 37.86.3515, is effective July 1, 2016.~~

~~(b)~~ (a) Mental health center services for adults reimbursement, as provided in ARM 37.88.907, is effective ~~July 1, 2016~~ October 1, 2017.

~~(c)~~ (b) Home and community-based services for adults with severe disabling mental illness, reimbursement, as provided in ARM 37.90.408, is effective ~~July 1, 2016~~ October 1, 2017.

~~(d) Targeted case management services for substance use disorders, reimbursement, as provided in ARM 37.86.4010, is effective July 1, 2016.~~

(c) Substance use disorder services reimbursement, as provided in ARM 37.27.908, is effective October 1, 2017.

(6) The department adopts and incorporates by reference, the fee schedule for the following program~~s~~ within the Developmental Services Division, on the date stated:

~~(a)~~ Mental health services for youth, as provided in ARM 37.87.901 in the Medicaid Youth Mental Health Services Fee Schedule, is effective ~~January 1, 2017~~ October 1, 2017.

~~(b) Mental health services for youth, as provided in ARM 37.87.1313 in the 1915(i) HCBS State Plan Program for Youth with Serious Emotional Disturbance Fee Schedule, is effective July 1, 2016.~~

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-125, 53-6-402, MCA

37.86.610 THERAPIES, REIMBURSEMENT (1) remains the same.

(2) Subject to the requirements of this rule, the Montana Medicaid program pays the following for therapy services:

(a) For patients who are eligible for Medicaid, the lower of:

(i) and (ii) remain the same.

(iii) for items or services where no RBRVS or Medicare fee is available, the fee schedule amount will be calculated using the following methodology:

(A) Establishing a fee for a service that has been billed at least 50 times by all providers in the aggregate during the previous 12-month period. The department

will set each fee ~~at 44% of the average charge billed by all providers in the aggregate~~ at the payment-to-charge ratio in accordance with ARM 37.85.105(2)(d).

(B) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.705 AUDIOLOGY SERVICES, REIMBURSEMENT (1) remains the same.

(2) Subject to the requirements of this rule, the Montana Medicaid program pays the following for audiology services:

(a) For patients who are eligible for Medicaid, the lowest of:

(i) the provider's usual and customary charge for the service;

(ii) the reimbursement provided in accordance with the methodologies described in ARM 37.85.212;

(iii) ~~100%~~ 96.53% of the Medicare Region D allowable fee; or

(iv) for items or services where no RBRVS fee is available, the fee schedule amount will be calculated using the following methodology:

(A) Establishing a fee for a service or item that has been billed at least 50 times by all providers in the aggregate during the previous 12-month period. The department will set each fee at ~~44% of the average charge billed by all providers in the aggregate~~ the payment-to-charge ratio under ARM 37.85.105(2)(d).

(B) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.805 HEARING AID SERVICES, REIMBURSEMENT (1) The department will pay the lowest of the following for covered hearing aid services and items:

(a) and (b) remain the same.

(c) ~~100%~~ 96.53% of the Medicare Region D allowable fee.

(2) For items or services where no Medicare allowable fee is available, the fee schedule amount in (1)(b) will be calculated using the following methodology:

(a) Establishing a fee for a service that has been billed at least 50 times by all providers in the aggregate during the previous 12-month period. The department will set each fee at ~~44% of the average charge billed by all providers in the aggregate~~ the payment-to-charge ratio under ARM 37.85.105(2)(d).

(b) For supplies or equipment, reimbursement will be set at ~~75%~~ 72.4% of the manufacturer's suggested retail price. For items without a manufacturer's suggested retail price, the charge will be considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount. For items that are custom-fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

(c) and (3) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.1101 OUTPATIENT DRUGS, DEFINITIONS (1) and (2) remain the same.

(3) "Allowed ingredient cost" means the "Average Acquisition Cost (AAC)" or "submitted ingredient cost," whichever is lower. If AAC is not available, drug reimbursement is determined at the lesser of "Wholesale Acquisition Cost (WAC) minus 3.47%," "Federal Maximum Allowable Cost (FMAC)," or the "submitted ingredient cost."

(4) through (15) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.1105 OUTPATIENT DRUGS, REIMBURSEMENT (1) through (12) remain the same.

(13) Specialty pharmacies, hemophilia treatment centers, or centers of excellence that dispense clotting factors:

(a) not purchased through the 340B program will be reimbursed at the lesser of the usual and customary charge, submitted ingredient cost, or wholesale acquisition cost minus 3.47%, plus the professional dispensing fee; or

(b) when purchased through the 340B program, will be reimbursed the lesser of the usual and customary charge or wholesale acquisition cost minus 3.47%, plus the professional dispensing fee.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-113, MCA

37.86.1406 CLINIC SERVICES, REIMBURSEMENT (1) Ambulatory surgical center (ASC) services as defined in ARM 37.86.1401(2) provided by an ASC will be reimbursed on a fee basis as follows:

(a) ~~100%~~ 96.53% of the Medicare allowable amount. For purposes of determining the Medicare allowable amount for ASC services to Medicaid members under this rule, the department adopts and incorporates by reference the methodology at 42 CFR part 416, subpart ~~E (2005)~~ F, and the schedule listing the allowable amounts for ASC services in the Medicare ~~Carriers Manual, section 5243~~ Claims Processing Manual. The cited authorities are federal regulations and manuals specifying the methods and rules used to determine reasonable cost for purposes of the Medicare program. ~~Copies of the cited authorities may be obtained from the Department of Public Health and Human Services, Health Resources Division, P.O. Box 202951, Helena, MT 59620-2951.~~ The Medicare Claims Processing Manual can be found on the Centers for Medicare and Medicaid website at www.cms.gov. The Code of Federal Regulations can be found at www.gpo.gov.

(i) For purposes of applying the provisions of 42 CFR part 416, subpart ~~E (2005)~~ F, and the Medicare ~~Carriers Manual, section 5243~~ Claims Processing Manual, any reference in such authorities to Medicare, Medicare beneficiary,

beneficiary, intermediary or secretary shall be deemed to refer also to Medicaid, Medicaid member, member, or the department.

(b) through (2) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-141, MCA

37.86.1807 PROSTHETIC DEVICES, DURABLE MEDICAL EQUIPMENT, AND MEDICAL SUPPLIES, FEE SCHEDULE (1) and (2) remain the same.

(3) The department's DMEPOS Fee Schedule for items other than those billed under generic or miscellaneous codes as described in (1) will include fees set and maintained according to the following methodology:

(a) ~~100%~~ 96.53% of the Medicare region D allowable fee;

(b) Except as provided in (4), for all items for which no Medicare allowable fee is available, the department's fee schedule amount will be ~~75%~~ 72.4% of the provider's usual and customary charge.

(i) remains the same.

(ii) Items having no product retail list price, such as items customized by the provider, will be reimbursed at ~~75%~~ 72.4% of the provider's usual and customary charge as defined in (3)(b)(i).

(4) The department's DMEPOS Fee Schedule, referred to in ARM 37.86.1807(2), for items billed under generic or miscellaneous codes as described in (1) will be ~~75%~~ 72.4% of the provider's usual and customary charge as defined in (3)(b)(i).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2005 OPTOMETRIC SERVICES, REIMBURSEMENT (1) remains the same.

(2) For items or services where no RBRVS or Medicare is available, the fee schedule amount in (1)(c) will be calculated using the following methodology:

(a) Establishing a fee for a service that has been billed at least 50 times by all providers in the aggregate during the previous 12-month period. The department will set each fee ~~at 44% of the average charge billed by all providers in the aggregate~~ at the payment-to-charge ratio in accordance with ARM 37.85.105(2)(d).

(b) For supplies or equipment, reimbursement will be set at ~~75%~~ 72.4% of the manufacturer's suggested retail price. For items without a manufacturer's suggested retail price, the charge will be considered reasonable if the provider's acquisition charge from the manufacturer is at least 50% of the charge amount. For items that are custom-fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

(c) and (3) remain the same.

AUTH: 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.2605 AMBULANCE SERVICES, REIMBURSEMENT (1) through (3) remain the same.

(4) For supplies or equipment, where there is no Medicare or Medicaid set fee, the provider's usual and customary charge in (1)(a) will be considered reasonable if set at ~~75~~ 72.4% of the manufacturer's suggested retail price. For items without a manufacturer's suggested retail price, the charge will be considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount.

(5) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants.

(a) through (c) remain the same.

(d) For cost report periods ending ~~on or after~~ January 1, 2006 through September 30, 2017, for each hospital which is a critical access hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of inpatient and outpatient hospital services shall be limited to 101% of allowable costs, as determined in accordance with (1).

(e) For cost report periods ending on or after October 1, 2017, for each hospital which is a critical access hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of inpatient and outpatient hospital services will be limited to 97.50% of allowable costs, as determined in accordance with (1).

(2) and (3) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA

37.86.2806 COST-BASED HOSPITAL, GENERAL REIMBURSEMENT

(1) Cost-based reimbursement shall be applied as follows:

(a) Critical access hospital (CAH) interim reimbursement is based on a hospital specific Medicaid inpatient cost-to-charge ratio (CCR), not to exceed 100%. For dates of service on or after October 1, 2017, critical access hospital (CAH) interim reimbursement is based on a hospital-specific Medicaid inpatient cost-to-charge ratio (CCR), less 3.47%, not to exceed 100%.

(b) For cost report periods ending on or prior to September 30, 2017, CAH final reimbursement is for reasonable costs of hospital services limited to 101% of allowable costs, as determined in accordance with ARM 37.86.2803(1). For cost report periods ending on or after October 1, 2017, CAH final reimbursement is for reasonable costs of hospital services limited to 97.50% of allowable costs as determined in accordance with ARM 37.86.2803(1).

(2) through (8) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-113, MCA

37.86.2905 INPATIENT HOSPITAL SERVICES, GENERAL REIMBURSEMENT (1) remains the same.

(2) Interim reimbursement for cost-based facilities is based on a hospital-specific Medicaid inpatient cost-to-charge ratio, not to exceed 100%. For dates of service on or after October 1, 2017, the interim reimbursement is based on a hospital-specific Medicaid inpatient cost-to-charge ratio, less 3.47%, not to exceed 100%. Cost-based facilities will be reimbursed their allowable costs as determined according to ARM 37.86.2803. ~~Final~~ For cost report periods ending on or prior to September 30, 2017 final cost settlements for CAH facilities will be reimbursed at 101% of allowable costs. For cost report periods ending on or after October 1, 2017, final cost settlements for CAH facilities will be reimbursed at 97.50% of allowable costs.

(3) through (5) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2912 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CAPITAL-RELATED COSTS (1) remains the same.

(2) The interim payment made to CAHs is based on the hospital-specific cost-to-charge ratio and includes capital costs. For dates of service on or after October 1, 2017, the interim payment made is based on the hospital-specific cost-to-charge ratio, less 3.47%, and includes capital costs.

(3) remains the same.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3007 OUTPATIENT HOSPITAL SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, CLINICAL DIAGNOSTIC LABORATORY SERVICES

(1) Clinical diagnostic laboratory services, including automated multichannel test panels (commonly referred to as "ATPs") and lab panels, will be reimbursed on a fee basis as follows with the exception of hospitals reimbursed under ARM 37.86.3005 and specific lab codes which are paid under ARM 37.86.3020:

(a) The fee for a clinical diagnostic laboratory service is the applicable percentage of the Medicare fee schedule as follows:

(i) ~~60%~~ 57.918% of the prevailing Medicare fee schedule for a birthing center or where a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are nonhospital patients;

(ii) ~~62%~~ 59.8486% of the prevailing Medicare fee schedule for a hospital designated as a sole community hospital as defined in ARM 37.86.2901; or

(iii) ~~60%~~ 57.918% of the prevailing Medicare fee schedule for a hospital that is not designated as a sole community hospital as defined in ARM 37.86.2901.

(b) and (c) remain the same.

(2) For purposes of this rule, clinical diagnostic laboratory services include the laboratory tests listed in codes defined in the HCPCS and listed in the Clinical Diagnostic Fee Schedule (CLAB) published ~~December 14, 2005~~ January 1, 2017.

(3) remains the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3109 OUTPATIENT CARDIAC AND PULMONARY REHABILITATION REIMBURSEMENT (1) Critical access hospital (CAH) interim reimbursement is based on a hospital-specific Medicaid outpatient cost-to-charge ratio, not to exceed 100%. For dates of service on or after October 1, 2017, the interim reimbursement is based on the hospital specific Medicaid outpatient cost-to-charge ratio (CCR), less 3.47% not to exceed 100%. CAHs will be reimbursed their actual allowable costs determined according to ARM 37.86.2803.

(2) and (3) remain the same.

AUTH: 53-2-201, 53-6-111, MCA
IMP: 53-2-201, 53-6-101, MCA

37.86.3205 NONHOSPITAL LABORATORY AND RADIOLOGY (X-RAY) SERVICES, REIMBURSEMENT (1) through (3) remain the same.

(4) For clinical laboratory services, the department pays the lower of:

(a) remains the same.

(b) ~~60%~~ 57.918% of the Medicare fee schedule for physician offices and independent labs and hospitals functioning as independent labs; or

(c) remains the same.

AUTH: 53-6-113, MCA
IMP: 53-6-113, 53-6-141, MCA

37.87.1226 OUT-OF-STATE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES, REIMBURSEMENT (1) ~~Out-of-state psychiatric residential treatment facility (PRTF) services will be reimbursed at 50% of their usual and customary charges.~~ Reimbursement for the out-of-state Psychiatric Residential Treatment Facility (PRTF) is established in the department's Medicaid fee schedule, as adopted in ARM 37.85.105.

(2) through (4) remain the same.

AUTH: 53-6-101, MCA
IMP: 53-6-113, MCA

4. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department) is proposing the amendment of ARM 37.40.830, 37.85.104, 37.85.105, 37.86.610, 37.86.705,

37.86.805, 37.86.1101, 37.86.1105, 37.86.1406, 37.86.1807, 37.86.2005, 37.86.2605, 37.86.2803, 37.86.2806, 37.86.2905, 37.86.2912, 37.86.3007, 37.86.3109, 37.86.3205, and 37.87.1226 pertaining to updating the effective dates of non-Medicaid and Medicaid fee schedules to October 1, 2017.

The following introductory explanation represents the reasonable necessity for these proposed changes in this MAR notice to these rules.

The Department of Public Health and Human Services (department) administers the Montana Medicaid and non-Medicaid program to provide health care to Montana's qualified low income, elderly and disabled residents. Medicaid is a public assistance program paid for with state and federal funds appropriated to pay health care providers for the covered medical services they deliver to Medicaid members. Non-Medicaid programs are funded primarily with state funds or grants. The legislature delegates authority to the department to set the reimbursement rates Montana pays Medicaid and non-Medicaid providers for members' covered services.

The purpose of the proposed rule amendment is to update and set provider rates to take into consideration the funding appropriated by the 65th Montana Legislature. The department has determined the new proposed rates are consistent with efficiency, economy, and quality of care. These rates are sufficient to enlist enough providers so that care and services under the Montana Medicaid program are available to the extent that such care and services are available to the general population in the geographic area.

Updates to these rules are needed to: 1) reflect the re-basing of the Resource Based Relative Value Scale (RBRVS) reimbursement methodology used by several divisions in the department which is necessary to stay within the legislative appropriation; 2) reflect the re-basing of the All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement methodology for inpatient hospital services used by several divisions in the department which is necessary to stay within the legislative appropriation; 3) reflect appropriation reductions contained in House Bill 2 (HB2) adopted by the 65th Legislature; 4) reflect the mandated legislative reductions required to comply with Senate Bill 261 (SB261) if revenue projections do not meet certain levels on August 15, 2017; 5) comply with the House Bill 639 (HB639) increase to the conversion factor used in the RBRVS physician fee calculations that is codified at 53-6-125, MCA; 6) update and reflect current pharmacy dispensing fee practice; 7) update descriptive Medicaid terminology; and 8) remove references to Targeted Case Management for adults with severe mental illness, children with serious emotional disturbance, and children and adults with substance use disorder from these rules.

These rules apply to services for all people and eligibility categories for Montana Medicaid, including the Montana Medicaid Health and Economic Livelihood Partnership (HELP) Program that serves the Medicaid Expansion population.

SB261 requires the department to decrease expenditures if certain state revenue levels are not achieved on August 15, 2017. These rules are being proposed with an effective date of October 1, 2017 to comply with the reductions mandated by the legislature in anticipation that these revenue levels will not be met. If one of the necessary levels of revenue is received, the proposed reductions will be modified or eliminated prior to adoption of these rules. The department has chosen to notice these rules at this time rather than wait until after August 15, 2017 revenue is known because delay of notice and implementation would increase the size of the proposed reductions as the same dollar amount of reduction would need to occur over fewer months.

Due to anticipated decreases in revenues, the department is implementing an across the board decrease in payment for certain Medicaid and non-Medicaid services and supplies paid under RBRVS, APR-DRG, Outpatient Prospective Payment System (OPPS) for outpatient hospital services, fee for service, and Medicare payment methodologies. The reduction needed to stay within legislatively approved appropriations in HB2 and SB261 is calculated at 3.47%.

Detailed explanations for the different payment methodologies and what changes are being proposed are listed below rather than in each rule line explanation to avoid redundancy. For services where the calculation varies based on additional factors, as an example payment-to-charge ratio in ARM 37.85.105(2)(d), a specific explanation is made.

Conversion Factor Changes

The October 1, 2017 conversion factor changes for rates subject to the RBRVS rate methodology were calculated in a multi-step process to apply the changes in HB639, HB2, and SB261. For the physician services conversion factor the department achieved budget neutrality with the new CMS Relative Value Units (RVU) and Geographic Practice Cost Indices (GPCI). Budget neutrality was calculated by decreasing the conversion factor to offset any changes to RVUs or GPCIs. With budget neutrality achieved, the department applied the HB639 increase to the current physician conversion factor of $37.28. This increase is for a 12-month period, but is being applied over nine months, beginning October 1, 2017; therefore, a 0.67% increase was used to increase the physician's conversion factor to $37.53. In accordance with SB261 and HB2 the department then applied the 3.47% reduction to the physician conversion factor, resulting in the proposal of $36.23. The 3.47% reduction was calculated based on the reduction needed to stay within allocated appropriations in HB2 and SB261.

For the allied health, mental health, and anesthesia conversion factors, the department utilized the same methodology applied to the physician's conversion factor with the exception of the HB639 increase. Therefore, the conversion factor for allied health, mental health, and anesthesia was modified to account for the RVU and GPCI changes and then the 3.47% reduction was applied.

Hospital Rate Changes

The department is proposing to adopt a new version of the APR-DRG grouper effective October 1, 2017. Version 34 of the APR-DRG grouper contains changes to DRG weights, average length of stays, and adds new DRGs. In addition to adopting a new grouper version, the department is also proposing a decrease to hospital base rates to meet the appropriated budget for inpatient hospitals. This budget incorporates the reductions associated with HB2 and SB261. The Outpatient Prospective Payment System (OPPS) conversion factor will be reduced by 3.47% to institute rate reductions needed to comply with HB2 and SB261.

Fee Schedule Changes

The department is proposing the adoption of October 1, 2017 fee schedules. The rates contained within these proposed fee schedules were modified to incorporate the 3.47% rate reductions that are proposed in accordance with HB2 and SB261 appropriations. In addition to incorporating rate reductions, the department also adds and removes procedure codes to ensure that the newest most appropriate codes are available for providers to bill to Medicaid. Without these revisions, providers may be required to bill Medicaid with different codes than other major payers in the state, such as Medicare, resulting in administrative inefficiencies.

Medicare Rates

Many Montana Medicaid programs utilize Medicare rates for fee schedules, cost settlements, and reimbursements. The reductions required to comply with HB2 and SB261 appropriations result in the rates being reduced by 3.47%. The October 1, 2017 proposed fee schedules reflect the rate reduction, Medicare updates, and procedure code changes.

The Durable Medical Equipment fee schedule will continue to follow 2015 Medicare rates and procedure codes but the 2015 rates will be reduced by 3.47% to comply with SB261.

The 3.47% rate reduction also applies to the cost settlement and interim reimbursement rates for Critical Access Hospitals. Prior to this change, Montana Medicaid followed Medicare reimbursement at a cost settlement and interim rate of 101%.

Providers Not Subject to Rate Reductions

The department is not proposing rate reductions to the following: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Indian Health Service or Tribal 638 facilities, Average Acquisition Cost for pharmacy ingredient, or member transportation.

In accordance with 42 U.S.C. 1396a(a), state Medicaid agencies are prohibited from adopting reimbursement methodologies that result in FQHC or RHC providers being reimbursed less than their calculated Prospective Payment System rate. Therefore, no reductions to FQHC and RHC providers are made.

Montana reimburses services provided by Indian Health Service (IHS) or Tribal 638 facilities funded by Title I or Title V of the Indian Self-Determination and Education Assistance Act at the rates negotiated between the CMS and the IHS, as published in the Federal Register. These funds are 100% Federal; therefore, there are no state fund decreases to implement within this program.

Montana and other states who implemented a state calculated Average Acquisition Cost (AAC) reimbursement for Outpatient Prescription Drugs in accordance with CMS-2345-FC are required to adhere to federal requirements in setting outpatient prescription drug rates. State-set AAC rates are to be based on actual invoice data from outpatient pharmacies. A rate reduction is not allowed within the federal statutes governing this reimbursement methodology.

Reductions to member transportation services were not proposed because the department wants to continue to ensure Medicaid members have adequate resources for travel to access care.

The following describes in detail the proposed amendments that will be made to ARM 37.85.105.

ARM 37.85.105(2)(a)

The department is proposing to revise the reference and effective date for the Federal Register regarding the RBRVS and to update the reference from 80 Federal Register 220, page 70886, November 16, 2015, effective January 1, 2016, to 81 Federal Register 220, page 80170 (November 15, 2016) effective January 1, 2017. This change is necessary to reflect the latest available Federal Register from CMS. This adoption allows providers to submit claims using the most recent codes and fees available; otherwise, the provider may need to bill Medicaid using different codes than other major payers, such as Medicare, resulting in administrative inefficiencies.

ARM 37.85.105(2)(b)

The department is proposing to update the effective date regarding RBRVS fee schedules to October 1, 2017. In addition, updates will occur to the physician services conversion factor. It will be updated from $37.89 to $38.12 per HB639 and then the 3.47% reduction per HB2 and SB261 will be applied making the final proposed conversion factor $36.23. The conversion factors for allied services is reduced from $25.38 to $24.17, the mental health services conversion factor from $24.90 to $23.95, and anesthesia services conversion factor from $29.76 to $28.73 to reflect appropriated amounts in HB2 and SB261.

ARM 37.85.105(2)(d)

The department is proposing to update the payment-to-charge ratio to align with rate decreases being taken in different areas, effective October 1, 2017. The department is proposing a change to 45.37% of the provider's usual and customary charges. The payment method utilizes a percent of charges; therefore to have a fiscal impact of 3.47%, the department needed to multiplicatively reduce 47% by 3.47%. A subtraction of 3.47% from 47% would erroneously result in a larger fiscal impact.

ARM 37.85.105(2)(i)

The department is proposing to update reimbursement for physician-administered drugs described at ARM 37.86.105 as determined at 42 CFR 414.904 (2016). The department is proposing a decrease in the percentage of average sales price (ASP) paid for physician administered drugs to align with the rate decrease in different areas. The department is proposing a change to 102.32% of ASP from 106% of ASP for reimbursement on physician-administered drugs.

ARM 37.85.105(2)(j)

The department is proposing to add the fee schedule for vaccines and provide an effective date of October 1, 2017. Fees will be reduced by 3.47%.

ARM 37.85.105(3)(a)(i)

The department is proposing to update and revise the APR-DRG fee schedule for inpatient hospitals as provided in ARM 37.86.2907 effective October 1, 2017. The base rate will be decreased as previously described.

ARM 37.85.105(3)(a)(ii)

The department adopts and incorporates by reference the APR-DRG Table of Weights and Thresholds effective October 1, 2017 and updates the APR-DRG grouper version 33 to version 34. The department proposes these changes to include the revisions to the weights, thresholds, and DRGs proposed in version 34 of the APR-DRG grouper. The new version contains new DRGs that will allow providers to bill and receive reimbursement for new inpatient procedures. This alignment allows providers to submit claims using the most recent codes and fees available from CMS; otherwise they would have to bill Medicaid using different codes than other major payers, such as Medicare, resulting in administrative inefficiencies.

ARM 37.85.105(3)(b)(i)

The department revises and adopts the Outpatient Prospective Payment System (OPPS) fee schedule as published by the CMS in 81 Federal Register 219, page 79562, effective January 1, 2017. This alignment allows providers to submit claims

using the most recent codes and fees available from CMS. Otherwise they would have to bill Medicaid using different codes than other major payers, such as Medicare, resulting in administrative inefficiencies.

ARM 37.85.105(3)(b)(ii)

The department is proposing to revise the conversion factor for outpatient services on or after October 1, 2017 from $56.64 to $54.67. The conversion factor for outpatient services is being decreased to align with the rate reductions being proposed in other areas.

ARM 37.85.105(3)(b)(iii)

The department is proposing to revise the outpatient statewide average cost to charge ratio from 45.2% to 39.91%. The statewide average cost to charge ratio was updated to reflect the calculated outpatient cost to charge ratio from the most recent, final and audited, Title XVIII/Title XIX cost reports available. These cost reports vary in dates based on the individual hospitals. The cost to charge ratio decreased by this amount rather than 3.47% because hospital charges increased disproportionally to costs.

ARM 37.85.105(3)(b)(iv)

The department is proposing to revise the composite Rate for Dialysis from $252.00 to $243.26 effective October 1, 2017. The composite Rate for Dialysis is being decreased to incorporate the 3.47% rate reductions proposed in association with appropriations in HB2 and SB261.

ARM 37.85.105(3)(c)

The department is proposing to revise the hearing aid services fee schedule effective October 1, 2017. Rates will decrease 3.47%.

ARM 37.85.105(3)(d)

The department is proposing to revise the relative value for dentists publish date to 2017 and revise the effective date to October 1, 2017; the dental conversion factor will decrease from $33.78 to $32.61. These changes are required to incorporate the most recently published relative value units for dentists. In addition, the department is proposing a decrease in the dental conversion factor to apply the 3.47% rate reduction being proposed in other areas.

ARM 37.85.105(3)(f)

The department is proposing to revise the effective date regarding the outpatient drugs reimbursement dispensing fee ranges to October 1, 2017. Pharmacies that do not complete the department's annual cost to dispense survey will be reimbursed

at the department's lowest calculated cost to dispense based on the annual dispensing fee survey. The department is revising the minimum and maximum dispensing fees. After finalizing pharmacy state plan negotiations with CMS, the department is proposing to reimburse providers subject to the minimum dispensing fee, the department's lowest calculated cost to dispense. Thus, the department is revising the minimum dispensing fee amount to reflect the lowest calculated cost to dispense based on the annual dispensing fee survey. The maximum dispensing fees for each prescription volume based band are being reduced to apply the rate reductions from HB2 and SB261.

ARM 37.85.105(3)(f)(i)

The department is proposing to revise the minimum and the maximum dispensing fees for pharmacies with prescription volumes between 0 and 39,999 for the minimum from $2.00 to $3.41 and for the maximum from $15.00 to $14.48.

ARM 37.85.105(3)(f)(ii)

The department is proposing to revise the minimum dispensing fee for pharmacies with prescription volumes between 40,000 and 69,999 from $2.00 to $3.41 and for the maximum dispensing fee from $13.00 to $12.55.

ARM 37.85.105(3)(f)(iii)

The department is proposing to revise the minimum dispensing fee for pharmacies with prescription volumes greater than 70,000 from $2.00 to $3.41 and for the maximum dispensing fee from $11.00 to $10.62.

ARM 37.85.105(3)(h)

The department is proposing to revise the outpatient drugs reimbursement, vaccine administration fee as provided in ARM 37.86.1105(6), from $21.32 to $20.58 for the first vaccine and from $13.00 to $12.55 for each additional administered vaccine effective October 1, 2017. The vaccine administration fees are being reduced to reflect appropriation amounts in HB2 and SB261.

ARM 37.85.105(3)(i)

The department is proposing to remove the language regarding the out-of-state dispensing fee. The remaining subsections in (3) will be renumbered accordingly to account for the removal of this subsection. This change is being proposed to align the Administrative Rules of Montana with the State Plan for Outpatient Drugs approved by the CMS. Out of state pharmacies are subject to the same dispensing fee requirements as in-state pharmacies. Therefore, if an out-of-state pharmacy does not return the annual dispensing fee survey, they will be assigned the minimum dispensing fee allowed.

ARM 37.85.105(3)(j)

The department is proposing to revise the effective date of the home infusion therapy services fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(k)

The department is proposing to revise the effective date of the reference to the Region D Supplier Manual to October 1, 2017. The department will be making 3.47% reductions to the 2015 Medicare rates, department set fees, and MSRP rates using the July 1, 2015 fee schedule. Effective date of the revised fee schedule is October 1, 2017.

ARM 37.85.105(3)(l)

The department is proposing to revise the effective date regarding the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) fee schedule for private duty nursing, nutrition, and orientation and mobility specialists to October 1, 2017. The department is also proposing to include the children's special health services fee schedule effective October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(o)

The department is proposing to revise the effective date regarding the ambulance services fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(p)

The department is proposing to revise the effective date for the audiology services fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(q)

The department is proposing to update the reference to the therapies reimbursement rule from ARM 37.85.610 to ARM 37.86.610. This change is to correct an administrative error in rule reference. The department is also proposing to revise the effective date of the fee schedule for occupational therapists, physical therapists, and speech therapists to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(r)

The department is proposing to revise the effective date of the optometric fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(s)

The department is proposing to revise the effective date of the chiropractic fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(t)

The department is proposing to revise the effective date of the lab and imaging fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(u)

The department is proposing to correct a typographical error and change "Federal" to "Federally" Qualified Health Center. The department is proposing to update the language for Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services from education health to add-on services and revise the effective date of the FQHC and RHC fee schedule to October 1, 2017. Add-on services are not subject to the federal regulations regarding the calculated Prospective Payment System rate. A 3.47% rate reduction is proposed for add-on services only.

ARM 37.85.105(3)(v)

The department is proposing to revise the effective date of the Targeted Case Management for Children and Youth with Special Health Care Needs fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(w)

The department is proposing to revise the effective date of the Targeted Case Management for High Risk Pregnant Women fee schedule to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(x)

The department is proposing to add a reference to the mobile imaging fee schedule effective October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(3)(y)

The department is proposing to add a reference to the licensed direct entry midwife fee schedule effective October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.86.610, 37.86.705, and 37.86.2005

ARM 37.86.610, 37.86.805, and 37.86.2005 set forth the statewide payment to charge ratio within their stated reimbursement methodologies. In order to maintain consistency with the structure of Medicaid reimbursement rules, the department is proposing to remove the listed percentage and instead reference ARM

37.85.105(2)(d). The payment to charge ratio for the state was reduced multiplicatively to incorporate the 3.47% reduction proposed in other areas.

ARM 37.86.705 and 37.86.805

The department is proposing that the Montana Medicaid program pays the following for audiology and hearing aid services:

(a) For patients who are eligible for Medicaid, the lowest of:

(i) the provider's usual and customary charge for the service;

(ii) the reimbursement provided in accordance with the methodologies described in ARM 37.85.212;

(iii) 96.53% of the Medicare Region D allowable fee.

This proposal incorporates the 3.47% rate reductions that are being applied to comply with HB2 and SB261 appropriations.

ARM 37.86.1101

The department is proposing to update the definition of "Allowed ingredient cost" to be the "Average Acquisition Cost (AAC)" or "submitted ingredient cost," whichever is lower. If AAC is not available, drug reimbursement is determined at the lesser of "Wholesale Acquisition Cost (WAC) minus 3.47%," "Federal Maximum Allowable Cost (FMAC)," or the "submitted ingredient cost." This proposal applies the rate reductions discussed in association with HB2 and SB261 appropriations.

ARM 37.86.1105

The department is proposing to include a reduction to WAC of 3.47%, within the clotting factor reimbursement calculation when dispensed by specialty pharmacies, hemophilia treatment centers, or centers of excellence. This reduction is to both 340B and non-340B dispensed drugs and is proposed to apply the rate reductions necessary to meet the requirements of HB2 and SB261.

ARM 37.86.1406

The department is proposing to update the language for reference materials because the current language is outdated. The proposed rule will reflect the appropriate federal authority in which Montana Medicaid adopts and incorporates the schedule of Medicare allowable amounts paid to ASCs. The department is also proposing to decrease the Medicare allowable rate by 3.47% to enact appropriation decreases in HB2 and SB261.

ARM 37.86.1807

The department proposes to modify the department's DMEPOS Fee Schedule for items other than those billed under generic or miscellaneous from 100% to 96.53% of the Medicare region D allowable fee. The department proposes to multiplicatively

modify the Medicaid fee for all items for which there is no Medicare allowable fee available. The department is modifying the percentage of the provider's usual and customary charge to 72.4%, effective October 1, 2017. In addition, for items that have no product retail list price, the department is proposing a reimbursement of 72.4% of the provider's usual and customary charge, effective October 1, 2017. These changes are being proposed to apply the rate reductions proposed to satisfy the budget reduction within HB2 and SB261.

ARM 37.86.805, 37.86.2005, and 37.86.2605

The department is proposing to change, from 75% to 72.4%, the percentage of the manufacturer's suggested retail price that is considered reasonable when there is no established Medicare or Medicaid fee. For items without a manufacturer's suggested retail price, the charge will be considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount effective October 1, 2017. This change was calculated multiplicatively and is being proposed to maintain consistency with the rate reductions proposed in other areas.

CHANGES FOR CRITICAL ACCESS HOSPITALS

ARM 37.86.2803, 37.86.2806, 37.86.2905, 37.86.2912, and 37.86.3109

The department is proposing two changes for critical access hospitals to incorporate the rate reductions proposed. These changes are mentioned in the following rules: ARM 37.86.2803; 37.86.2806; 37.86.2905; 37.86.2912; and 37.86.3109. The first change is to decrease the final cost settlement amount to 97.50% from 101%. This is a multiplicative 3.47% reduction that applies to cost reporting periods ending on or after October 1, 2017.

The second change is to decrease the interim payment for all Critical Access Hospitals (CAHs). For interim payments, CAHs are paid their cost to charge ratios. In order to incorporate the rate reductions being applied to provider reimbursement, the department will be modifying the interim payments for CAHs, to their individual cost to charge ratios, less 3.47%. This change will apply to claims with dates of service on or after October 1, 2017.

ARM 37.86.3007

The department is proposing a nonrounded multiplicative decrease to the percentage of the prevailing Medicare fee schedule for clinical diagnostic laboratory services. The proposed reductions are to incorporate the rate reductions that are being applied to other sections. The revised percentages are as follows: 57.918% for a birthing center or where a hospital laboratory acts as an independent laboratory; 59.8486% for a hospital designated as a sole community hospital; and 57.918% for a hospital that is not designated as a sole community hospital. These proposed reductions are effective October 1, 2017 and are being made to comply with appropriated amounts in HB2 and SB261.

ARM 37.86.3205

The department is applying a nonrounded multiplicative decrease to the percentage of the Medicare fee schedule for nonhospital laboratory and radiology services. The proposal is 57.918%, a change from 60%. This reduction is necessary to apply the rate reduction being proposed to implement the budget reduction enacted under HB2 and SB261.

Fiscal Impact

Health Resources Division will reduce provider reimbursements by $3,922,143 in state funds plus corresponding federal funds. This amount corresponds to the 3.47% reduction to stay within the legislatively approved appropriations in HB2 and SB261. The total fiscal impact is displayed in the table below.

The following table displays the number of providers affected by the increase identified above, as well as the fiscal impact to state funds for SFY 2018.

Provider Type	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrolled Provider count
HOSPITAL - INPATIENT	($966,236)	($1,831,204)	($2,797,439)	376
HOSPITAL - OUTPATIENT	($537,472)	($1,018,614)	($1,556,087)	315
CRITICAL ACCESS HOSPITAL	($532,720)	($1,009,608)	($1,542,328)	50
PHYSICIAN	($636,353)	($1,206,012)	($1,842,364)	8,830
PHARMACY DISPENSING FEE	($128,935)	($244,356)	($373,291)	425
PHARMACY WAC	($228,695)	($433,422)	($662,118)	425
DENTAL	($413,364)	($783,405)	($1,196,770)	584
AUDIOLOGIST	($846)	($1,603)	($2,448)	59
LICENSED PROFESSIONAL COUNSELOR	($16)	($30)	($45)	657
PHYSICAL THERAPIST	($29,384)	($55,688)	($85,071)	634
PODIATRIST	($7,605)	($14,412)	($22,017)	67

PRIVATE DUTY NURSING AGENCY	($26,654)	($50,515)	($77,169)	4
PSYCHIATRIST	($1,469)	($2,784)	($4,253)	260
PSYCHOLOGIST	($8)	($15)	($22)	192
OCCUPATIONAL THERAPIST	($19,945)	($37,799)	($57,743)	155
SOCIAL WORKER	($290)	($549)	($839)	454
SPEECH PATHOLOGIST	($21,238)	($40,251)	($61,489)	171
AMBULANCE	($38,087)	($72,182)	($110,268)	160
AMBULATORY SURGICAL CENTER	($47,225)	($89,500)	($136,725)	23
CASE MNGMNT - TARGETED HRPW/CYSHCN	($4,204)	($7,967)	($12,171)	15
CHILDRENS SPECIAL HEALTH SVCS	($1,958)	($3,710)	($5,668)	3
CHIROPRACTOR	($8,592)	($16,284)	($24,876)	208
DENTURIST	($17,458)	($33,086)	($50,544)	19
DIALYSIS CLINIC	($25,489)	($48,307)	($73,796)	21
DURABLE MEDICAL EQUIPMENT	($149,040)	($282,460)	($431,500)	443
HEARING AID DISPENSER	($1,502)	($2,847)	($4,350)	35
HOME INFUSION THERAPY	($8,876)	($16,822)	($25,698)	15
INDEP DIAG TESTING FACILITY	($3,244)	($6,148)	($9,393)	19
LABORATORY	($28,935)	($54,837)	($83,772)	161
MID-LEVEL PRACTITIONER	($140,360)	($266,009)	($406,368)	3,127
NUTRITIONIST/ DIETICIAN	($256)	($485)	($741)	62
OPTICIAN	($899)	($1,704)	($2,604)	34
OPTOMETRIST	($39,465)	($74,794)	($114,258)	195
OUTPATIENT CENTER / PRIMARY CARE	($145)	($275)	($420)	2

ORIENTATION AND MOBILITY	($234)	($444)	($678)	3

The proposed rule is estimated to affect 261,160 Medicaid members. In addition, it will impact the provider populations outlined in the tables above.

SUMMARY OF PROPOSED AMENDMENTS - SENIOR AND LONG TERM CARE DIVISION (SLTC) - PROPOSED AMENDMENTS TO ARM 37.40.830 AND 37.85.105

ARM 37.40.830

This rule will implement the 3.47% provider rate decreases for the hospice program. The department proposes to update the fee schedule date from October 1, 2015 to October 1, 2017. A rate reduction of 3.47% is proposed.

The following describes in detail the proposed amendments that will be made to ARM 37.85.105 in Senior and Long Term Care.

ARM 37.85.105(4)(a)

The department proposes to update the fee schedule date for Home and Community Based Services (HCBS) Waiver program to October 1, 2017. A rate reduction of 3.47% is proposed for services except for member transportation/mileage.

ARM 37.85.105(4)(b)

The department proposes to update the fee schedule date for Home Health Services to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(4)(c) and (d)

The department proposes to update the fee schedule date for Personal Assistance Services to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(4)(e)

The department proposes to update the fee schedule date for Community First Choice program services to October 1, 2017. A rate reduction of 3.47% is proposed.

Fiscal Impact

Medicaid Provider Type	SFY2018 State Funds Impact	SYT 2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrolled Provider Count

HOME HEALTH AGENCY	($5,415)	($10,030)	($15,445)	26
HOSPICE	($31,933)	($59,149)	($91,082)	30
PERSONAL CARE	($22,650)	($98,239)	($75,589)	Included with CFC
COMMUNITY FIRST CHOICE	($392,482)	($958,110)	($1,350,593)	71
HOME & COMMUNITY BASED SERVICES - BIG SKY WAIVER	($389,202)	($720,900)	($1,110,101)	583

Approximately 561 home health, 3245 CFC, 853 PAS, and 2,729 HCBS waiver members will receive services in state fiscal year 2017 in one or more of these programs. 253 Montana Medicaid members received hospice services in FY 2017.

ADDICTIVE AND MENTAL DISORDERS DIVISION (AMDD) - PROPOSED AMENDMENTS TO ARM 37.85.104 AND 37.85.105

The department proposes to amend ARM 37.85.104 and 37.85.105.

ARM 37.85.104(1)(a), (b), and (d)

The Addictive and Mental Disorders Division (AMDD) is updating the effective date of the mental health services plan, the 72-hour presumptive eligibility for adult crisis stabilization services, and substance use disorder services fee schedules to October 1, 2017. This includes updating codes. The previously described methodology for RBRVS and fee for service methodologies will apply to comply with HB639, HB2, and SB261.

ARM 37.85.105(5)(a) and (d)

The department proposes to remove T1016, HB Targeted Case Management Services (TCM) for Adults with a Severe Disabling Mental Illness (SDMI) reimbursed at $18.22 for a 15-minute unit from the Medicaid Mental Health Fee Schedule and the Mental Health Services Plan Fee Schedule, effective October 1, 2017 located in ARM 37.87.105(5)(a). The department proposes to remove T1016, HF Targeted Case Management Services (TCM) reimbursed at $11.47 for a 15-minute unit from the Substance Use Disorder Medicaid Provider Fee Schedule and the Substance Use Disorder Contract Provider Fee Schedule effective October 1, 2017 located in ARM 37.87.105(5)(d).

The department proposes to adopt a new rule through MAR Notice No. 37-801 to implement the Medicaid Behavioral Health Targeted Case Management Fee Schedule to align SED, SUD, and SDMI rates for TCM which is a necessary first step in integrating behavioral health programs.

ARM 37.85.105(5)(a)

ARM 37.85.105(5)(b) is renumbered to 37.85.105(5)(a). The department proposes to update the fee schedule date for mental health center services to October 1, 2017. A rate reduction of 3.47% is proposed for most services. Physician services will be affected as described previously in the RBRVS methodology.

ARM 37.85.105(5)(b)

ARM 37.85.105(5)(c) is renumbered to 37.85.105(5)(b). The department proposes to update the fee schedule date for home and community based services to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(5)(c)

The department proposes to add and incorporate a reference for substance use disorder services reimbursement with an effective date of October 1, 2017. A rate reduction of 3.47% is proposed.

Fiscal Impact

The Addictive and Mental Disorders Division (AMDD) proposes a reduction in provider reimbursements. The fiscal impact is in the table below as well as a count of active or recertifying providers enrolled in Medicaid potentially impacted by rate reductions.

Medicaid Provider Type Medicaid Mental Health Adult (AMDD)	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrollment Provider Count
CASE MANAGEMENT - MENTAL HEALTH (PT60)	See MAR Notice No. 37-801			19
*CHEMICAL DEPENDENCY CLINIC (SUD) (PT32)	($38,523)	($73,015)	($111,538)	23
CRITICAL ACCESS HOSPITAL (PT74)	($5,054)	($9,578)	($14,632)	50
HOME & COMM BASED SERVICES (PT28)	($40,436)	($76,634)	($117,070)	583
HOSPITAL - INPATIENT (PT01)	($26,653)	($50,513)	($77,167)	141
HOSPITAL - OUTPATIENT (PT02)	($7,473)	($14,163)	($21,636)	315
INDEP DIAG TESTING FACILITY (PT72)	($2)	($3)	($5)	19
LABORATORY (PT40)	($4,817)	($9,129)	($13,945)	161

LICENSED PROFESSIONAL COUNSELOR (PT58)	($41,307)	($78,285)	($119,591)	657
MENTAL HEALTH CENTER (PT59)	($166,229)	($315,036)	($481,264)	19
MID-LEVEL PRACTITIONER (PT44)	($15,303)	($29,001)	($44,304)	3,127
PHYSICIAN (PT27)	($12,472)	($23,637)	($36,109)	8,830
PSYCHIATRIST (PT65)	($10,719)	($20,314)	($31,032)	260
PSYCHOLOGIST (PT17)	($1,685)	($3,194)	($4,879)	192
SOCIAL WORKER (PT42)	($20,760)	($39,345)	($60,105)	454
1115 WAIVER FOR ADDITIONAL SERVICES OR PEOPLE	($64,007)	($121,305)	($185,312)	192
Medicaid Mental Health Adult (AMDD) Total	($455,440)	($863,152)	($1,318,592)	

*Includes all SUD services with the exception of SUD TCM, which can be found at MAR Notice No. 37-801.

DEVELOPMENTAL SERVICES DIVISION - CHILDREN'S MENTAL HEALTH BUREAU - PROPOSED AMENDMENTS TO ARM 37.85.104, 37.85.105, AND 37.87.1226

The department is proposing the amendment of ARM 37.85.104, 37.85.105, and 37.87.1226 pertaining to updating Medicaid and non-Medicaid fee schedules and updating effective dates to October 1, 2017.

ARM 37.85.104(1)(c)

The department proposes to amend the Medicaid Youth Mental Health Fee Schedule to update the effective date to October 1, 2017. A rate reduction of 3.47% is proposed.

ARM 37.85.105(6)

The department is proposing to amend ARM 37.85.105 to incorporate by reference the new fee schedules to implement the rates set by Montana Medicaid's resource based relative value scale (RBRVS) reimbursement for psychologists, social workers, and professional counselors. The department proposes to update the fee schedule date from January 1, 2017 to October 1, 2017. A rate reduction of 3.47% is proposed.

It is necessary for the department to incorporate new assigned relative values to implement rates set by Montana Medicaid's RBRVS reimbursement for

psychologists, social workers, and professional counselors. The RBRVS is located in ARM 37.85.212.

The department is updating rule references to include the ARM chapter and subchapter only. The department is adding existing service unit limits to the fee schedule for easy reference. These changes are necessary to ensure accuracy and to allow easy reference of limits.

The department proposes to remove T1016, HA Targeted Case Management Services (TCM) for Youth with Serious Emotional Disturbance (SED) from the Medicaid Youth Mental Health Services Fee Schedule, effective October 1, 2017 located in ARM 37.85.105(6)(b). The department proposes to adopt a new rule in MAR Notice No. 37-801 to implement the Behavioral Health Targeted Case Management Fee Schedule, effective October 1, 2017 to align TCM rates for children with serious emotional disturbance, people with substance use disorders, and adults with serious and disabling mental illness. This is a necessary first step in integrating behavioral health programs.

The department proposes to repeal the HCBS State Plan Program for Youth with Serious Emotional Disturbance Fee Schedule, which is effective July 1, 2016. Application and approval of the 1915(i) HCBS State Plan amendment to the CMS expires September 30, 2017. Less than 10 children were being served in the program and they have been transitioned to other services.

ARM 37.87.1226

The department is proposing to amend ARM 37.87.1226 to remove the reimbursement rate of 50% of their usual and customary charges from ARM. The reimbursement rate for out-of-state PRTFs is also referenced on the Medicaid Youth Mental Health Services Fee Schedule incorporated by reference by rule. It is necessary to remove the reference to avoid conflicting information. The department is proposing to reduce the rate of reimbursement from 50% to 48.27% of their usual and customary charges. This reduction is necessary as mandated by SB261 and HB2.

Fiscal Impact

The Developmental Services Division-Children's Mental Health Bureau proposes a reduction in provider reimbursements. The fiscal impact is in the table below as well as a count of active or recertifying providers enrolled in Medicaid potentially impacted by rate reductions. Comprehensive School and Community Treatment (CSCT) is displayed separately as CSCT State Funds is provided by school match.

Medicaid Provider Type Medicaid Mental Health Youth (CMH/DD)	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrollment Provider Count

CASE MANAGEMENT - MENTAL HEALTH	See MAR Notice No. 37-781			19
CRITICAL ACCESS HOSPITAL	($4,284)	($8,120)	($12,404)	50
HOME & COMMUNITY BASED SERVICES 1915i	($366)	($693)	($1,059)	583
HOSPITAL - INPATIENT	($59,891)	($113,504)	($173,395)	141
HOSPITAL - OUTPATIENT	($22,103)	($41,889)	($63,991)	315
INDEP DIAG TESTING FACILITY	($7)	($14)	($21)	19
LABORATORY	($8,344)	($15,813)	($24,157)	161
LICENSED PROFESSIONAL COUNSELOR	($76,917)	($145,773)	($222,690)	657
MENTAL HEALTH CENTER	($60,694)	($115,027)	($175,722)	26
MID-LEVEL PRACTITIONER	($13,107)	($24,841)	($37,948)	3,127
PHYSICIAN	($17,465)	($33,100)	($50,566)	8,830
PSYCHIATRIC RES TREATMENT FACILITY	($167,514)	($317,472)	($484,986)	15
PSYCHIATRIST	($18,385)	($34,842)	($53,227)	260
PSYCHOLOGIST	($5,750)	($10,898)	($16,648)	192
SOCIAL WORKER	($43,934)	($83,264)	($127,199)	454
HOME SUPPORT SERVICES or THERAPEUTIC FOSTER CARE	($89,585)	($169,782)	($259,367)	14
THERAPEUTIC GROUP HOME	($185,795)	($352,117)	($537,912)	16
Medicaid Mental Health Youth (CMH/DD) Total	($774,142)	($1,467,149)	($2,241,291)	

The table below displays Comprehensive School and Community Treatment (CSCT) impacts.

Medicaid Provider Type Medicaid Mental Health Youth (CMH/DD)	SFY2018 State Funds Impact	SFY2018 Federal Funds Impact	SFY2018 All Funds Impact	Enrollment Provider Count
Comprehensive School & Community Treatment (PT45)	($448,473)	($849,943)	($1,298,415)	464

The proposed amendments affect about 19,000 Medicaid eligible youth.

5. The department intends the proposed rule amendments to be applied effective October 1, 2017.

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., August 4, 2017.

7. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct this hearing.

8. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 6 above or may be made by completing a request form at any rules hearing held by the department.

9. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

10. The bill sponsor contact requirements of 2-4-302, MCA, apply and have been fulfilled. The primary bill sponsors were notified by electronic mail (e-mail) on June 20, 2017.

11. With regard to the requirements of 2-4-111, MCA, the department has determined that the amendment of the above-referenced rules will not significantly and directly impact small businesses.

12. Section 53-6-196, MCA, requires that the department, when adopting by rule proposed changes in the delivery of services funded with Medicaid monies, make a determination of whether the principal reasons and rationale for the rule can be assessed by performance-based measures and, if the requirement is applicable, the method of such measurement. The statute provides that the requirement is not applicable if the rule is for the implementation of rate increases or of federal law.

The department has determined that the proposed program changes presented in this notice are not appropriate for performance-based measurement and therefore are not subject to the performance-based measures requirement of 53-6-196, MCA.

/s/ Brenda K. Elias
Brenda K. Elias
Rule Reviewer

/s/ Mary E. Dalton acting for
Sheila Hogan, Director
Public Health and Human Services

Certified to the Secretary of State June 26, 2017.