

Inpatient Hospital Reimbursement Proposed Rule Amendments

Effective April 1, 2012 unless otherwise noted

The Health Resources Division is proposing to amend the following rules related to hospital reimbursement:

ARM 37.86.2803(1) – This change updates references to the Medicare Provider Reimbursement Manual to the current transmittal number and current effective date for cost reporting periods occurring prior to May 1, 2010, and for cost reporting periods occurring on or after May 1, 2010. The proposed amendments to ARM 37.86.2803 will update two separate references to a federal publication regarding two distinct cost reporting periods.

ARM 37.86.2907 - The department proposes changes to weights, thresholds, and grouper version number used to assign an APR-DRG to each Medicaid client discharge in accordance with the current APR-grouper. The department also proposes a change to the Montana average base rate from \$4,129 to \$4,630 and the base rate for hospitals designated as Centers of Excellence from \$6,890 to \$7,725. The department is proposing a change in the hospital base rates to offset the reduced weights that take effect with the implementation of the new APR grouper.

The department is also proposing to change the date as to when the department will update the APR grouper. The APR grouper is available in October of each year and will be updated by the department the following April. The delay in implementation allows the department to analyze the impact of changes to the grouper and calculate a base rate changes reflective of the appropriation and version changes.

ARM 37.86.2918(3) - Language was added to clarify that outpatient services provided by an entity owned or operated by the hospital and that occur the day of or the day prior to the inpatient hospital admission, must be bundled into the inpatient claim and that payment for these services is included in the inpatient rate.

ARM 37.86.2925(3) – language was added to clarify how the department will collect Disproportionate Share Hospital (DSH) overpayments and redistribute DSH payments based upon audit findings. It is necessary for the department to add this language to rule as DSH audits are required by CMS. The added language will clarify to providers how the department will collect any overpayments and address the redistribution of these overpayments.

Diabetes and Cardiovascular Disease Prevention Proposed Rule and State Plan Amendment

Effective February 2, 2012

The Public Health and Safety Division received a five-year grant in 2011 to conduct a study regarding providing incentives to people covered by Medicaid to attend diabetes and cardiovascular disease prevention sessions. PHSD partnered with Health Resources Division to design the study, based on services PHSD has funded in 14 Montana communities since 2008. In an effort to make these prevention services sustainable, Medicaid added diabetes and cardiovascular disease prevention services to the Medicaid State Plan, which was submitted to CMS on February 29, 2012. An Administrative Rule change is also in progress. The state plan and rule specify providers that may deliver the services and limit the type of services that may be provided. PHSD is also working with other payers to facilitate payment of these prevention services.

Physician and other Professional Reimbursement Proposed Rule Amendment

Effective July 1, 2012

The Health Resources Division is proposing amendments to ARM 37.85.212. This rule implements Montana Medicaid's resource based relative value scale (RBRVS) reimbursement method to calculate the fees Montana Medicaid pays to 20 types of health care professionals. The RBRVS system is used nationwide by many health plans, including Medicare and Medicaid. The relative value unit (RVUs) component of the RBRVS system is revised annually by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association. The Department annually proposes to amend ARM 37.85.212(1)(i) to adopt current relative value units. The department annually calculates conversion factors for physicians, mental health professionals and allied health providers, by applying conversion factors set in statute or by dividing the estimated available appropriation for Medicaid healthcare during the upcoming State Fiscal Year by the estimated total units of health care, expressed as total RVUs paid, to be provided during the upcoming State Fiscal Year. The RVU for a procedure multiplied by the conversion factor and any applicable policy adjustments is the fee paid for the procedure.

ARM 37.86.105 (4) addresses the reimbursement of physician administered drugs. The Department follows the reimbursement methodology used by Medicare for many physician administered drugs. The amendment to ARM 37.86.105(4) allows the Department to update fees for these drugs by using the most current information provided by Medicare.

The proposed RBRVS and ASP rule amendments will be expected to be budget neutral for the department.