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

In the matter of the adoption of New Rules I through IV, and the amendment of ARM 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.2801, 37.86.2803, 37.86.2901, 37.86.2905, 37.86.2912, 37.86.2918, 37.86.2943, 37.86.2947, 37.86.3001, 37.86.3005, 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3025, 37.88.206, 37.88.306, 37.88.606, and 37.88.1106 pertaining to Medicaid reimbursement of hospitals, provider based entities, and birthing centers	)	NOTICE OF ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On November 9, 2006, the Department of Public Health and Human Services published MAR Notice No. 37-395 pertaining to the public hearing on the proposed adoption and amendment of the above-stated rules, at page 2793 of the 2006 Montana Administrative Register, issue number 21.

2. The department has adopted New Rules I (37.86.3031), and III (37.86.3035) as proposed.

3. The department has amended ARM 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.2801, 37.86.2803, 37.86.2901, 37.86.2905, 37.86.2912, 37.86.2918, 37.86.2943, 37.86.3005, 37.86.3007, 37.86.3016, 37.86.3018, 37.86.3025, 37.88.206, 37.88.306, and 37.88.606 as proposed.

4. The department has adopted the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

<u>RULE II (ARM 37.86.3033) PROVIDER BASED ENTITY SERVICES, RECIPIENT ACCESS AND NOTIFICATION</u> (1) Hospitals granted a provider based status by the department may not restrict access to Medicaid clients ~~and must comply with antidumping rules in 42 CFR 489.20~~.

(2) A physician, clinic, or mid-level practitioner who practices primary care and is a provider based entity, except as described in (3) is required to participate in the Passport to Health and Team Care programs (ARM 37.86.5101 through 37.86.5120 and ARM 37.86.5201 through 37.86.5306). The provider:

(a) through (c) remain as proposed.

(d) must ~~set a Passport to Health caseload limit of at least 100 per physician~~

~~or mid-level unless the department grants approval for a lower level~~ accept new Medicaid clients at the same rate non-Medicaid clients are accepted; and

(e) through (5)(a) remain as proposed.

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

RULE IV (37.86.3037) PROVIDER BASED ENTITY SERVICES, REIMBURSEMENT (1) and (2) remain as proposed.

(3) Provider based entity facilities must bill using revenue code 510 for CPT codes for Evaluation and Management services (E and M codes) and procedural codes ~~with the exception of laboratory services as in ARM 37.86.3007(3)~~ as per Medicare guidelines in Chapter III and in Appendix 3 of the Uniform Billing Editor. HCPCS/CPT codes must be mapped to the 510 revenue code when the procedure was performed in a provider based clinic setting unless Medicare issued instructions for use of another revenue code.

(4) Provider based entity professionals must bill using the correct site-of-service so that appropriate payment amounts may be determined as in ARM 37.86.105, 37.86.205, 37.86.506, 37.88.206, and 37.88.606.

(a) Unless otherwise noted, only CPT codes for Evaluation and Management services, professional components, and procedural codes may be billed for professional reimbursement in provider based entities.

(i) through (6) remain as proposed.

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

5. The department has amended the following rules as proposed with the following changes from the original proposal. Matter to be added is underlined. Matter to be deleted is interlined.

37.86.3001 OUTPATIENT HOSPITAL AND BIRTHING CENTER SERVICES, DEFINITIONS (1) and (2) remain as proposed.

(3) "Birthing center" means a facility that provides comprehensive obstetrical care for women in which births are planned to occur away from the mother's usual residence following normal, uncomplicated, low risk pregnancy and is either:

(a) a licensed outpatient center for primary care with medical resources as defined at 50-5-101, MCA~~, that is used~~; or

(b) a private office of a physician or certified nurse mid-wife that is accredited by a national organization as an alternative to a homebirth or a hospital birth.

(4) through (18) remain as proposed.

(19) For purposes of provider based entity billing, a professional is a physician, podiatrist, mid-level, licensed clinical social worker, licensed professional counselor, or a licensed psychologist.

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

37.86.3009 OUTPATIENT HOSPITAL SERVICES, PAYMENT METHODOLOGY, EMERGENCY VISIT SERVICES (1) For emergency visits that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901, reimbursement will be based on the ambulatory payment classifications APC methodology in ARM 37.86.3020, ~~(~~except~~)~~ emergency room visits with CPT codes 99281 and 99282 will be reimbursed based on ~~clinical fees for APC 00600~~ the lowest level clinical APC weight.

(a) and (2) remain as proposed.

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

37.86.3020 OUTPATIENT HOSPITAL AND BIRTHING CENTER SERVICES, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) METHODOLOGY, AMBULATORY PAYMENT CLASSIFICATION (1) through (1)(h) remain as proposed.

(2) The department adopts and incorporates by reference the OPPS Schedules published by the Centers for Medicare and Medicaid Services (CMS) in 71 Federal Register ~~163~~ 226, ~~August 23~~ November 24, 2006, ~~proposed~~ effective ~~date~~ January 1, 2007. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

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

37.88.1106 INPATIENT PSYCHIATRIC SERVICES, REIMBURSEMENT

(1) through (3)(b) remain the same.

(4) Reimbursement for inpatient psychiatric services provided to Montana Medicaid recipients in facilities located outside the state of Montana will be ~~reimbursed 50% of usual and customary billed charges for medically necessary services~~ as provided in ARM 37.86.2905.

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

6. The department is withdrawing the amendments proposed at the December 1, 2006 hearing to ARM ARM 37.86.2947.

The department is making changes to ARM 37.86.3009 and 37.86.3020 based on changes to the adopted Medicare Payment Rules for Outpatient Hospital Services Federal Register 226, November 24, 2006 effective date January 1, 2007.

The department is not going ahead with its proposal to amend ARM 37.86.2820 Desk Reviews, Overpayments, and Underpayments, which would have changed the repayment period of cost reports from 30 days to 60 days. It will propose this

amendment in a future rulemaking notice.

The department is dropping its proposed amendment to ARM 37.86.2947 Out-of-State Inpatient Hospital Reimbursement, which would have clarified the proposal to exempt inpatient psychiatric services from the preferred out-of-state hospital rules. Out-of-state hospitals that provide mental health services may elect to become preferred out-of-state facilities and receive interim reimbursement at hospital specific cost to charge ratio and cost settlement up to 100% of costs. All inpatient mental health services for in-state, out-of-state preferred hospitals, and out-of-state diagnosis related group (DRG) hospitals must still obtain authorization from the department's designee (currently First Health). Out-of-state residential treatment centers will still be reimbursed at 50% of charges. The rule has been restored to its original condition.

7. The department has thoroughly considered all commentary received. The comments received and the department's response to each follows:

COMMENT #1: The department has proposed that provider based facilities notify the department within 30 days of staff changes. There are already sufficient measures in place to accommodate this request without placing another requirement on providers. In order for a physician or facility to provide reimbursable services to Medicaid recipients, an enrollment process must be completed. This enrollment process should be sufficient notification to the department.

RESPONSE: Once NPI (National Provider Identification) is in place June 2007, provider enrollment will track this information electronically. Until then, providers must notify the department directly because the department has no easy means of tracking the information.

COMMENT #2: The department is proposing that reimbursement of provider based entity services under revenue code 510 be 80% of the applicable rate. While we understand that the department is seeking to control expenditures, we don't feel that reducing payment on this particular revenue code should be implemented. Provider based reimbursement recognizes that facilities have extraordinary costs in delivering services. Reducing this to a lower level than would be allowed in other settings establishes a precedent that we believe is not in the best interest of the program. The department is proposing in Rule II (ARM 37.86.3033) that all provider based facilities not restrict access to Medicaid clients as well as maintain a substantial Passport caseload, so we believe that the providers should be compensated fairly under this arrangement.

RESPONSE: The department's proposed reduction in reimbursement for certain services in a provider based setting amounts to only 9.59% overall. This is still 27.1% more than received by freestanding physician clinics, which is the equivalent settling. The department feels that it is a fair trade off to require Passport enrollment and specific caseload requirements for this higher rate of reimbursement.

COMMENT #3: The proposed rules for reimbursement of provider based entities requires a minimum caseload of at least 100 Passport patients per physician. Physician availability and caseload management of Passport patients will vary greatly among physicians due to a number of variables such as:

a. Number of established patients for a physician in the practice.
b. Whether a physician is a full-time or part-time employee.
c. Current case mix and medical complexity of established patient base.

We recommend that this requirement and caseload for a provider based practice be based on:

a. Number of Passport patients in the area or region.
b. Number of provider based clinics in the area served.
c. Number of primary care physician or providers in the area.
d. Wait times as well as access problems for current Passport patients in the service area.

A caseload limit by practice, based upon the number of full-time equivalent physicians and providers, as well as the current established patient base for each physician, would be a more practical and appropriate way to ensure access for Passport patients.

While we understand that the language for this requirement is taken from the Passport requirements, this has never been the practice of Medicaid. In recent communication with Montana Medicaid, we were told the minimum caseload is one patient. We would be happy to supply you with that information we received.

Montana hospitals employ or contract for services from providers to treat all patients regardless of their insurance status or ability to pay for care. The provider may be an employee or may merely be providing medical services on a part time basis. The provider may practice at more than one location. For example, a physician may provide some care in a hospital based clinic, and other services in private practice or at other hospitals.

RESPONSE: The department received a suggestion for alternative language to the caseload of 100 Passport to Health patients per physician or mid-level that we believe will meet our goal of ensuring access for Medicaid clients to the extent that services are available in the community. Please see the response to Comment #17 for further detail.

There was some misinformation provided regarding the current Passport rule. The current Passport rule has a maximum limit of 1000. The Centers for Medicare and Medicaid Services (CMS) has a maximum limit of 1500 per provider. It does not have a minimum limit. Currently, there is no minimum caseload requirement for participation in the Passport to Health program. We apologize for the confusion.

COMMENT #4: In Rule I(1) (ARM 37.86.3031) the department proposes to impose new administrative requirements on hospitals that seek provider based status for some clinic services. The requirements include providing notice to the department of provider based status conferred by the Centers for Medicare and Medicaid Services prior to billing services.

Montana Medicaid currently allows provider based clinic billing, and has done so for more than three years. It appears that the department intends merely to follow federal regulatory policy for these services. We are concerned that the department is proposing to apply the new rule retroactively to services provided back to August 1, 2003. We request that the department amend the rule to reflect the date the proposed rule is adopted.

RESPONSE: Section (1) was originally ARM 37.86.3025(6) and dates back to August 1, 2003. Sections (2), (3), and (4) are new to the rule effective January 1, 2007. The department does not intend to apply any portions of new Rules I through IV (ARM 37.86.3031, 37.86.3033, 37.86.3035, and 37.86.3037) retroactively. The other sections that were previously in ARM 37.86.3025(6) are already applicable since August 1, 2003.

COMMENT #5: Rule II(1) (ARM 37.86.3033) states that the hospital may not restrict access to Medicaid clients and must comply with antidumping rules in 42 CFR 489.20. This language is simply unnecessary. Hospitals, including their provider based entities must comply with antidumping rules as a matter of federal law. We request that the department strike this entire sentence from the regulation.

RESPONSE: Thank you for your comment. The department has considered this and decided to keep the section stating that the hospital may not restrict access to Medicaid clients (which dates back to the August 2003 rule) but will strike "and must comply with antidumping rules in 42 CFR 489.20".

COMMENT #6: Rule II (ARM 37.86.3033) states that hospitals may not "restrict access to Medicaid clients". This wording could be taken to mean that hospitals must serve patients other than those covered by Medicaid. In other words, the hospital could not establish a "Medicaid-only" clinic. An alternative meaning is that the department intends to grant unlimited access to care for Medicaid clients. The sentence could be taken to mean that a hospital could not deny services regardless of medical necessity or any other reason. Hospitals do attempt to restrict access to persons who are seeking unneeded medical care, including prescription drugs. Medical providers, including hospitals, already must comply with department rules provided in ARM Title 37, chapter 86, subchapters 2 and 3. These rules address access, medical necessity, and prohibit discrimination against Medicaid beneficiaries.

RESPONSE: The department does not believe that this sentence could be interpreted to mean anything other than a provider based facility must allow Medicaid recipients access to services as stated in Rule II(2) through (4) (ARM

37.86.3033). As the commenter noted, the department has specific rules in place in both the general Medicaid rule and the hospital rule that prohibit reimbursement of services that are not medically necessary.

COMMENT #7: The department has, since the inception of the Passport to Health program, barred hospitals from participating in this program. A physician that practices primary care at a hospital-based clinic is not himself alone a "provider based entity". If the department intends by this regulation to require a hospital to participate in the Passport program, the rule should be so worded, and the Passport regulations amended to reflect facility contracts rather than practitioner contracts. We suggest that the department allow the hospital to sign the Passport to Health contract instead of requiring each provider to sign a separate agreement. We are prepared to work with the department to create the appropriate participation criteria for hospitals and provider based entities.

RESPONSE: The goal of the Passport to Health program is to establish a medical home between the Medicaid client and the primary care provider. Primary care providers are eligible to be Passport to Health providers. The department intends to require physicians and mid-levels, while operating under the umbrella of the provider based entity, to participate in the Passport program unless exempted by the department.

COMMENT #8: We are not aware of any shortage of Passport to Health providers, especially in the hospital-based clinics that already exist. In fact, most hospital-based clinics have providers who are participating in the Passport to Health program. Further, some hospital-based clinics are the sole remaining practice setting open to new Medicaid clients. The department's proposal may actually be counterproductive to the access Medicaid clients now enjoy.

RESPONSE: The department has only identified one area (with a provider based entity) that consistently experiences an access problem. In the majority of areas with provider based entities, the Passport to Health providers associated with these provider based entities are carrying a larger case load than 100. However, some of these areas are nearing the point where access could become an issue. This proactive step would ensure our clients continue to experience access to care. Also, the department has had many conversations with the Montana Hospital Association (MHA) and hospital emergency rooms over the years. During those conversations MHA and hospital personnel frequently stated that it was necessary for clients to go to the emergency room because they did not have access to their Passport primary care physicians.

COMMENT #9: Rule II(5)(a) (ARM 37.86.3033) is redundant of federal requirements. A hospital is already required to notice Medicare-eligible patients of their deductible and co-payment obligations.

RESPONSE: A hospital is required to notify Medicare recipients under federal regulations but not Medicaid recipients. Montana Medicaid asked an in-state

hospital to comply with this regulation in regard to Medicaid recipients last year and was told that since the Medicaid regulation did not specifically require them to do so, they would not. We are requiring them to do so here.

COMMENT #10: We object to all of the provisions of Rule III (ARM 37.86.3035). We are unable to detect which provisions of this rule are redundant to existing regulatory sanctions imposed on providers and which are new standards. Further, a physician who provides care at the hospital may be responsible to bill their own services. The hospital should not be sanctioned by the department for the failure of a physician to fulfill the obligations imposed by the Passport to Health program (Rule II) (ARM 37.86.3033) or billing with the appropriate site of service codes (Rule IV) (ARM 37.86.3037). A physician that only provides minimal services at the provider based entity could fail to comply with Passport requirements elsewhere and end up bringing sanctions onto the hospital.

RESPONSE: The department intends this rule to apply to the provider based entity and only to the professionals when they are doing business under the umbrella of the provider based entity. If the professional is responsible for billing their own services yet is performing the service under the umbrella of the provider based entity, then the department would expect to sanction the entity (be the "parent" a hospital, a physician owned corporation, or any other type of owner) for the professional failure to comply with any parts of Rules I through IV (ARM 37.86.3031, 37.86.3033, 37.86.3035, and 37.86.3037). A professional providing minimal services in a provider based entity is subject to only certain provisions of Rule II (ARM 37.86.3033). The professional would however be subject to all provisions of Rule IV (ARM 37.86.3037) every time they perform a service for the provider based entity and bill that service to Montana Medicaid.

The department is adding a definition of professional to ARM 37.86.3001(19). For purposes of provider based entity billing, a professional is a physician, podiatrist, mid-level practitioner, licensed clinical social worker, licensed professional counselor, or a licensed psychologist.

COMMENT #11: We are also concerned about how the department intends to determine compliance with the proposed regulations, especially the federal requirements that are surveyed by CMS or where compliance is determined by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The department seems to indicate that this rule requires sanctions for any violation, in any circumstance for any patient. A hospital may be in substantial compliance with the body of regulation, but make an occasional error. This rule does not address how this circumstance will be addressed.

RESPONSE: Licensing requirements and CMS surveys are conducted by the Department of Public Health and Human Services (DPHHS) Quality Assurance Division (QAD). CMS requires Montana Medicaid to impose sanctions on any entity that fails a survey. The department will continue to follow CMS's lead in sanctions for surveys.

DPHHS Surveillance and Utilization Review unit (SURS) has in the past and will continue in the future to conduct periodic post payment audits to determine provider compliance with billing regulations. This will include review of compliance for Rule IV (ARM 37.86.3037).

COMMENT #12: The current regulations that enforce Medicaid rules are sufficient to police and impose remedial action on hospitals and physicians. We request that the department withdraw this proposed regulation (Rule III) (ARM 37.86.3035). In the alternative, the department should explain why the current body of state enforcement and appeals regulations fails to address department concerns.

RESPONSE: The department has decided to keep and enforce this rule. General rules do not cover all situations for provider based entities. Specifically, they do not cover enforcement of the new Passport rule.

COMMENT #13: The department proposes to require a hospital to bill provider based clinic services using revenue code 510 for E&M codes and for most procedural codes. The department then proposes to pay 80% of the ambulatory payment classification (APC) amount rather than the full APC currently paid to a provider based clinic. No payment change is proposed for the physician component of a provider based clinic service. Department staff questions why a hospital based service should be paid more than a community based physician service. At least some services are paid at greater amounts at hospitals than at private physician offices. There are, too, some services, such as certain infusion services, that are paid higher amounts when delivered by a private practice physician as compared to a hospital. This proposed regulation is objectionable for several reasons:

- The department proposes to reduce most payments to hospital provided care but does not correct underpayment circumstances.

- The amount of payment reduction is arbitrary. The result may be payments for some procedures that are lower than amounts paid to community physicians; and

- The policy, modified at the pubic hearing to apply to most procedures, may apply even when those services are not available or typically provided at private physician's offices.

The department revised the proposed rules to require adherence to standard coding procedures provided by a hospital based clinic. This language is an improvement to the original proposal. But there are some procedures that may be billed, at the option of the provider, with Revenue Code 510, or elsewhere. The modified regulation extends that discretion to the hospital. As such, a surgical procedure could be billed using revenue codes other than 510. We recommend that the department specify its coding instruction for Revenue Code 510 requires only those

procedures that are integral to the E&M code itself be reported under Revenue Code 510.

RESPONSE: The proposed modification by the department does not extend the choice of using Revenue Code 510 to the hospital's discretion. All evaluation and management (E&M) codes must map to revenue code 510. Procedure codes must be mapped to the 510 Revenue Code when the service was performed in a provider based clinic setting unless Medicare issued specific instructions to use another code. The department does not intend to change this requirement.

COMMENT #14: While the department is addressing its concern about payment fairness between a community based physician and a provider based service, we are concerned that the department maintain payment equity among hospitals for similar services. By example, we illustrate our concern:

Case 1: Hospital A, Physician B. No provider based clinic in place.

The physician sees a patient at the office and diagnoses the need for an outpatient surgical procedure to be performed at the hospital. The physician claim has the office E&M code with site of service office, plus a surgical procedure, site of service hospital. The physician is paid the full E&M fee, plus a fee for surgery with the amount reduced to reflect no practice expense relative value unit (RVUs) due to the hospital site of service.

The hospital bills the surgical procedure and is paid the full APC.

Case 2: Hospital C, Physician D, Service at a provider based clinic.

The physician sees a patient at the hospital clinic and diagnoses the need for an outpatient surgical procedure also to be performed at the hospital. The physician claim has the hospital clinic E&M code, with site of service hospital, plus a surgical procedure, also with site of service hospital. The physician claim is paid a reduced visit fee, plus a reduced fee for surgery, both to reflect no practice expense RVUs.

The hospital bills the facility component for E&M services plus the surgical procedure and is paid the full APC amount for both services. The APC paid for E&M clinic services is calibrated to reflect that only the technical component of the service is included in the payment.

Under the proposed Medicaid rule, Hospital A receives full payment for the surgery, although there is no facility component for the E&M service. But Hospital C receives a 20% reduction of the surgery and a 20% reduction for the E&M APC. This case shows that a hospital that offers a clinic could be paid less money for surgery than a hospital without a clinic.

The situation becomes more confusing when Hospital C has a patient seen by Physician D in the provider based clinic, but the surgery is performed by a physician

that is not part of the provider based clinic.
In this case, the bill for Physician B is just the E&M code, paid at the reduced amount to show site of service hospital. Physician C bills the surgery, and is paid the fee also reduced by practice expense RVUs. The hospital bills the facility E&M code as provider based service, but bills the surgery as regular outpatient hospital and is paid 100% of the APC.

The department's modified proposal may address these concerns. The regulation should also be amended to provide parity for hospital services that are paid below the amount allowed in private physician offices.

RESPONSE: The department believes that the modified proposal has addressed some of these concerns. It should be noted though that there still is not payment equity between a provider based facility and a nonprovider based facility. The provider based facility is still receiving higher reimbursement than if this service were performed in a nonprovider based setting. Using the examples provided by the commenter (and an actual claim identical to the example submitted by a provider based entity) the department can demonstrate that the provider based entity is receiving a higher reimbursement for the same service than a nonprovider based service or a combination of provider based and nonprovider based. This example is for an impacted ear wax removal:

Case 1: Nonprovider based

Physician services	
99214 Office/outpatient visit est. patient in physician office	$ 66.11
69210 Impacted ear wax removal in outpatient hospital	27.86
Total to physician	$ 93.97
Outpatient Hospital services	
69210 Impacted ear wax removal	$ 29.30
RC 250 pharmacy (bundled)	0.00
RC 270 supplies (bundled)	0.00
Total to hospital	$ 29.30
Total Medicaid allowed to hospital and physician	$123.27

Case 2: Current payment for provider based services

Physician services	
99214 Office/outpatient visit est. patient in outpatient	$ 48.92
69210 Impacted ear wax removal in outpatient hospital	27.86
Total to physician	$ 76.78
Outpatient Hospital services	
99214 Office/outpatient visit est. patient in outpatient	$ 70.34
69210 Impacted ear wax removal	29.30

RC 250 pharmacy (bundled)	0.00
RC 270 supplies (bundled)	0.00
Total to hospital	$ 99.64
Total Medicaid allowed to provider based entity	$176.42

Case 3: Proposed payment for provider based services

Physician services	
99214 Office/outpatient visit est. patient in outpatient	$ 48.92
69210 Impacted ear wax removal in outpatient hospital	27.86
Total to physician	$ 76.78
Outpatient Hospital services	
99214 Office/outpatient visit est. patient in outpatient	$ 56.27
69210 Impacted ear wax removal	23.44
RC 250 pharmacy (bundled)	0.00
RC 270 supplies (bundled)	0.00
Total to hospital	$ 79.71
Total Medicaid allowed to provider based entity	$156.49

The department believes that requiring Passport participation of provider based entities would help balance out this inequity between provider based reimbursement and nonprovider based reimbursement.

The Outpatient Prospective Payment System (OPPS) is not designed to be equitable to individual departments within a facility. Some departments will receive higher reimbursement and some less depending upon the services offered. Overall, all provider based entities are receiving higher reimbursement from Montana Medicaid.

COMMENT #15: At ARM 37.86.3001(16) the department includes the term professional providers in the definition of a provider based entity as in 42 CFR 413.65. The federal differs from the state by using the term personnel rather than professional provider. The department should amend its rule to be consistent with federal wording.

RESPONSE: The federal term of "personnel" does not meet the department's needs. The department is adding a definition of professional to ARM 37.86.3001(19). For purposes of provider based entity billing, a professional is a physician, podiatrist, mid-level practitioner, licensed clinical social worker, licensed professional counselor, or a licensed psychologist. The department will add this definition to ARM 37.86.3001(19).

COMMENT #16: We oppose adoption of Rule II(2) (ARM 37.86.3033). The provider based entity status is granted to the facility. Yet this proposed regulation

also imposes regulations on the physician or mid-level practitioner. At best this requirement seems misplaced. At worst, the regulation may be tantamount to tortuous interference with a hospital's provider contract arrangements.

The state interferes with a hospital's relationship with the physician by requiring the physician to enter into a separate contract with Medicaid that imposes requirements on their practice that extend beyond their relationship with the hospital. An independent right to contract with the department does not exist in the case of an employed physician. In such cases, the hospital would be the contractor.

RESPONSE: The department disagrees. The requirement that physicians treating Medicaid clients be enrolled Medicaid providers does not interfere with a hospital's right to contract with physicians who are not enrolled. Participation as a Medicaid provider is optional, but a physician who wishes to receive Medicaid reimbursement must be enrolled and abide by Medicaid rules and requirements. Similarly, a provider based entity wishing to receive Medicaid facility reimbursement, which is greater than free standing clinic reimbursement, must be enrolled and abide by Medicaid rules. The rule simply means an enrolled provider based entity may not bill Medicaid for facility reimbursement for a Medicaid client who is treated there by a physician who is not an enrolled Medicaid provider.

COMMENT #17: The department has not provided any quantitative evidence, during this rulemaking process or in the past as part of our participation, that there is a Passport or overall Medicaid access issue, either for primary or specialty care in our state and specifically, in our service area. The department, in this proposed rule, is further stipulating that primary care providers must meet a Passport caseload of 100 per provider, if they are part of a provider based entity. Department staff has verbally stated that this caseload threshold is current rule and/or practice. We have reviewed the Passport to Health Provider Handbook and our recent Agreement for Participation as a Primary Care Provider in the Montana Medicaid Passport to Health and Team Care programs and do not find this threshold of 100 per provider. Instead, we note the options of signing up as a Passport provider as a solo provider or group provider with a case load range of 1 to 1000.

We are very willing to provide, manage, and coordinate care for Medicaid clients. We demonstrated that in the past through our participation in the Medicaid managed care plan.

Going forward, given our size and group practice structure, we would, as well, be willing to work with the department to design a care coordination program for a defined population of Medicaid Passport clients.

We are also concerned that the department may have negative bias toward provider based entities given the additional reimbursement structure. From Medicare inception, the government has recognized that hospital operated sites of care have different cost structures than freestanding facilities. CMS has identified a number of beneficial aspects of the hospital based policy. In addition, CMS believes the policy

promotes enhanced beneficiary access to a wider range of health care services by allowing entities that are sufficiently integrated with the hospital to be treated as part of the hospital for reimbursement purposes. CMS regulations set forth detailed requirements that must be met for an entity to be considered hospital based. Satisfying the hospital based criteria imposes financial burdens. In addition to the CMS policy governing provider based status, there are market forces that motivate an increasing number of physicians in our rural state to choose to become employees of a larger health care organization, and in Montana, that is the local hospital. The number of provider based clinics will grow given this reality. Certainly, patients benefit from reducing the fragmentation of health care delivery.

Given these provider based entities are all part of not-for-profit Montana hospitals and the department has not demonstrated measurable access problems for Passport clients, we would suggest the broader language of "accepting new Medicaid clients at the same rate non-Medicaid clients are accepted" as the contingency for both primary and specialty care providers. In addition to our policy concerns about linking provider based status to Passport access, we must communicate the hardship of this reimbursement reduction. We estimate that financial impact of these cuts to be $311,625/year. Though we have worked over the past several months with the department to adjust the provider based reimbursement methodology, nonetheless, this proposed rule adoption means further erosion of Medicaid's willingness to cover the costs of care.

RESPONSE: The department provided some misinformation regarding the current Passport rule. The current Passport rule has a maximum limit of 1000 (CMS has a maximum limit of 1500 per provider). It does not have a minimum limit. Currently, there is no minimum caseload requirement for participation in the Passport to Health program. We apologize for the confusion.

In a recent survey of Medicaid Passport to Health caseload in Montana's seven major cities done by our Passport to Health enrollment broker it was determined that the physicians and mid-levels in the area served by this provider based entity were providing unlimited access to new Medicaid patients and were in fact carrying more than double the proposed caseload of 100. The department thanks the facilities in this area for their willingness to go above and beyond in providing care and access to Medicaid recipients. Unfortunately the department has identified provider based entities in which access by Medicaid recipients is a problem.

The department does not have a negative bias toward provider based entities and recognizes the beneficial aspects of this type of organization for Medicaid recipients. In fact, Montana Medicaid is currently the only state Medicaid that recognizes and allows for provider based billing. Because we are willing to offer additional reimbursement for this type of entity and because we also recognize the fact that the number of provider based entities will grow, the department must take steps to contain reimbursement within its existing budget. If the department does not reduce, at least in part, the higher reimbursement to these entities it may be forced to make cuts in other areas.

The department agrees with the suggested alternative language and will strike the current wording in Rule II(2)(d) (ARM 37.86.3033) and instead insert "must accept new Medicaid clients at the same rate non-Medicaid clients are accepted". The department's intent is that Medicaid clients have the same access to services as non-Medicaid clients. This proposed change in language accomplishes this goal.

The department welcomes the opportunity to discuss care coordination for Medicaid Passport clients.

COMMENT #18: We agree with the comments made during the November 3, 2006 conference call with providers, that taking money from the hospital fund to reimburse birthing centers is not a good thing. As mentioned in the call, birthing centers are essentially specialty hospitals that cater to the less acute patient. When complications arise, the patient is brought to one of our hospitals. The overall impact of lumping the birthing centers in with hospitals is decreased reimbursement for hospitals. We recommend the department find other sources of funding for birthing centers.

RESPONSE: Medicaid pays for births in a hospital as they occur. There is no hospital fund for births that equates to a set amount of money divided by a number of births in a year. Under current payment methodology, if a woman delivers in hospital A rather than hospital B, hospital A will be reimbursed. While hospital B may suffer a loss of volume or potential funding for deliveries, it would not suffer an actual loss of reimbursement because the birth did not occur at hospital B and they provided no service they could charge for. In other words, they provided no service, and subsequently they were not paid. With the advent of payment for birthing centers, a similar situation occurs. The birthing center provides a delivery service and is paid. While a hospital may lose a potential delivery, they did not perform a service and thus did not experience an actual decrease in funding.

Over the past year, several Montana Medicaid recipients have elected to deliver in a birthing center. Because this was not a Medicaid covered service, the recipient had to cover the cost of the birth herself. By adding coverage for deliveries in birthing centers, the department is not taking money from the hospitals but is deflecting out of pocket reimbursement on behalf of Medicaid recipients. Coverage of a facility fee to birthing centers may reduce potential reimbursement to hospitals but it does not reduce actual reimbursement. Reimbursement to birthing centers will be tracked separately from the hospital budget.

Birthing centers are a new provider type to the department. Therefore, we have limited cost and charge information available. Because the birthing centers do not provide services for difficult births and the array of services are very limited, the department did not wish to reimburse a birthing center at a higher rate than normal newborn deliveries in a hospital setting. The department determined that use of the OPPS payment methodology was the best payment system to use until further cost and charge information can be gathered and analyzed. The payment rate will be the

same for birthing centers as it is for outpatient hospitals but will be less than the payment for inpatient hospital births.

Since they are not hospitals, birthing center deliveries will not be included in the annual October rebase of diagnosis related groups (DRGs). If hospitals do end up handling more difficult cases because normal deliveries are done in a birthing center setting, that will be reflected in the casemix calculation when the department rebases its budget.

COMMENT #19: We oppose the inclusion of birthing centers into the hospital rules. Birthing centers do not provide the array of services available at a hospital nor do they incur the costs associated with hospitals. Utilizing the OPPS payment methodology will result in birthing centers being paid a rate which is proportionally higher than hospitals. We would ask that the department consider including birthing centers into the rules for Ambulatory Surgical Centers (ASC) and set payment rates based on this model. By their very nature, they are more similar to ASCs than hospitals and it would seem to make sense to have a payment rate based upon a consistent grouping. This would result in more equitable and even payment distribution to the providers.

RESPONSE: Birthing centers are a new provider type to the department. Therefore, we have no cost information available. Because the birthing centers do not provide services for difficult births and their array of services are very limited, the department did not wish to reimburse a birthing center at a higher rate than normal newborn deliveries in a hospital setting. The ASC payment methodology is not designed for normal newborn deliveries, the OPPS methodology is. The payment rate will be the same for birthing centers as it is for outpatient hospitals but will be less than the payment for inpatient hospital births. The department will gather cost information and will continue to analyze these services.

COMMENT #20: In proposed ARM 37.86.3001(3) the department defines a birthing center as a licensed outpatient center for primary care that is used as an alternative to a homebirth or a hospital birth. We oppose the adoption of this regulation. According to Montana Hospital Association (MHA) COMPdata database for outpatient services only three infants were delivered on an outpatient basis at Montana hospitals. Two of the three births were delivered in emergency rooms.

The department is reducing hospital payments because utilization growth, higher than expected outlier payments, and babies with substantial medical problems are causing hospital payments to grow beyond budgeted amounts. Yet the department proposes to potentially worsen this trend by creating an entirely new Medicaid provider type at the same time it cuts hospital payments.

We also object to the department's plan to use funds budgeted for hospitals to pay for new physician services. The department should either use funds budgeted for physician services for this new service, or delay implementation of the proposal until this plan is approved and funded by the Montana legislature. This proposal has the

appearance of cutting hospital spending to make room for a program expansion.

Physicians who choose to deliver patients in their office should not receive a facility payment in addition to their professional fee. A physician that provides global obstetric services and delivers a baby in the outpatient hospital setting receives no facility payment, nor does the hospital receive any other payment for outpatient care. That is, there is no APC payment for an outpatient delivery provided with a global obstetric service.

RESPONSE: Over the past year, several Montana Medicaid recipients have elected to deliver in a birthing center. Because this was not a Medicaid covered service, the recipient had to cover the cost of the birth herself. By adding coverage for deliveries in birthing centers the department is not taking money from the hospitals (hospitals were not paid for these births in the first place) but is deflecting out of pocket reimbursement on behalf of the recipient.

Because the birthing centers do not provide services for difficult births and the array of services are very limited, the department does not wish to reimburse a birthing center at a higher rate than normal newborn deliveries in a hospital setting. The department determined that use of the OPPS payment methodology was the best payment system to use until further cost and charge information can be gathered and analyzed. There is not an APC for payment of a global service but there is an APC for the delivery. The department has reimbursed both physician and outpatient hospital departments for normal newborn births in the past under the APC payment methodology (most of these were out-of-state).

The payment rate will be the same for birthing centers as it is for outpatient hospitals but will be less than the payment for inpatient hospital births.

Coverage of a facility fee to birthing centers will not reduce reimbursement to hospitals. Reimbursement to birthing centers will be tracked separately from the hospital budget.

COMMENT #21: We recommend that the department require a birthing center to meet national accreditation standards as a condition of participation in the Medicaid program. The current license category cited by the department has no substantive facility, program, or treatment requirements. It is reasonable for the department to require more of a birthing center than merely holding a state operating license.

Since every birthing center is obligated to pre-select only those cases that are predicted to be uncomplicated, the facility should not be paid at the average payment amount allowed for a hospital that provides services to both complicated and uncomplicated services. The department also should recognize that cases that begin care at a birthing center, but that become complicated, will be referred to a hospital emergency room or inpatient unit for additional care. It is fair to predict that hospitals are not anxious to inherit the liability, both financial and professional, for outpatient deliveries that become complicated cases.

The department should require that a bona fide transfer agreement exists between a hospital and a birthing center as a minimum standard for Medicaid provider status. Admitting privilege at a hospital is not a transfer agreement. A transfer agreement should address communication needs, transportation protocols, and whether the case will be handed off to the hospital emergency department (ED) staff or that the birthing center physician intends to provide continuing professional care at the hospital. A hospital should be able to address indemnification for liability for accepting a birthing center's complex cases. For the department to do less is to place the safety of the mother and the baby unnecessarily at risk.

Finally, hospitals are likely to see the case mix intensity for delivery services increase, their outlier case experience worsen, and their average costs increase due to this policy. This policy is incongruent with payment reductions imposed on hospitals for these very problems. The department should be prepared to boost payments for inpatient hospital and out-of-state hospital care.

RESPONSE: DPHHS Health Resources Division (HRD) will recommend to DPHHS Quality Assurance Division (QAD) (who oversees licensing requirements) that they review the rules to determine if they should require compliance with national accreditation standards and should require transfer agreements.

Since they are not hospitals, birthing center deliveries will not be included in the annual October rebase of DRGs. If hospitals do end up handling more difficult cases because normal deliveries are done in a birthing center setting, that will be reflected in the casemix calculation in the rebase. In addition, the department is looking at a DRG alternative payment methodology for 2008 that it anticipates will generate a major reduction in complexity and a major improvement in incentives for neonatal care in Montana. This payment methodology will take into account severity and complexity in its reimbursement structure.

Birthing centers are a new provider type to the department; therefore, we have no cost information available. The department will gather cost information and will continue to analyze these services to determine if this is the best reimbursement option.

COMMENT #22: The department expects that the addition of a new category of specialty provider (birthing centers) will provide savings to the state. As stated in the rationale, the difference between a global obstetric fee and a facility fee is less than the same service delivered as a hospital inpatient. This analysis is inadequate to support the notion that there will be cost savings.

The APC payment method is proposed for the facility payment portion provided to birthing center. The APC for a global obstetric code is zero dollars. The only way for a birthing center to qualify for a facility payment is to provide obstetric care in a fashion that is not billed as a global procedure. The department states that the facility payment for a birthing center will be $3242. If the APC is billed with a global

code the fee is zero. The department should further explain how it calculated the payment amount. Further, a birthing center is also, by definition, a provider based entity. It appears that the department should also reduce the expected payment by 20% of the outpatient APC amount.

RESPONSE: The two birthing facilities in Montana have not received CMS designations as provider based entities, which is a Montana Medicaid requirement for provider based services.

We have recalibrated the estimated savings based on new fee schedules since this proposal was first put forth. Estimates for birthing center reimbursement are based on the following:

Vaginal delivery (Vag Del)	$ 1728
Additional tests billed in office	200
Professional reimbursement	$ 1928
APC for Vag Del w/o complications	$ 986
Diagnostics, lab, newborn assessment	328
Facility reimbursement	$1314

Total estimated birthing center reimbursement was $3242 – this should also include an APC for delivery of the afterbirth which was not included in the original estimate. This amount is $698 which would bring the total to $3940. There is not a separate payment for the newborn as there is in an inpatient setting.

Facility reimbursement for an inpatient birth in Montana is approximately $4394. This is a normal newborn DRG (391) of $723 and a vaginal delivery without complications delivery DRG (373) of $1506. Adding in physician reimbursement of $1928 plus a possible epidural reimbursement of $750 could bring the total inpatient reimbursement to $5144. Compared to an estimated reimbursement of $3940 in a birthing center there could be savings for outpatient births in a birthing center to the department.

COMMENT #23: DPHHS proposed a new rule pertaining to Medicaid which defines birth centers. In the proposal birth centers were defined as "a facility to provide, under the direction of a licensed physician, either diagnosis, treatment, or both to ambulatory patients". Although certified nurse midwives do use physician consultation and collaboration in their practices, advanced practice registered nurses are licensed independent providers in the state of Montana. Free standing birth centers traditionally are owned and operated by certified nurse midwives. A licensed physician is not required to direct such a practice or birth center. We request that the definition delete the phrase under the direction of a licensed physician as this is not part of the definition of a birth center as designated by American Public Health Association Guidelines for Licensing and Regulating Birth Centers.

RESPONSE: The phrase "under the direction of a licensed physician" is not

included in the proposed amendment to ARM 37.86.3001(3) which defines a birthing center. The proposed rule refers to 50-5-101, MCA, which contains this phrase. The department will amend the definition in ARM 37.86.3001(3) to the following:

(3) "Birthing center" means a facility that provides comprehensive obstetrical care for women in which births are planned to occur away from the mother's usual residence following normal, uncomplicated, low risk pregnancy and is either:
(a) a licensed outpatient center for primary care with medical resources as defined at 50-5-101, MCA; or
(b) a private office of a physician or certified nurse mid-wife that is accredited by a national organization as an alternative to a homebirth or a hospital birth.

Change to the Montana Code Annotated will require legislative action. We will refer these comments to the DPHHS Quality Assurance Division's licensing department and suggest that they work with the birthing centers and the Montana Nurses Association in this matter.

COMMENT #24: I am commenting on ARM 37.86.3001 Outpatient Hospital and Birthing Centers. The significant portion of the rule reads as follows:

37.86.3001(3) Birthing center means a licensed out patient center for primary care with medical resources as defined at 50-5-101, MCA that is used as an alternative to home birth or hospital birth.

The consequences of this new definition is to revoke the independent licensure of the certified nurse midwife (CNM) which is clearly outlined in statute and administrative rule. The certified nurse midwife is an independently licensed health care provider who functions within a clearly defined, nationally recognized scope of practice with no statutory requirement for physician supervision in Montana law.

My assumption is that using 50-5-101, MCA as a modifier for birthing centers was an oversight in rule writing, because in essence it applies an inappropriate, non sequitur to the independent, professional, clinical activities of the certified nurse midwife. The modifier reads as follows:

55-5-101(41) "Outpatient center for primary care" means a facility that provides under the direction of a licensed physician, either diagnostic or treatment, or both, to ambulatory patients and that is not an outpatient center for surgical services.

Ultimately, this rule denies the license of a certified midwife to function independently by applying requirements based on building site. This is not appropriate, imposing a layer of restrictions not present in the Nurse Practice Act and subsequent administrative rules.

If as, one solution that was proposed, the reference to 55-5-101, MCA is simply removed the problem would not be solved. By virtue of keeping in the term "out patient center for primary care" the problem remains because section (41) of the

statute still defines the "out patient center for primary care" as a facility that provides (care) under the direction of a licensed physician. All this does actually is obscure the reference a bit and make a researcher look a little harder in statute to find a definition.

The following language was adopted by North Carolina Medicaid in 1994 and may be used at least as a guide for us in meeting our state needs:

Birth Center is "a freestanding health care facility which is not a part of a hospital, or in a hospital, and provides comprehensive obstetrical care to women in which births are planned to occur away from the mother's usual residence following normal, uncomplicated, low risk pregnancy".

I would suggest the following language for ARM 37.86.3001(3):

"Birth center" - means a licensed facility that is not in a hospital or part of a hospital, that provides comprehensive obstetrical care and post delivery care of the newborn, and is used as an alternative to a home birth or hospital birth following an uncomplicated, low risk pregnancy.

RESPONSE: The department has chosen to amend ARM 37.86.3001(3) to read:

(3) "Birthing center" means a facility that provides comprehensive obstetrical care for women in which births are planned to occur away from the mother's usual residence following normal, uncomplicated, low risk pregnancy and is either:
(a) a licensed outpatient center for primary care with medical resources as defined at 50-5-101, MCA; or
(b) a private office of a physician or certified nurse mid-wife that is accredited by a national organization as an alternative to a homebirth or a hospital birth.

We do not wish to insert language which could potentially eliminate coverage of a birthing center that is a distinct part of a hospital.

COMMENT #25: We support the changes proposed for reimbursement of out-of-state inpatient hospital reimbursement and applaud the department for its efforts to contain expenses in this high cost area.

RESPONSE: The department thanks you for your comments and support.

COMMENT #26: We are supportive of the amendment of ARM 37.86.2901 - Inpatient Hospital Services Definitions and the addition of a preferred out-of-state hospital category that includes a requisite contract with the state for the provision of specialized services. We were directly impacted by inpatient and outlier reimbursement reductions due to recent budget variances in the Medicaid inpatient hospital expense category, due in part, to out-of-state neonatal charges and believe these changes are fiscally prudent and equitable.

RESPONSE: The department thanks you for your comments and support.

COMMENT #27: We support the language changes in the emergency department reimbursement rule. We thank the department for listening to our concerns during the past several years regarding the inefficient practice of determining whether an emergency department patient was suffering from an emergency medical condition. While we still have some concerns related to the decrease payment levels for Current Procedural Terminology (CPT) codes 99281 and 99282, we believe that this is a step in the right direction for eliminating a significant administrative burden.

RESPONSE: The department thanks you for your comments and support.

COMMENT #28: At ARM 37.86.3009 the department proposes to eliminate the emergency medical condition list and to pay a single APC rate for low intensity use of hospital emergency rooms (ER). We support this policy change. This proposal is consistent with hospitals' long held view that the problem of overuse of the ED is not corrected by underpaying the very providers who deliver services to Medicaid clients. We continue to pledge assistance to the department to reduce unneeded ER use. We have suggested a variety of educational and other operational strategies to accomplish this task. We understand that the change will boost some hospital and physician payments. The change will also reduce the administrative burden on ER physicians and the hospital staff and improve the relationship between the provider community and state regulators.

RESPONSE: The department thanks you for your comments and support.

COMMENT #29: We support the revisions proposed in ARM 37.86.3009 – Outpatient Hospital Services, Payment Methodology, and Emergency Visit Services. We appreciate the responsiveness of the department to the short comings of the Emergency Diagnosis and Procedure Code List methodology and applaud its elimination.

RESPONSE: The department thanks you for your comments and support.

COMMENT #30: We support the department's proposal to amend the emergency room policy at ARM 37.86.3009. The department proposes to eliminate the payment limits related to the department's list of emergency diagnosis codes.

The policy change will boost the physician payment for some emergency department services. The policy will also reduce the administrative burden on our hospital and medical staff. We support the modified APC payment amounts.

We will continue to work with department staff to reduce unneeded emergency room care.

RESPONSE: The department thanks you for your comments and support.

COMMENT #31: Earlier this fall, despite our opposition during the rulemaking process, we experienced a $726,900/year reduction in our inpatient hospital reimbursement and have recently protested the proposed Department of Revenue rule relating to the hospital utilization fee for inpatient hospital bed days. Should that process keep the fee at current levels, we will experience a $1 million erosion in reimbursement.

The cumulative impact of these Medicaid changes will force our organization to evaluate its ability to continue to offer unlimited access to Medicaid clients in our inpatient, outpatient, physician clinics and long term care settings.

RESPONSE: In both the July and October rule changes, the department determined that without a change to DRG weights and outliers, that we could overpay some services and experience a budget overrun. The department recognizes the fact that these changes may affect some facilities more than others because of the nature of the services they provide. The department is willing to work with facilities to do an analysis of the services being offered to Medicaid recipients upon request.

The utilization fee is not part of this rule and we cannot comment because it is outside the scope of this proposed rule change.

8. These rule amendments and adoptions are to be effective January 1, 2007.

/s/ John Koch
Rule Reviewer

/s/ Joan Miles
Director, Public Health and Human Services

Certified to the Secretary of State December 11, 2006.