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

In the matter of the adoption on New Rules I through III, and the amendment of ARM 37.86.4401, 37.86.4402, 37.86.4406, 37.86.4412, 37.86.4413, and 37.86.4420 pertaining to rural health clinics and federally qualified health centers	)))))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT

TO: All Concerned Persons

1. On August 15, 2019, at 11:00 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 adoption and 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 August 6, 2019, to advise us of the nature of the accommodation that you need. Please contact Gwen Knight, 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 adopted provide as follows:

NEW RULE I RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, REQUIREMENTS FOR CHANGE IN SCOPE OF SERVICE REQUEST (1) An RHC or FQHC experiences a change in scope of service if it has experienced a change in the type, intensity, duration, or amount of an RHC or FQHC service. A change in scope of service may result in an incremental change to the baseline PPS rate.

(2) An RHC or FQHC must apply to the department if it experiences a change in scope of service, even if the change in scope of service will not result in an incremental change to the baseline PPS rate. An RHC or FQHC must follow the procedures in [NEW RULE II and NEW RULE III] to apply for a change in scope of service.

(3) A change in scope of service is limited to the following circumstances, and an RHC or FQHC applying for a change in scope of service must demonstrate at least one of the following:

(a) the addition of a new service not incorporated in the baseline PPS rate or deletion of a service incorporated in the baseline PPS rate;

(b) the addition or deletion of a covered Medicaid RHC or FQHC service under the State Plan;

(c) a change necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

(d) a change in service due to a change in applicable technology or medical practices utilized by the RHC or FQHC not otherwise paid for through state or federal funds;

(e) a change in the types of patients served, including but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care, corresponding to a change in the services provided by the RHC or FQHC;

(f) a change in operating costs attributable to capital expenditures corresponding to a change in the services provided by the RHC or FQHC; or

(g) a change in the provider mix, including, but not limited to:

(i) a transition from mid-level providers to physicians with a corresponding change in the services provided by the RHC or FQHC; or

(ii) the addition or removal of specialty providers with a corresponding change in the services provided by the RHC or FQHC.

(4) An RHC or FQHC must demonstrate how one or more of the circumstances in (3) impacts services provided by the RHC or FQHC and must demonstrate an overall change to the RHC or FQHC. For example, the RHC or FQHC may increase services to a high need population; however, this increase may be offset by growth in the number of lower intensity visits, thereby not warranting an incremental change to the baseline PPS rate.

(5) The following circumstances alone do not constitute a change in scope of service rate adjustment:

(a) a change in ownership, including acquisition by another healthcare entity or RHC or FQHC;

(b) a change in the number of staff furnishing an existing service;

(c) an increase or decrease in administrative staff;

(d) a change in the number of encounters;

(e) a change in the cost of supplies for existing services;

(f) a change in salaries and benefits not directly related to a change in scope of service;

(g) a change in patient type and/or volume without a corresponding change in the services provided;

(h) capital expenditures for losses covered by insurance;

(i) a change in office location or office space;

(j) a change in office hours not directly related to a change in the scope of service as described in (3);

(k) expansion or remodel not directly related to a change in the scope of service as described in (3); or

(l) the addition of a new site or removal of an existing site, which offers the same RHC or FQHC services.

(6) The circumstances in (5) may be factors in demonstrating a change in scope of service as long as the RHC or FQHC also demonstrates one or more of the circumstances in (3).

(7) RHCs or FQHCs that choose to participate in contracted programs to provide services outside of the PPS rate must meet the requirements and adhere to the rules outlined in the applicable contract.

(a) Contracts for services outside of RHC or FQHC services will be reimbursed outside the PPS rate and such services will not be included in calculation of the baseline PPS rate or in a request for change in scope of service. Providers who chose to enter contracted programs and meet all related requirements will receive a separate payment as established in the Montana Medicaid State Plan or Centers for Medicare and Medicaid Services approved waiver.

(b) If an RHC's or FQHC's existing baseline PPS rate includes costs associated with contracted programs, the RHC or FQHC must submit a change in scope of service to remove the contracted services from the baseline PPS rate.

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

NEW RULE II PROSPECTIVE CHANGE IN SCOPE OF SERVICE (1) A prospective change in scope of service is a change the RHC or FQHC plans to implement in the future. An RHC or FQHC may file an application for a prospective change in scope of service and, if approved, may receive a temporary PPS rate, pending final approval of the incremental change to the baseline PPS rate.

(2) An application is deemed timely if the department receives the completed application for a prospective change in scope of service no later than 120 days in advance of the prospective change in scope of service, or otherwise the application is deemed untimely.

(3) An application is completed if it includes the information in (4), and, if applicable, (5).

(4) To apply for a prospective change in scope of service rate adjustment, an RHC or FQHC must submit the following application materials:

(a) a narrative description of each change in scope of service;

(b) the date on which the change in scope of service is scheduled to occur;

(c) a description of each cost center(s) on the cost report that will be affected by the change in scope of service;

(d) the cost report for the fiscal year prior to the year in which the prospective change in scope of service is scheduled to be implemented; and

(e) a projected cost report for the fiscal year in which the change in scope of service is implemented, which considers the change in scope of service. If a projected cost report cannot be completed, the RHC or FQHC must provide sufficient cost and encounter information to establish a temporary rate.

(5) The department may request additional information from the RHC or FQHC. The requested information must be received by the department no later than 30 calendar days from the date of the request to be deemed timely. If the requested

information is not received within that timeframe, the application for a prospective change in scope of service is deemed untimely.

(6) No later than 90 days after receiving a completed application, the department shall:

(a) establish the temporary PPS rate by calculating the RHC's or FQHC's allowable cost of services both with and without the added or removed services; and

(b) notify the RHC or FQHC of the temporary PPS rate.

(7) After the change in scope of service occurs, the RHC or FQHC shall notify the department in writing of the implementation date, even if the change is implemented on the scheduled date.

(8) For timely applications, the effective date of the temporary PPS rate is the date the change in scope of service is implemented.

(9) For untimely applications, the effective date of the temporary PPS rate is the later of:

(a) the date the department receives the RHC's or FQHC's completed application materials in (4) and, if applicable, (5); or

(b) the date the change in scope of service is implemented.

(10) No later than six months after the close of the RHC's or FQHC's fiscal year in which the change in scope of service occurred, the RHC or FQHC must supplement its application by filing with the department the following materials:

(a) a narrative description of each change in scope of service, including how the services were provided both before and after the change;

(b) the date on which the prospective change in scope of service was implemented;

(c) the RHC's or FQHC's as-filed Medicare cost reports for the fiscal year prior to the year in which the change in scope of service occurred and for the fiscal year in which the change in scope of service occurred;

(d) for the FQHCs the Uniform Data System reports for the calendar year prior to the change in scope of service, and the calendar year in which the change in scope of service occurred;

(e) a description of each cost center on the cost report affected by the change in scope of service;

(f) an attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the RHC or FQHC; and

(g) any approved changes in scope of project as defined by the federal Health Resources and Service Administration (HRSA).

(11) The department may request additional information to process the application and must receive the additional information no later than 30 calendar days from the date of the request, or otherwise the application is deemed untimely. The request for additional information will include a notice that failure to submit the materials within the requested 30 calendar days will result in suspension of payments for Medicaid services billed to the department until such time as the supplemental materials are received by the department.

(12) The department must receive the supplemental materials no later than six months after the close of the RHC's or FQHC's fiscal year in which the change in scope of service occurred, or otherwise the application is deemed untimely. Thirty

days prior to the expiration of the six-month deadline, if the department has not yet received the supplemental materials, the department shall send a notice to the RHC or FQHC and inform it that failure to submit the materials in a timely manner will result in suspension of payments for Medicaid services billed to the department until such time as the supplemental materials are received by the department.

(13) No later than 90 days after receiving the supplemental materials, the department shall:

(a) establish the incremental change in the baseline PPS rate by calculating the RHC's or FQHC's allowable costs of services both with and without the added or removed services; and

(b) notify the RHC or FQHC of the incremental change in the baseline PPS rate.

(14) For timely filed supplemental materials, the effective date of the incremental change to the baseline PPS rate is the date the change in scope of service was implemented. If the final PPS rate differs from the temporary PPS rate, the department shall calculate the amount of underpayment or overpayment to the RHC or FQHC and reimburse or recoup the amount from future payments to the RHC or FQHC.

(15) If an RHC or FQHC fails to timely submit supplemental materials, the department shall suspend all payments to the RHC or FQHC for Medicaid services billed to the department until such time as the supplemental materials are received. Once all required supplemental materials are received the effective date of the incremental change to the baseline PPS rate is the date the change in scope of service was implemented.

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

NEW RULE III RETROSPECTIVE CHANGE IN SCOPE OF SERVICE

(1) A retrospective change in scope of service occurs when a change took place in the past and the RHC or FQHC is seeking to adjust its rate based on that change. An approved retrospective change in scope of service request may result in an incremental change to the baseline PPS rate.

(2) An RHC or FQHC may apply for an incremental change to the baseline PPS rate for a retrospective change in scope of service once per calendar year. In order to be deemed timely, the completed application must be received by the department no later than six months after the close of the RHC's or FQHC's fiscal year in which the change in scope of service occurred, or otherwise the application is untimely. A completed application must include the information in (3) and, if applicable, (4).

(3) To apply for an incremental change to the baseline PPS rate for a retrospective change in scope of service, an RHC or FQHC must submit the following application materials:

(a) a narrative description of each change in scope of service, including how services were provided both before and after the change;

(b) the RHC's or FQHC's as-filed Medicare cost reports for the fiscal year prior to the change in scope of service, and the fiscal year in which the change in scope of service occurred;

(c) for FQHCs the Uniform Data System reports for the calendar year prior to the change in scope of service, and the calendar year in which the change in scope of service occurred;

(d) a description of each cost center on the cost report affected by the change in scope of service;

(e) an attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the RHC or FQHC; and

(f) any approved changes in scope of project as defined by the Health Resources and Services Administration (HRSA).

(4) The department may request additional information from the RHC or FQHC. The requested information must be received by the department no later than 30 calendar days from the date of the request, or otherwise the application is deemed untimely.

(5) After receiving a completed application, the department shall calculate the RHC's or FQHC's allowable cost of services both with and without the added or removed services to establish the incremental change to the baseline PPS rate. The department shall notify in writing the RHC or FQHC of the incremental change to the baseline PPS rate within 90 calendar days of receiving the information requested in (3) and (4).

(6) For timely applications, the effective date of the incremental change to the baseline PPS rate is the beginning of the facility's fiscal year following the retrospective change in scope of service. For untimely applications, the effective date of the incremental change to the baseline PPS rate is the date all required information is received by the department.

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

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

37.86.4401 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, DEFINITIONS (1) "Allowable costs" are the costs incurred by an RHC or FQHC, which are reasonable in amount and necessary and proper to the efficient delivery of services. Allowable costs are defined in accordance with reasonable cost principles in 42 CFR Parts 405 and 413.

(2) "Baseline PPS rate" is defined as the PPS rate established in accordance with ARM 37.86.4413(1).

(1) remains the same but is renumbered (3).

~~(2)~~ (4) "Change in the scope of service" means a change that affects the type, intensity, duration, or amount of services provided by an ~~FQHC~~ RHC or ~~RHC~~ FQHC. The change in the scope of service must reasonably be expected to last at least one year. ~~The term includes but is not limited to:~~

~~(a) a change in intensity attributable to changes in the types of patients served, including but not limited to HIV/AIDS, the homeless, elderly, migrant or other chronic diseases, or special populations;~~

~~(b) any changes in services or provider mix provided by an FQHC or RHC or one or their sites;~~

~~(c) changes in operating costs that have occurred during the fiscal year and that are attributable to capital expenditures, including new service facilities or regulatory compliance; and~~

~~(d) any approved changes in scope of project as defined by the Health Resources and Service Administration (HRSA).~~

(3) remains the same but is renumbered (5).

~~(4)~~ (6) "Federally qualified health center (FQHC)" means an entity ~~which is a federally qualified health center~~ as defined in 42 USC 1396d(l)(2)~~(B) 2003 Supp.)~~. ~~For purposes of defining "federally qualified health center" the department adopts and incorporates by reference 42 USC 1396d(l)(2)(B) (2003 Supp.), which is a federal statute defining "federally qualified health center" for purposes of the Medicaid program.~~ A copy of the cited statute is available upon request from the Department of Public Health and Human Services, Health Resources Division, Hospital and Physicians Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(5) "FQHC core services" means the FQHC ambulatory services defined in 42 USC 1396d(l)(2)(A) and described in 42 USC 1395x(aa)(1). For purposes of defining and describing FQHC core services, the department adopts and incorporates by reference 42 USC 1396d(l)(2)(A) and 42 1395x(aa)(1) (2003 Supp.). The cited statutes are federal Medicaid and Medicare statutes defining certain FQHC services for purposes of the Medicaid and Medicare programs. Copies of the cited statutes are available upon request from the Department of Public Health and Human Services, Health Resources Division, Hospital and Physicians Services Bureau, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(6) "FQHC other ambulatory services" means ambulatory FQHC services, other than FQHC core services, that would be covered under the Montana Medicaid program if provided by an individual or entity other than an FQHC in accordance with applicable Medicaid requirements.~~

(7) "FQHC services" ~~means FQHC core services and FQHC other ambulatory services~~ are as defined in 42 USC 1396d(l)(2).

(8) "Health professional" means services furnished by a:

(a) through (d) remain the same.

(e) licensed clinical psychologist (LCP);

(f) licensed clinical social worker (LCSW);

(g) licensed professional counselor (LCPC);

(h) and (i) remain the same.

(9) "Incremental change" means a positive or negative adjustment to a baseline PPS rate.

~~(9)~~ (10) "Independent entity" means ~~a rural health clinic~~ an RHC or an FQHC that is not a provider-based entity.

(11) "Interim PPS rate" is the rate established when an RHC or FQHC initially opens and is set in accordance with ARM 37.86.4413(1) and (2).

~~(10)~~ (12) "Provider" means the entity enrolled in the Montana Medicaid program as ~~a provider of~~ an RHC or FQHC ~~services~~.

(11) and (12) remain the same but are renumbered (13) and (14).

~~(13)~~ (15) "Rural health clinic (RHC)" means ~~a clinic determined by the Secretary of the United States Department of Health and Human Services to meet the rural health clinic conditions of certification specified in 42 CFR, part 491, subpart A~~ an entity as defined in 42 USC 1396d(l)(1).

~~(14) "RHC core services" means the rural health clinic services described in 42 CFR 440.20(b)(1) through (4).~~

~~(15) "RHC other ambulatory services" means other ambulatory services furnished by an RHC as described in 42 CFR 440.20(c).~~

(16) "Rural health clinic (RHC) services" ~~means RHC core services and RHC other ambulatory services~~ are as defined in 42 USC 1396d(l)(1).

(17) "Temporary PPS rate" is the rate established in accordance with [NEW RULE II].

~~(17)~~ (18) "Visit" ~~means a face-to-face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services. For purposes of this subchapter, the terms of ARM 37.86.4402 must be used to determine whether an encounter or series of encounters is one or more visits~~ has the meaning set forth in ARM 37.86.4402.

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

37.86.4402 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, VISITS AND ENCOUNTERS (1) ~~For purposes of this subchapter, a face-to-face encounter between a clinic or center patient and a clinic or center health professional for the purpose of providing RHC or FQHC core or other ambulatory services constitutes a single visit.~~ A visit is a face-to-face encounter between an RHC or FQHC patient and an RHC or FQHC health professional for the purpose of providing RHC or FQHC services. Reimbursement is available for one encounter per day per eligible member unless it is necessary for the member:

(a) to be seen by different health professionals with different specialties; or

(b) to be seen multiple times per day due to unrelated diagnoses.

(2) ~~Encounters that take place on the same day and at a single location constitute a single visit, although the encounters were:~~ Encounters with the same primary diagnosis are not considered separately billable visits, regardless of the health professional providing the service.

~~(a) with more than one clinic or center health professional; or~~

~~(b) multiple encounters with the same clinic or center health professionals.~~

~~(3) Each additional encounter with clinic or center health professionals that takes place on the same day as a medical visit to the same clinic or center constitutes an additional visit if, after the first encounter:~~

~~(a) the patient suffers an additional illness or injury requiring additional diagnosis or treatment;~~

~~(b) the patient has a mental health visit consisting of one or more mental health encounters; or~~

~~(c) the patient has a dental visit consisting of one or more dental encounters.~~

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

37.86.4406 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, SERVICE REQUIREMENTS (1) and (2) remain the same.

(3) RHC or FQHC services are covered by Montana Medicaid when provided in accordance with these rules to a member ~~at the clinic, the member's residence, or other medical facility. RHC services are not covered by Montana Medicaid when provided to a hospital patient~~ in an outpatient setting, including the RHC or FQHC, other medical facility (including a dental office), or a member's place of residence. A member's place of residence may be a nursing facility or other institution.

(4) ~~FQHC services are covered by Montana Medicaid when provided in accordance with these rules to a member in an outpatient setting only, which may include the member's place of residence. The member's place of residence may include a skilled nursing facility or a nursing facility. FQHC services are not covered by Montana Medicaid when provided to a hospital patient.~~ Services provided to a member in a hospital setting are not reimbursed in accordance with these rules.

(5) The Montana Medicaid program will cover and reimburse RHC or FQHC services only if the services are provided in accordance with the same requirements that would apply if the service were provided by an individual or entity other than an RHC or an FQHC, except as specifically provided otherwise in this subchapter. These requirements include but are not limited to the following:

(a) through (e) remain the same.

(f) Reimbursement will be made to RHCs and FQHCs for RHC and FQHC services as provided in ARM 37.86.4412 through 37.86.4414, ~~and~~ 37.86.4420, [NEW RULE I, NEW RULE II, and NEW RULE III], rather than as provided in the rules applicable to the particular category of services. This rule ~~shall not be construed to provide that~~ does not permit reimbursement of services provided by health professionals ~~will be made~~ under ARM 37.86.4412 through 37.86.4414, ~~and~~ 37.86.4420, [NEW RULE I, NEW RULE II, and NEW RULE III] when the services are not provided as an RHC or FQHC service and when the health professional is separately enrolled in and providing services under a particular Medicaid service category, subject to the rules applicable to the particular service category.

~~(6) A provider must notify the department, in writing, of a change in the scope of service offered by the RHC or FQHC to Medicaid members. Upon the request of a provider, the department will determine if the reported change qualifies as a change in the scope of service, and if so, the amount and effective date of any rate change.~~

~~(a) As a condition of approval, the department may require the provider to submit documentation and information necessary to demonstrate compliance with requirements applicable to the category of service. The department may also require information necessary to determine the change in the reimbursement rate~~

~~due to a change in the scope of service including any change in the costs of the service and any change in the number of visits.~~

~~(b) Medicaid coverage and reimbursement of an additional category of service will not be available to a provider unless department approval was requested prior to provision of the services and unless the services comply with all applicable requirements.~~

~~(c) Any increase in the rate of reimbursement due to a change in the scope of service is effective from the date of notification by the provider to the department. Any decrease in the rate of reimbursement due to a change in the scope of service is effective from the date the department was notified by the provider or the date the department determines the change in the scope of services occurred, whichever occurs first.~~

~~(d) The department must complete the determination within 60 days of the written request or within 60 days of receipt of any required documentation and information, whichever is later.~~

(6) A provider must notify the department, in writing, of a change in the scope of service offered by the RHC or FQHC to Medicaid members, in accordance with [NEW RULE I, NEW RULE II, and NEW RULE III].

(7) ~~If clinic or center services are provided in more than one location, each location is independently considered for approval as an RHC or FQHC Medicaid provider, unless prior approval was granted by the department, to operate both locations under one provider number. To be considered for operation under one provider number, both sites must share medical staff, office staff or administrative staff. The provider must notify the department of this change in status as provided in (6).~~ The opening of new or additional service locations absent of a change in scope of service will be assigned the same baseline PPS rate as the primary RHC or FQHC.

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

37.86.4412 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, REIMBURSEMENT (1) through (5) remain the same.

(6) For ~~clinics or centers~~ RHCs or FQHCs that had their initial Medicaid prospective payment system base visit rate calculated in 2001 or starting with the third fiscal year (for "new" ~~clinics or centers~~ RHCs or FQHCs as defined at ARM 37.86.4413), the prospective payment system per-visit rate may be adjusted to take into account any increase or decrease in the scope of service.

~~(a) The department will determine the new rate according to the following formula:~~

$$NR = \frac{(R \times PV) + C}{(PV + CV)}$$

~~(i) "NR" represents the new reimbursement rate adjusted for the increase or decrease in the scope of service;~~

~~(ii) "R" represents the present outpatient prospective payment system (OPPS) Medicaid rate;~~

~~(iii) "PV" represents the present number of total visits which is the total number of visits for the RHC or FQHC during the 12-month time period prior to the change in scope of service;~~

~~(iv) "C" represents the expected change in costs due to the change in scope of service; and~~

~~(v) "CV" represents the expected change in the number of visits due to the change in scope of service.~~

(7) and (8) remain the same.

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

37.86.4413 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, ESTABLISHMENT OF ~~INITIAL~~ INTERIM PAYMENT FOR NEW ~~CLINICS OR CENTERS~~ RHC OR FQHC (1) ~~To determine the initial~~ The interim Medicaid prospective payment system (PPS) base per-visit rate for a newly qualified RHC or FQHC or an FQHC shifting from non-state government operated to privately operated ~~reimbursement~~ shall be equal to 100% of the average PPS ~~prospective payment system rates~~ rate for other RHCs or FQHCs located in the same or adjacent area with a similar caseload. In the event that there is no such RHC or FQHC, payment shall be made in accordance with the methodology provided in (2) ~~through (4)~~.

(2) ~~During the RHC's or FQHC's first two fiscal years, the RHC or FQHC will be reimbursed~~ If there is no RHC or FQHC located in the same or adjacent area with a similar caseload, the interim PPS rate shall be ~~on a per visit basis~~ equal to the RHC's or FQHC's total projected allowable costs divided by the RHC's or FQHC's total projected allowable visits. The provider must submit to the department or its agent an estimate of budgeted costs and visits for the RHC or FQHC for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate. The projected allowable cost and allowable visit information is subject to a reasonableness review by the department.

(3) At the end of the RHC's or FQHC's first two complete fiscal years, the department will establish the facility specific baseline PPS rate. ~~a new per visit rate shall be established that is equal to 100% of the allowable costs of the RHC or FQHC furnishing such services during the RHC's or FQHC's first two fiscal years which are reasonable and related to the cost of furnishing such services. The provider must submit to the department or its agent the costs and visits for the RHC or FQHC for the reporting period in the form and detail required by the department and such other information as the department may require to establish a rate.~~

(4) The department must receive the RHC's or FQHC's as-filed Medicare cost reports for the first two complete fiscal years no later than six months after the end of the RHC's or FQHC's first two complete fiscal years, or otherwise the request is deemed untimely.

(a) The department may request additional information from the RHC or FQHC, and the facility is required to submit the requested information within 30 days of the department's request. If the requested information is not received within that timeframe, the request is deemed untimely. The request for additional information will include a notice that failure to submit the materials within the requested 30 calendar days will result in suspension of payments for Medicaid services billed to the department until such time as the supplemental materials are received by the department.

(b) If the department has not received the materials in (4)(a) thirty days prior to the expiration of the six month deadline, the department shall send a notice to the RHC or FQHC and inform it that failure to submit the materials in a timely manner will result in suspension of payments for Medicaid services billed to the department until such time as the materials are received by the department.

~~(a)~~ (5) ~~The formula for calculating this new base per visit rate is~~ Upon receiving the RHC's or FQHC's as-filed Medicare cost reports and any additional information requested pursuant to (4)(a), the department will establish the RHC's and FQHC's baseline PPS rate by calculating the total allowable cost of RHC or FQHC ~~core and other ambulatory~~ services for the first two complete fiscal years divided by the total allowable visits ~~core and other ambulatory visits~~ for the first two complete fiscal years. ~~This base cost per visit rate~~ The baseline PPS rate may be adjusted to take into account any increase or decrease in the scope of service as provided in ARM 37.86.4412.

~~(b) The department shall reimburse the RHC or FQHC this new base rate retroactive to the effective date of their enrollment as an RHC or FQHC.~~

(6) The department will provide written notification of the calculated baseline PPS rate to the RHC or FQHC within 90 days of receiving all information related to the request.

(7) The department shall reimburse the RHC or FQHC the baseline PPS rate for requests submitted within the timeframe specified in (4)(a) and (b) effective the date of the RHC or FQHC enrollment.

(8) If an RHC or FQHC fails to timely submit the materials in (4)(a), or if applicable (2)(b), the department shall suspend all payments to the RHC or FQHC for Medicaid services billed to the department until such time as the supplemental materials are received. Once all required materials are received the effective date of the baseline PPS rate is the effective date of the RHC or FQHC enrollment.

~~(4)~~ (9) Reimbursement ~~for the third year forward shall be~~ after the baseline PPS rate is only modified through the processes outlined ~~as~~ in ARM 37.86.4406, [NEW RULE I, NEW RULE II, NEW RULE III], and 37.86.4412.

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

37.86.4420 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS, ALTERNATIVE PAYMENT METHODOLOGIES (1) remains the same.

(2) Beginning July 1, 2019, RHC or FQHC providers may elect to be reimbursed under an Alternative Payment Methodology (APM) equal to the per-visit

cost as calculated utilizing the two most recently completed as-filed Medicare cost reports and/or other requested information. Examples include the Uniform Data Systems report, audited financial statements, and Electronic Health Record visit reconciliation.

(a) The APM per-visit rate will not be less than the RHC's or FQHC's existing baseline PPS rate.

(b) RHC or FQHC providers who choose to be reimbursed under the APM, must make the request to the department in writing no later than July 1, 2020.

(c) The department will provide a written notification of the calculated APM per-visit rate to the RHC or FQHC within 90 days of receiving all information related to the request.

(3) The effective date of the APM per-visit rate will be the later of the start of the facility's fiscal year following the most recent submitted Medicare as-filed cost report or July 1, 2019.

(4) If the required information as outlined in (2) is not received prior to July 1, 2020, the option to be reimbursed on the APM is not available.

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

5. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department) administers the Montana Medicaid and non-Medicaid programs to provide healthcare to Montana's qualified low income, elderly, and disabled residents. Medicaid is a public assistance program paid for with state and federal funds appropriated by the legislature to pay health care providers for the covered medical services they deliver to Medicaid members.

These rules propose the following, effective July 1, 2019:

(1) implement an Alternative Payment Methodology, a process that is optional for RHCs and FQHCs to participate;

(2) amend the change in scope of service process;

(3) update the process for assigning a facility's baseline Prospective Payment Rate (PPS); and

(4) update references, definitions, and modify existing rules for clarity.

Alternative Payment Methodology

Some RHC and FQHC providers have incurred costs beyond standard change in scope of service requests and the annual inflationary Medicare Economic Index increases. The proposed Alternative Payment Methodology (APM), within ARM 37.86.4420, is intended to ensure RHC and FQHC PPS rates accurately reflect the cost of the current services they provide. The proposed APM will allow RHC and FQHC providers the option to submit two years of current cost reporting information to establish a per-visit rate derived from current cost. The APM will be available for a year, allowing providers sufficient time to gather and submit required information.

The APM process is not mandatory, as RHCs and FQHCs may choose to participate in the process. Thereafter, any request to change a facility's PPS rate will be in accordance with the proposed change in scopes of service process outlined below:

Change in Scope of Service

Montana Medicaid is proposing three new rules to encompass a newly developed process for requesting an incremental change in the PPS rate due to a change in scope of service. The reasonable necessity for the proposed new rules is to create a streamlined process that will allow the department and RHCs and FQHCs to better manage and navigate the system for establishing an incremental change to the baseline PPS rates. The proposed process:

(1) describes what constitutes a change in scope of service;

(2) categorizes the types of requests a provider may make in requesting an incremental change to the baseline PPS rate;

(3) establishes the information and documentation a provider must submit in requesting an incremental change to a PPS rate due to a change in scope of service; and

(4) establishes timelines for submitting the required information and documentation and consequences for failing to meet certain deadlines.

NEW RULE I

New Rule I provides:

(1) the circumstances that constitute a change in scope of service; and

(2) examples of what is not a change in scope of service.

NEW RULE II

New Rule II is proposed to allow for prospective change in scope of service requests. A prospective change in scope of service is a change an RHC or FQHC intends to implement in the future. This rule provides:

(1) a timeline for submission;

(2) the required information to process the request;

(3) the department's timelines associated with processing a prospective change in scope of service;

(4) a potential temporary PPS rate prior to final approval of the incremental change to the baseline PPS rate; and

(5) the implications of an untimely request.

NEW RULE III

New Rule III is a rule proposed to provide the process for submitting a retrospective change in scope of service request. A retrospective change in scope of service is when a change took place in the past. This rule provides:

(1) a timeline for submission;

(2) the required information to process the request;

(3) the department's timelines associated with processing a retrospective change in scope of service; and

(4) the implications of an untimely request.

New Rules II and III utilize a new process for calculating the incremental change to the baseline PPS rate because of a change in the scope of service. The department proposes to move from using projected budgets to using the provider's actual cost.

In addition, within ARM 37.86.4412 the department proposes to remove the formula for a change in scope of service rate adjustment because the methodology is covered in New Rule I.

Interim and Baseline PPS Rate

The department is proposing to clarify in ARM 37.86.4413(1), how the interim PPS rate for a newly established RHC or FQHC is determined.

Additional rule language is proposed to clarify the necessary financial information to calculate a baseline PPS rate. In addition, the department proposes a timeframe for a facility to submit the necessary information. The department provides definitions of a timely versus an untimely request, and the implications of an untimely request.

The numbering of ARM 37.86.4413 is restructured to incorporate the proposed changes.

Updated References, Definitions, and Modify Existing Rules for Clarity

Throughout ARM Title 37, chapter 86, subchapter 44, the department is updating federal register or Code of Federal Regulation references. In addition to reference updates, the department has clarified some definitions and policies. The below referenced rules are proposed to amend and add definitions, update references, or modify rule language to provide clarity.

ARM 37.86.4401

The proposed amendments to the definitions in ARM 37.86.4401 are intended to clarify the terminology used in the rules relating to RHCs and FQHCs. In addition, the proposed changes are for the following reasons:

(1) Subsections (a) through (d) from ARM 37.86.4401(2) are removed and added to New Rule I.

(2) The definition section of the Social Security Act describing FQHC services is updated to conform to federal law.

(3) The definition and references to other ambulatory services in (6) and (15) are clarified to explain they are services covered under the Medicaid State Plan.

(4) The definition of an RHC is updated to refer to the federal law, 42 USC 1396d(l)(1)(B).

(5) Definitions of interim, temporary, and baseline PPS rate and incremental change were added to further differentiate the various stages or components of an RHC or FQHC PPS rate.

ARM 37.86.4402

The reasonable necessity for the proposed amendments to ARM 37.86.4402 is to clarify what is a reimbursable encounter at an RHC or FQHC and to ensure that the Medicaid program will pay for one encounter per day when multiple encounters relate to the same primary diagnosis. Exceptions are noted in the rule. In addition, "billable" was added to clarify that these rules are specific to Medicaid billable services.

ARM 37.86.4406

The department is proposing to streamline references to service location requirements by combining similar references in (3) and (4). There are not substantive changes proposed, merely how the requirements are stated in the rule. The policy prohibiting reimbursement for services in a hospital setting remains the same. Billing guidance for the facility practitioner providing services in a hospital setting is outlined in the provider manual. New Rules I, II, and III are referenced in this rule, as appropriate in (5)(f). Section (6) has been changed to reflect that the change in scope of services process has been moved to New Rule I.

The department is proposing to add a statement in (7) to remove the ambiguity surrounding the rate for satellite facilities. This section emphasizes satellite facilities receive the same baseline PPS rate. If a change in scope of service occurs, the baseline may be updated and applied to the primary and satellite facilities.

ARM 37.86.4412, 37.86.4413, and 37.86.4420

The proposed amendments to these rules are explained above.

Fiscal Impact

The following table displays the number of providers affected, as well as the fiscal impact to State general and federal funds for State Fiscal Year 2020 based on the proposed amendments.

Federally Qualified Health Centers	State Budget Impact	Federal Budget Impact	Total Budget Impact	Providers Impacted
SFY 2020	$2,457,998	$ 8,896,625	$11,354,623	18

Rural Health Clinics	State Budget Impact	Federal Budget Impact	Total Budget Impact	Providers Impacted
SFY 2020	$2,207,405	$ 6,264,891	$ 8,472,296	53

The department intends these rules to be effective July 1, 2019. The proposed rulemaking is estimated to effect 262,243 Medicaid members.

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: Gwen Knight, 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 23, 2019.

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. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

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

11. 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/ Sheila Hogan
Sheila Hogan, Director
Public Health and Human Services

Certified to the Secretary of State July 16, 2019.