Montana Department of Public Health and Human Services

Montana Healthcare Programs Inpatient Hospital Payment Method as of October 1, 2021

Frequently Asked Questions

Preface

For the information of hospitals and other interested parties, this document provides information on the DRG payment method used by Montana Healthcare Programs for hospital inpatient claims. The payment policy changes described in this document will take effect on October 1, 2021. We invite additional questions, and we welcome suggestions.

Please note that this FAQ document does not supersede applicable laws, regulations, and policies.

A DRG Pricing Calculator is available on the Montana Healthcare Programs website. It is very useful in understanding the payment method and in predicting payment for specific claims. The APR-DRG calculator may be found at https://medicaidprovider.mt.gov/01#186035117-fee-schedules.

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OVERVIEW QUESTIONS

1. In general, how does Montana Healthcare Programs pay for hospital inpatient care?

- Montana Healthcare Programs pays for almost all inpatient hospital stays using a method based on All Patient Refined Diagnosis Related Groups (APR-DRGs). The current approach has been in place since October 1, 2008, with some refinements since then. In moving to payment by APR-DRG, our goals were to implement a DRG grouper that is appropriate for Medicaid, improve incentives, reduce complexity, and reduce reliance on Medicare cost reports.

2. Which providers and services are affected?

- The DRG payment method applies to almost all stays provided by acute care hospitals. This method applies to both general hospitals and specialty hospitals, as well as to specialty distinct-part units of general hospitals. Specialty hospitals include psychiatric, rehabilitation, long-term acute care, and hospitals that specialize in specific surgeries.

- Within these hospitals, the DRG payment method is not used for Medicare crossover stays or for swing-bed (nursing facility) stays. The DRG payment also does not apply to critical access hospitals, Indian Health Service hospitals, or the Montana State Hospital.

3. What are the most important policy changes effective October 1, 2021?

- APR-DRG version. Planned update from V.37 to V.38.

- Cost outlier payment policy. No updates.

- The charge cap will remain in place and continue to calculate at the lesser of the assigned APR-DRG rate or the claim billed charges.

- Payment adjustors. Increase the adult age adjustor to 1.00, increase the mental health age adjustor to 1.65, increase the neonate policy adjustor to 1.50, and add a new obstetric policy adjustor of 1.30.

PAYMENT CALCULATIONS

4. How are payments calculated?

- For over 80% of stays, payment is calculated straightforwardly as the DRG relative weight times the DRG base price, which is known as the Gross DRG Amount. In addition, special payment calculations are made in the following special situations:

    - ***Cost outlier payments.*** For exceptionally expensive cases, a cost outlier payment will be added. The cost of the stay will be estimated by multiplying charges on the claim by the hospital-specific cost-to-charge ratio as calculated by Montana Healthcare Programs. (Statewide CCRs are used for some out-of-state hospitals). The estimated cost minus the Gross DRG Amount equals the hospital's estimated loss on the stay. If the loss exceeds the cost outlier threshold (See DRG Calculator) then the outlier payment equals the difference between the estimated loss and the cost outlier threshold times the marginal cost percentage of 50% to yield the cost outlier payment. This approach is very similar to the Medicare formula, though the numerical values differ.

    - ***Transfer adjustment.*** If the patient is transferred to another acute care setting (discharge statuses 02, 05, 43, 62, 63, 65, 66) then the stay will be checked for applicability of a transfer adjustment. The Gross DRG Amount will be divided by the nationwide average length of stay for that DRG to yield a per diem amount. The per diem amount will be multiplied by the actual length of stay plus one day (to reflect additional hospital costs associated with admission). If the calculated amount is less than the Gross DRG Amount, then the calculated amount will be paid. Otherwise, the Gross DRG Amount will be paid. Unlike Medicare, the Department does not have a post-acute transfer policy.

    - ***Prorated eligibility.*** In situations where the patient has Montana Healthcare Programs eligibility for fewer days than the length of stay, an adjustment will be made. The Gross DRG Amount, plus the cost outlier payment if applicable, will be divided by the nationwide average length of stay for that DRG to yield a per diem amount. The hospital will be paid the per diem amount times the number of days of Medicaid coverage, up to a maximum of the Gross DRG Amount plus the cost outlier payment.

    - ***Interim claims.*** For stays equal to or exceeding 30 days at the same hospital and the hospital receives prior authorization, then the hospital may receive interim payments for interim claims. The interim payment will be a flat per diem rate ($400) times the number of covered days for the claim. When the patient is discharged, the hospital would submit a DPHHS

Individual Adjustment Request for each interim claim, asking that the previous claim be credited in Section 8. The hospital would then submit a single admit-thru-discharge claim for the entire stay with type of bill 111; that claim would then be priced by DRG. If the hospital submits an admit-thru-discharge claim before adjusting the interim claims, the admit-thru-discharge claim will be denied as a duplicate. If the admit-thru-discharge claim is submitted with type of bill 114, the claim will be denied.

- The Individual Adjustment Request Form is available at https://medicaidprovider.mt.gov/forms#240933497-forms-g--l.
- Montana Healthcare Programs does not accept electronic adjustments (e.g., institutional bill types 117 for replacements or 118 for voids).
- The availability of interim payments, which is unusual among DRG payers, is intended to promote access to care for patients whose care requires exceptionally long lengths of stay. Submission of interim claims is optional; the hospital can choose to wait and submit a single claim after discharge.

- ***Hospital residents.*** In rare circumstances, a patient may be in a hospital for more than 180 days. Payment for the first 180 days would be by DRG, with cost outlier payments as applicable. Payment for days exceeding 180 days would be 80% of estimated cost, which would be calculated as charges times the hospital-specific cost-to-charge ratio. In order to be eligible for the special hospital resident payment provision, the hospital must obtain prior approval from DPHHS and meet hospital residency status requirements in accordance with the Administrative Rule of Montana (ARM) 37.86.2921. The DRG requirements can be found at https://rules.mt.gov.

5. What is the DRG base price and how is it updated?

- The base price is reviewed each year, with changes subject to the public notice requirements of the Administrative Rules of Montana.
- Effective October 1, 2021, the DRG base price will be set at:
  - $5,365 for Montana Hospitals, Border Hospitals, and most Out-of-State Hospitals.
  - $7,995 for Centers of Excellence, which are out-of-state hospitals that provide specialized services unavailable within Montana.
  - $7,250 for Long Term Acute Care (LTAC) Hospitals.

6. Do DRG payments include Disproportionate-Share Hospital (DSH) Payments and Medical Education Payments?

- No. Most DSH payments are made separately from the claim payments for specific stays.
- The Graduate Medical Education payment is a supplemental payment made to eligible hospitals.

ALL PATIENT REFINED DRGS

7. Why does Montana Healthcare Programs use APR-DRGs and not Medicare DRGs?

- APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially regarding neonatal and pediatric care. They incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.
- Each stay is assigned first to one of 330 base APR-DRGs. Then, each stay is assigned to one of four levels of severity (minor, moderate, major, or extreme) that are specific to the base APR-DRG.
- APR-DRGs have become an accepted standard in inpatient hospital payments and are used in over 20 states for Medicaid reimbursement.
- MS-DRGs—The algorithm now used by Medicare—were designed only for a Medicare population using only Medicare claims. In the Medicare program, fewer than 4% of stays are for obstetrics, pediatrics, and newborn care. In the Montana Healthcare Programs, these categories represent 70% of stays.

8. In order to be paid, does my hospital need to buy APR-DRG software?

- No. The Medicaid claims processing system will assign the DRG and calculate payment without any need for the hospital to put the DRG on the claim.
- For hospitals interested in learning more about APR-DRGs, information is available from 3M at https://multimedia.3m.com/mws/media/910941O/3m-apr-drg-ebook.pdf.

9. What version of APR-DRGs will be implemented?

- For all stays with an admit date on or after October 1, 2021, Montana Healthcare Programs will use APR-DRG V.38.

10. How has the implementation of ICD-10 diagnosis and procedure codes affected APR-DRG grouping?

- Effective October 1, 2015, all U.S. hospitals must submit claims with ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes. The Montana Healthcare Programs claims processing system currently passes ICD-10 codes directly into V.37 of the APR-DRG grouping software. Version 38 of the APR-DRG grouper, planned for implementation on October 1, 2021, will also use native ICD-10 codes for grouping.

CODING AND BILLING

11. Does the Department require submission of the present on admission (POA) indicator?

- Yes. All hospitals must indicate whether the principal diagnosis and each secondary diagnosis was present on admission for inpatient stays. The POA indicator must be reported in accordance with Medicare guidelines. Medicare reporting guidelines for the POA indicator are on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Reporting.html

- If a valid POA indicator is not reported, the claim will be denied.

12. What stays must have prior authorization?

- The following inpatient stays require prior authorization:
    - All transplant stays defined by the APR-DRG, ICD-10-CM diagnosis codes, and/or ICD-10-CM procedure codes;
    - All interim claims if the hospital is seeking interim payment (applies only to stays exceeding 29 days);
    - All stays exceeding 180 days if the hospital is seeking hospital resident payment;
    - All stays in out-of-state hospitals. This requirement does not apply to hospitals recognized by the Department as a border hospital (that is, within 100 miles of the Montana state line); and
    - Any specific ICD-10-CM diagnosis or procedure codes that currently require prior authorization.

13. Are outpatient services related to the inpatient stay bundled?

- Yes. A "related" service is defined as any outpatient service provided by the admitting hospital, or by another provider under arrangement with the admitting hospital, that is provided on the same calendar day as the admission or on the calendar day before the admission. This definition is intended to strike the appropriate balance between simplicity and precision in defining related outpatient services.

- In the rare circumstance that a hospital provides emergency department services that are unambiguously unrelated to the admission, the hospital may appeal to the Department for separate payment of the ED services.

14. How do the recent policy changes on early elective deliveries and long- acting reversible contraceptives affect DRG payment?

- Effective January 1, 2015, Montana Healthcare Programs allows separate payment for long-acting reversible contraceptive devices that are inserted immediately post-partum. The hospital submits an outpatient claim (bill type 131) for approved CPT and HCPCS codes and receives separate payment. For more information, see the Montana Healthcare Programs Notice dated January 9, 2014.

- Effective October 1, 2014, Montana Healthcare Programs reduces payment for induction of labor before 39 weeks that is not medically necessary and for cesarean deliveries at any gestational age that are not medically necessary. For more information, see the Montana Healthcare Programs Notice dated June 24, 2014.

OTHER QUESTIONS

15. Are hospitals required to submit cost reports?

- Yes. The Department uses cost reports to calculate hospital utilization fees and in reviewing hospital payments overall.

16. Are payments subject to adjustment after cost reports have been submitted?

- No. Payment based on DRG is final.

17. Where can I find more information?

- *Montana Healthcare Programs Website*. The DRG Pricing Calculator, updates of this FAQ and other documents are posted to Montana Healthcare Programs website at https://medicaidprovider.mt.gov/01.

- *Montana Healthcare Programs Claim Jumper.* Check our monthly provider relations newsletter for updates. The Claim Jumper is available on the website at https://medicaidprovider.mt.gov/cjnewsletters.

- *Questions about specific claims, prior authorizations, etc.* Call Montana Healthcare Programs Provider Relations at (800) 624-3958.

- *Questions about Department policy.* Jessica Coe, Hospital Program Officer, Montana Department of Public Health and Human Services, Jessica.Coe@mt.gov or (406) 444-4834. Hospitals are reminded to never send patient information by email.

- *Technical questions about APR-DRGs , outliers, etc.* Renee Quintana, Supervisor, Operations Research Section, Montana Department of Public Health and Human Services, Renee.Quintana@mt.gov or (406) 444-3675.