

## ***Montana Medicaid Inpatient Hospital Payment Method as of July 1, 2014***

*For the information of hospitals and other interested parties, this document provides information on the DRG payment method used by Montana Medicaid for hospital inpatient claims. Specific details apply to the fiscal year starting July 1, 2014. We invite additional questions and we welcome suggestions. Please note that this FAQ document does not supersede applicable laws, regulations, and policies.*

### **OVERVIEW QUESTIONS**

#### **1. In general, how does Montana Medicaid pay for hospital inpatient care?**

Montana Medicaid pays for almost all inpatient hospital 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, reduce complexity, improve incentives, and reduce reliance on Medicare cost reports.

#### **2. What 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, 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, and the Montana State Hospital.

#### **3. How much money is affected?**

Montana Medicaid pays hospitals approximately \$90 million a year for inpatient care, excluding Medicare crossover stays, supplementary disproportionate share payments, and payments to critical access hospitals.

## PAYMENT CALCULATIONS

### 4. How are payments calculated?

For over 90% 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

- **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 will not have a post-acute transfer policy.
- **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 Medicaid. (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 (\$50,000 as of July 1, 2014) then the outlier payment equals the difference between the estimated loss and the cost outlier threshold times the marginal cost percentage of 60% to yield the cost outlier payment. This approach is very similar to the Medicare formula, though the numerical values differ.
- **Prorated eligibility.** In situations where the patient has Medicaid 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** If a stay exceeds 29 days 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 is available at <http://medicaidprovider.hhs.mt.gov/providerpages/forms.shtml>. Montana Medicaid does not accept electronic adjustments (e.g., institutional type of bill 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 the following hospital residency status requirements in accordance with the Administrative Rule of Montana (ARM) 37.86.2921:

- (1) A recipient who is unable to be cared for in a setting other than the acute care hospital is eligible for hospital residency status.
- (2) To obtain hospital residency status, the recipient must meet the following requirements:
  - (a) the recipient must utilize a ventilator for a continuous period of not less than eight hours in a 24-hour period or require at least 10 hours of direct nursing care in a 24-hour period; and
  - (b) the recipient must have been an inpatient in an inpatient hospital for a minimum of six continuous months.
- (3) The provider will have the responsibility of determining whether services could be provided in a skilled nursing care facility or by the home and community based waiver program to a Medicaid recipient within the state of Montana.
- (4) The provider shall maintain written records of inquiries and responses about the present and future availability of openings in nursing homes and the home and community based waiver program.
- (5) A redetermination of nursing home or waiver availability must be made at least every six months.

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

Effective July 1, 2014, the DRG base price will be set at:

- \$5,175 for Montana hospitals, border hospitals, and most out-of-state hospitals
- \$8,095 for centers of excellence, which are out-of-state hospitals that provide specialized services unavailable within Montana

The base price is reviewed each year, with changes subject to the public notice requirements of the Administrative Rules of Montana.

## **6. Are there separate payments for capital?**

No. These payments were folded into the DRG base price as of October 1, 2008.

## **7. 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 particular stays. About \$2 million in DSH payments are made on the claim, but the calculations are unrelated to the DRG payments.

Payments related to medical education are made separately from the claims payments.

## **ALL PATIENT REFINED DRGS**

### **8. Why does Montana Medicaid use APR-DRGs and not Medicare DRGs?**

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal and pediatric care, and because 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 314 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.

MS-DRGs—the algorithm now used by Medicare—were designed only for a Medicare population using only Medicare claims. In the Medicare program, less than 4% of stays are for obstetrics, pediatrics, and newborn care. In the Montana Medicaid program, these categories represent 70% of stays.

### **9. Who developed APR-DRGs? Who uses them?**

APR-DRGs were developed by 3M Health Information Systems and the Children's Hospital Association (formerly NACHRI). Many Medicaid programs use APR-DRGs, including California, Florida, Mississippi, New York, Pennsylvania, Rhode Island, South Carolina and Texas.

### **10. What was done to verify that APR-DRGs are appropriate for the Montana Medicaid population?**

Xerox State Healthcare, LLC conducted a feasibility study of alternative DRG algorithms. Using the statistical tests that are standard in payment method development, the contractor found that APR-DRGs consistently fit the Montana data better than Medicare DRGs. Results from the study were published in the January/February 2008 issue of *Health Affairs*.

The results for the Montana Medicaid population were similar to those found in an evaluation of national data that focused on neonatal care. That evaluation, published in the journal *Pediatrics*, is available at no charge from [http://pediatrics.aappublications.org/content/103/Supplement\\_E1/302.full.html](http://pediatrics.aappublications.org/content/103/Supplement_E1/302.full.html).

### **11. 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 [http://solutions.3m.com/3MContentRetrievalAPI/BlobServlet?lmd=1225920498000&assetId=1180606514429&assetType=MMM\\_Image&blobAttribute=ImageFile](http://solutions.3m.com/3MContentRetrievalAPI/BlobServlet?lmd=1225920498000&assetId=1180606514429&assetType=MMM_Image&blobAttribute=ImageFile).

### **12. What version of APR-DRGs will be implemented?**

Effective July 1, 2014, Montana Medicaid uses APR-DRG V.31.

## **CODING AND BILLING**

### **13. How does the use of a DRG payment method affect hospital coding and billing?**

Assignment of the APR-DRG and calculation of payment uses the standard information already on the hospital claim. APR-DRG assignment depends chiefly on the diagnosis fields and the ICD-9-CM procedure fields, so hospitals are advised to ensure that these fields are coded completely, accurately and defensibly.

### **14. How many diagnoses and procedures are used in DRG assignment?**

Montana Medicaid claims processing system uses the principal ICD-9-CM diagnosis, up to 24 other ICD-9-CM diagnoses, the principal ICD-9-CM procedure, and up to 24 other ICD-9-CM procedures.

### **15. Does the Department require submission of the present on admission (POA) indicator?**

Yes. Effective October 1, 2008, all hospitals must indicate whether or not 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 can be located on the CMS web site from <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf>.

If a valid Present on Admission (POA) indicator is not reported, the claim will be denied.

### **16. What stays must have prior authorization?**

Effective October 1, 2008, the following inpatient stays require prior authorization:

- All mental health stays, defined by APR-DRG. (For mental health stays, APR-DRG is almost always driven by the principal diagnosis code submitted by the hospital.)
- All transplant stays, defined by the APR-DRG, ICD-9-CM diagnosis codes, and/or ICD-9-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).
- Any specific ICD-9-CM diagnosis or procedure codes that currently require prior authorization.

### **17. 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.

## **OTHER QUESTIONS**

### **18. Are hospitals required to submit cost reports?**

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

### **19. Are payments subject to adjustment after cost reports have been submitted?**

No. Payment based on DRG is final.

### **20. Where can I find more information?**

- **Montana Medicaid website.** Updates of this FAQ and other documents are posted to the Montana Medicaid website at <http://medicaidprovider.hhs.mt.gov/providerpages/providertype/01.shtml>. The DRG Pricing Calculator is also available.
- **Montana Medicaid Claim Jumper.** Check our monthly provider relations newsletter for updates. It is mailed to all providers and is also available on the website.
- **Questions about specific claims, prior authorizations, etc.** Montana Medicaid Provider Relations, 800.624.3958.
- **Questions about Department policy.** Don Holmlund, Hospital Program Officer, Montana Department of Health and Human Services, [dholmlund2@mt.gov](mailto:dholmlund2@mt.gov), 406.444.0061. Hospitals are reminded to never send patient information by email.
- **Technical questions about APR-DRGs, outliers, etc.** Kevin Quinn, Vice President, Payment Method Development, Xerox State Healthcare, [kevin.quinn@xerox.com](mailto:kevin.quinn@xerox.com), 406.457.9550.