HOUSE BILL 2 INPATIENT NON-CRITICAL ACCESS HOSPITAL RATE CONTINGENCY

JULY 31, 2023

OVERVIEW

HB 2 from the 68th Montana Regular Legislative Session appropriated an approximate 4.0% provider rate increase for inpatient non-critical access hospitals (CAH). The appropriated increase is contingent upon the Department of Public Health Human Services (DPHHS) completing an evaluation of the Upper Payment Limit (UPL) payment methodology. The evaluation shall include at a minimum:

- how Medicaid rate increases impact the UPL,
- the integrity of the cost-to-charge ratio (CCR) calculation,
- allowable reportable hospital costs, and
- Alternative Upper Payment Limit calculation methods.

In addition to the evaluation, DPHHS shall require hospitals to report annually on how the UPL payments impact efficiency, economy, quality of care, and access. The HB 2 contingency language indicates that the DPHHS may assess graduated penalties to hospitals with high outlier cost-to-charge ratios.[1]

EVALUATION OF THE UPPER PAYMENT LIMIT PAYMENT METHODOLOGY

Supplemental payments when aggregated with total Medicaid payments cannot exceed the UPL. 42 CFR 447.321[2] defines UPL as "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles...". The DPHHS validates compliance with 42 CFR 447.321 through submission of an annual UPL demonstration. While CMS requires submission of the UPL demonstration by June 30th of every year, the DPHHS performs the UPL gap calculation prior to distributing the hospital supplemental payments.[3] The UPL gap calculation confirms that the difference between the UPL and Total Medicaid Payments is greater than zero.

UPL Gap Calculation	
Upper Payment Limit	= Medicaid Charges * Medicare CCR
Total Medicaid Payments	= Medicaid Claims Payments + HRA Payments[4] + GME Payments[5]
UPL Gap	= Upper Payment Limit – Total Medicaid Payments

[1] HB 2, 68th Legislature, 2023 Regular Session, and Section B of the HB 2 Narrative 2025 Biennium

[2] § 447.321 Outpatient hospital and clinic services: Application of upper payment limits.

[3] 53-6-149, MCA requires that the DPHHS distribute the inpatient and outpatient supplemental payments no later than May 5th of each year.

[4] ARM 37.86.2928 Inpatient Hospital Reimbursement, Hospital Reimbursement Adjustor The Hospital Reimbursement Adjustor (HRA) payments are two of the supplemental payments related to the inpatient hospital utilization fee.

[5] ARM 37.86.2950 Graduate Medical Education Payment Program The Graduate Medical Education (GME) payments are supplemental based to partially fund primary care and psychiatry residency programs for eligible hospitals in Montana. The revenue is generated through a transfer of funds from the Montana University System.

HOW MEDICAID RATE INCREASE IMPACT THE UPL

Provider rate increases are intended to increase Medicaid Claims Payments. If we assume all other variables from the UPL Gap Calculation remain constant, we will find that provider rate increases result in a decrease in the UPL gap. It is important to note that Medicaid provider rates are one variable in the UPL gap calculation and the actual impact of a provider rate increase on the UPL gap calculation may not result in a decrease in the UPL gap.

THE INTEGRITY OF THE COST-TO-CHARGE RATIO CALCULATION

The Inpatient Hospital Narrative Instructions[6] published by the Centers for Medicare and Medicaid Services (CMS), provides guidance on the acceptable source of UPL equivalent Medicare data that states are to use in the calculation of hospital CCRs. The DPHHS uses worksheet D-1 of the as-filed CMS 2552-10 [7]hospital cost reports to calculate the CCRs. Cost reporting periods can vary from facility to facility as the annual cost reports cover 12-months based upon the provider's accounting year. When the dates of the cost reports do not align with the dates of the UPL demonstration period CMS allows the DPHHS to use trend factors applied from mid-point to mid-point to align the cost report data with Medicaid paid claims.

Every two years, the DPHHS Legislative Audit Division audits the previous two year's UPL demonstrations and the calculations of the CCRs. The most recent audit was performed in quarter four of 2021 and required no changes to the established process.

During the Public Health Emergency, CMS extended deadlines of facility cost reporting, therefore, the SFY 2021 through SFY 2022 annual UPL demonstrations included CCRs that were trended from SFY 2020. The SFY 2023 UPL demonstrations contain CCRs from cost reports appropriately aligning with the Medicaid claims data for all Montana providers.

ALLOWABLE REPORTABLE HOSPITAL COSTS

The allowable reportable hospital costs reported by the hospitals in the Hospital and Hospital Health Care Complex Cost Report or CMS-2552-10 form are governed and audited by CMS. For the annual UPL demonstration the DPHHS uses specific worksheets and lines from the hospital specific as filed cost reports. The DPHHS matches Medicaid charges to the individual cost centers on the Medicare cost report lines. Only allowable cost for inpatient routine and ancillary services from worksheet D-1 are used in the CCR calculations.

ALTERNATIVE UPPER PAYMENT LIMIT CALCULATION METHODS

CMS has four accepted UPL calculation methods. They have also created and released an excel template which states are required to populate, submit, and certify the information to be complete and meet all the Upper Payment Limit Demonstration federal laws and regulations. The four calculation methods are as follows:

1. Inpatient (IP) Cost for cost-based demonstrations (e.g., cost-to-charge ratio x Medicaid covered IP charges),
2. IP Payment for payment-based demonstrations (e.g., payment-to-charge ratio x Medicaid covered IP charges),

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[6] Inpatient Hospital Narrative Instructions

[7] CMS Form Number CMS-2552-10 was most recently published on June 22, 2022.

3. IP Diagnosis-Related Group – Medicare Diagnosis-Related Group based demonstrations (acuity adjusted price-based demonstration), and
4. IP Per Diem for alternative methodologies (e.g., cost per diem or payment per diem).

The DPHHS was advised by Myers and Stauffer, an independent consultant, to follow the IP Cost for cost-based demonstration. During the evaluation of the UPL payment methodology the DPHHS considered other methods, however the CAHs are reimbursed by Medicaid using a cost-based payment method. CAHs are cost settled at 101% of cost. The non-cost based UPL methods would not be appropriate for the Critical Access Hospitals. The other UPL methodologies do have potential for the inpatient non-critical access hospitals. CMS does allow states to apply different UPL formulas for state government owned or operated facilities, non-state government owned or operated facilities and private facilities; however, the formula should be consistently applied to each provider within each category. All Montana inpatient hospitals and CAHs are privately owned, therefore the only appropriate UPL demonstration calculation method is the IP Cost for cost-based demonstration, the demonstration currently used by the DPHHS.

The IP Cost for cost-based demonstration is appropriate for the inpatient non-critical access hospitals due to the similar claim reimbursement methodologies between Medicaid and Medicare. Montana Medicaid follows the All Patient Refined - Diagnosis-Related Group payment methodology for inpatient non-critical access hospitals which is consistent with the current Medicare Severity - Diagnosis-Related Group payment methodology that Medicare follows. They are similar in that payments are based on patient acuity not length of stay, there is one payment per hospital stay, and each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in a particular DRG category. Therefore, converting Medicaid charges using CCRs calculated from specific Medicare cost centers from the facility specific Medicare cost report is an adequate method for calculating the Upper Payment Limit.

HOSPITAL REQUIRED EVIDENCE OF EFFICIENCY, ECONOMY, QUALITY OF CARE, AND ACCESS

The DPHHS is implementing a new annual process for hospitals to submit evidence in writing of the efficiency, economy, quality of care and access to health care the hospital supplemental payments provide for the people of Montana. The annual attestations from the hospitals will need to be received by the DPHHS for the previous year's cycle of supplemental payments beginning March 31, 2024.

ASSESSMENT OF GRADUATED PENALTIES TO HOSPITALS WITH HIGH OUTLIER COST-TO-CHARGE RATIOS

The DPHHS is discussing a strategy for assessing graduated penalties to hospitals with high outlier cost-to-charge ratios. The closer a CCR is to 1, the smaller the difference between the hospitals' charges and the total expenses incurred, and a ratio closer to 0 indicates a higher markup of costs. Providers with CCRs greater than 1 indicate their costs incurred were greater than the charges. Historically, providers with CCRs greater than 1 have been small rural CAHs where supplemental payments are essential, and penalties would be detrimental.