Medi-Cal DRG Payment One Year Later
HFMA Southern California and San Diego/Imperial Chapters’ Fall Conference

September 8, 2014 W410
Our Discussion Today

1. DRG background
2. Year 1 actual
3. Year 2 update
4. Looking forward

Appendix: DRG basics
DRG Background

DRG Policy Change

• **Timeline:**
  - Authorized by Senate Bill 853 in October 2010
  - 2011-2012: Policy development and consultation with hospitals
  - 2012-2013: Systems implementation and provider training
  - July 1, 2013: DRG Year 1 (first year of transition)*
  - January 1, 2014: NDPHs implemented
  - July 1, 2014: DRG Year 2 (second year of transition)
  - July 1, 2015: DRG Year 3 (third year of transition)
  - July 1, 2016: DRG Year 4 (statewide rates fully implemented)

• **Programs:** Medi-Cal fee-for-service, CCS only, GHPP only

• **Hospitals:** General acute care hospitals, including out-of-state, Medicare-designated CAH, Medicare-designated LTAC

• **Excluded Hospitals:** designated public hospitals, psychiatric hospitals (county)

• **Excluded Services:** rehabilitation (per diem), admin days (per diem), psych (counties)

*Refers to the year of transition for the implementation of the Diagnosis-Related Group (DRG) system.
DRG Background

Principles of DRG Payment

- **Value purchasing:** DRGs define “the product of a hospital,” enabling greater understanding of the services provided and purchased
  - DRGs reward better diagnosis and procedure coding, which should be complete, accurate and defensible
- **Fairness:** Moving toward statewide base rates with outlier policy for expensive patients
- **Efficiency:** Because payment does not depend on hospital-specific costs or charges, hospitals are rewarded for improving efficiency, such as reductions in lengths of stay
- **Access:** Higher DRG payment for sicker patients encourages access to care across the full range of patient conditions
  - Non-contract hospitals in closed areas may increase Medi-Cal volume
- **Transparency:** Payment methods and calculations on the Internet
- **Administrative ease:** Day-by-day TAR no longer required (except some limited-benefit beneficiaries)
- **Quality:** Sets foundation for improvement of outcomes
DRG Background

How States Pay for Inpatient Care

How Medicaid Pays for Hospital Inpatient Care

As of July 2014

<table>
<thead>
<tr>
<th>Per Stay -- CMS-DRGs</th>
<th>Per Stay -- AP or Tricare DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL*, KY**, MN, UT, VT, WV**</td>
<td>DC*, GA, IN, NE*, NJ, VA*, WA*</td>
</tr>
<tr>
<td>*Moving to APR-DRGs</td>
<td>*Moving to MS-DRGs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Stay -- MS-DRGs</th>
<th>Per Stay -- Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA, KS, MI*, NC, NH, NM, OK, OR, SD, WI*</td>
<td>DE, MA*</td>
</tr>
<tr>
<td>*Moving to APR-DRGs</td>
<td>*Casemix adjustment based on APR-DRGs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per Stay -- APR-DRGs</th>
<th>Per Diem</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA, CO, FL, MS, MT, ND, NY, OH, PA, RI, SC, TX</td>
<td>AK, AL, AZ*, HI, LA, MO, NV, TN, WY</td>
</tr>
<tr>
<td>*Moving to APR-DRGs</td>
<td>*Moving to APR-DRGs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Reimbursement</th>
<th>Other (Regulated Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR, CT*, ID, ME</td>
<td>MD*</td>
</tr>
<tr>
<td>*Moving to unspecified DRG grouper</td>
<td>*Casemix adjustment based on APR-DRGs</td>
</tr>
</tbody>
</table>

Guide: CMS-DRGs: Centers for Medicare and Medicaid Services Diagnosis Related Groups (used by Medicaid)
MS-DRGs: Medicare Severity DRGs (used by Medicare starting 10/1/07)
AP-DRGs: All Patient DRGs (3M)
APR-DRGs: All Patient Refined DRGs (3M)
Tricare-DRGs: DRGs used by Tricare (formerly Civilian Health and Medical Program for Uniformed Services)

Notes:
1. Sources: Individual states, MACPAC, Xerox State Healthcare LLC, 3M Health Information Systems, Navigant Inc.
2. Xerox State Healthcare LLC does not have a financial interest in any DRG grouping algorithm.
3. Payment method refers to the primary method of payment for general acute care hospitals.
# DRG Background

## Comparing MS-DRGs and APR-DRGs

<table>
<thead>
<tr>
<th></th>
<th>Medicare MS-DRGs</th>
<th>Medi-Cal APR-DRGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Developer</strong></td>
<td>Medicare (3M contractor)</td>
<td>3M and Children's Hospital Association (formerly NACHRI)</td>
</tr>
<tr>
<td><strong>Genesis</strong></td>
<td>2007--adaptation of CMS-DRGs to improve capture of complications and comorbidities (CC)</td>
<td>Early 1990s--new model</td>
</tr>
<tr>
<td><strong>Patient population</strong></td>
<td>Medicare only</td>
<td>All-patient, using the Nationwide Inpatient Sample (NIS)</td>
</tr>
<tr>
<td><strong>Total DRGs</strong></td>
<td>751</td>
<td>1,258</td>
</tr>
<tr>
<td><strong>DRG structure</strong></td>
<td>334 base DRGs; many conditions split &quot;with CC&quot; or &quot;with major CC&quot;</td>
<td>316 base DRGs, each with 4 severity of illness (SOI) levels. No CC list.</td>
</tr>
<tr>
<td><strong>Newborn DRGs</strong></td>
<td>7 DRGs; birthweight not used</td>
<td>29 x 4 = 116 DRGs; birthweight used</td>
</tr>
<tr>
<td><strong>Obstetric DRGs</strong></td>
<td>Unchanged since 1983</td>
<td>4 x 4 = 16 delivery DRGs, plus other obstetric DRGs</td>
</tr>
<tr>
<td><strong>Pediatric DRGs</strong></td>
<td>Previous CMS-DRG logic discontinued; now, pediatric age not considered</td>
<td>Pediatric age reflected in base DRGs (e.g., RSV) and severity</td>
</tr>
<tr>
<td><strong>Version</strong></td>
<td>V.32 for federal fiscal year 2015</td>
<td>V.31 for state fiscal year 2014-15</td>
</tr>
<tr>
<td><strong>Relative weights</strong></td>
<td>Calculated from Medicare population</td>
<td>Calculated from NIS; validated using Medi-Cal data</td>
</tr>
</tbody>
</table>
**DRG Background**

**Transition Period Moderates Impacts**

- Most CA hospitals receive transition DRG base rates
- Transition rates set with intention of narrowing year-to-year change +/- 5%*
- Hospitals advised in July 2013 of projected base rates for Years 2-4

*For non-designated public hospitals (NDPHs), the target bounds were +/- 1% in Year 1, +/- 5% in Year 2 and +/- 7.5% in Year 3.

![Number of California Hospitals by Transition Status](chart.png)

- Hospital counts exclude 19 hospitals that had no volume in the Year 1 simulation dataset
Best Information Sources

Recorded Webinars on the Medi-Cal Learning Portal

- **DRG Overview (Year 1)** 12/20/13
  [https://learn.medi-cal.ca.gov/_ngcdfvw/diagnosis_related_group_overview_recorded_webinar.aspx](https://learn.medi-cal.ca.gov/_ngcdfvw/diagnosis_related_group_overview_recorded_webinar.aspx)

- **DRG Ratesetting (Year 1)** Feb 2013
  [https://learn.medi-cal.ca.gov/_m07kbnh/diagnosis_related_group_ratesetting_recorded_webinar.aspx](https://learn.medi-cal.ca.gov/_m07kbnh/diagnosis_related_group_ratesetting_recorded_webinar.aspx)

- **DRG Billing July 2013**
  [https://learn.medi-cal.ca.gov/_f55izi/diagnosis_related_group_billing_recorded_webinar.aspx](https://learn.medi-cal.ca.gov/_f55izi/diagnosis_related_group_billing_recorded_webinar.aspx)

- **DRG Year 2**
  [https://learn.medi-cal.ca.gov/ivdetail/tabid/64/listingkey/354/diagnosis_related_group_year_2_recorded_webinar.aspx](https://learn.medi-cal.ca.gov/ivdetail/tabid/64/listingkey/354/diagnosis_related_group_year_2_recorded_webinar.aspx)

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**Diagnosis Related Group Hospital Inpatient Payment Methodology**

Payment by DRGs encourages access to care, rewards efficiency, improves transparency, and improves fairness by paying similarly across hospitals for similar care. Payment by DRGs also simplifies the payment process, encourages administrative efficiency, and bases payments on patient acuity and hospital resources rather than length of stay.

**History of DRG**

Senate Bill 853 (Statutes of 2010) added Section 14105.28 to the Welfare and Institutions Code which mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon Diagnosis Related Groups (DRGs).

**DRG Payment Method**

To find out about DRG specific information, please select from the pages below.

- **Contact Information**
- **Important Information**
- **Provider Education and Bulletins**

**Billing and TAR Changes**

- **Pricing Resources: SFY 2013/14**
- **Pricing Resources: SFY 2014/15**
May 20, 2014

CHEF FINANCIAL OFFICER
E-MAIL: <name>
E-ADDRESS: <address>
CITY: <city>, STATE: <state>
ZIP: <zip>

RE: Medi-Cal FFS Inpatient DRG Rate Notification

Dear Chief Financial Officer,

This letter serves as formal communication of your Diagnosis Related Group (DRG) inpatient fee-for-service (FFS) rates for State Fiscal Year (S) FY 2014-15. Effective July 1, 2014, through June 30, 2015.

The goal for Year 2 of DRG payment, which begins this year, is to stabilize the statewide base rate for hospitals. In Year 2 of the transition to DRG payment, the new statewide base rate will replace the current state policy rate for Year 2 transition base rates instead of the statewide rate for Year 2 transitioning hospitals.

Your hospital is a transition hospital. The application for future years will be the same as you were advised in August 2013. You should review the FY 1415 Transitioning Base Rate and related information.

Sincerely,

Toby Douglas
Director

DHCS
Year 1 Actual

DRG Payment One Year Later

- Overall - DRG payment seems well accepted
- Approaching more complete Year 1 data
- Year 2 update included technical updates and not policy changes
  - DHCS’ goal is stability and predictability to extent possible
- Impact on access
  - All hospitals may treat all Medi-Cal patients; no open vs closed distinction
  - Hospitals treating sicker patients immediately receive higher payment
  - No reports of access issues related to DRG implementation
- Administrative simplification
  - Reduction of almost one million days in day-to-day TAR requirement
  - No more multi-year cost settlement process for non-contract hospitals
  - No more split billing to FFS and managed care for individual patients
  - No more split billing to FFS and CCS for individual patients
  - Hospitals no longer required to submit DHCS Form 6004 for revenue rate changes
Year 1 Actual

Impact of Medicaid Expansion

• Noticeable increase in Medi-Cal FFS volume since January 2014
  - Increased revenue for hospitals, assuming these patients were previously uninsured
  - Average casemix appears higher than pre-existing FFS population
• Effect on FFS volumes and payments going forward depends on interaction of two trends:
  - Pace of new Medi-Cal enrollees under ACA Medicaid expansion
  - Pace of transition from FFS to managed care
Year 1 Actual

Other Billing Issues

- Paper Claims 22 line issue
  - paying correctly when electronically billed; resolution instructions to come

- Bill type 121
  - Medi-Cal recently implemented a fix for inpatient claims with type of bill code 121 that were erroneously denying with Remittance Advice Details (RAD) code 9952: Type of bill code for APR-DRG Claim Invalid or Missing.
    - Bulletin issued: Starting July 14, 2014, providers are instructed to resubmit DRG, type of bill 121 claims with dates of service on or after July 1, 2013, through June 30, 2014. Timeliness requirements are being waived for these until September 26, 2014; therefore, no delay reason code.
    - If providers are unable to resubmit claims on or before September 26, 2014, an Erroneous Payment Correction (EPC) will be processed by March of 2015 to capture remaining claims that received the erroneous denial of RAD code 9952.
Other Billing Issues

• Managed Care to FFS
  - Claims with a from-through time period, in which the recipient is Managed Care Plan (MCP) enrollee first month and Fee for Service (FFS) the second month, are receiving denial code 0037 (Health Care Plan enrollee, capitated services not billable to Medi-Cal) on the claim. DHCS and Xerox are working towards resolution.

• TAR Denial Issues
  - DRG claims are denying for RAD code 9968 (No approved TAR on file for APR-DRG inpatient admission) as the claims that have an admit date outside of the from-through date of the TAR will receive this denial.
  - Also, DRG claims denying for RAD code 0341 (Units of service billed exceed the TAR authorized days. Please resubmit with a new TAR control number.)
  - Claims being billed with Aid code K1 and 3F are receiving an erroneous denial. DHCS and Xerox are planning to add the aid codes K1 and 3F.
Year 1 Actual

How Claims Were Paid

Paid Stays by Category

- Neonate: 2.9%
- Outlier: 2.8%
- Pediatric: 12.1%
- Transfer: 1.6%
- Straight DRG: 80.6%

Total Stays: 322,881
Paid Claims thru 6/23/14
Year 1 Actual

Stays and Payment by MCC

Stays by Medicaid Care Category

- Obstetrics: 31%
- Normal newborn: 27%
- Misc adult: 12%
- Misc pediatric: 11%
- Gastroent adult: 5%
- Neonate: 4%
- Circ adult: 3%
- Resp adult: 3%
- Resp pediatric: 3%
- Other: 0%

Payment by Medicaid Care Category

- Misc Adult: 23%
- Misc Pediatric: 21%
- Neonate: 18%
- Resp Pediatric: 4%
- Normal Newborn: 4%
- Resp Adult: 4%
- Circ Adult: 5%
- Obstetrics: 14%
- Other: 0%

Total Stays: 322,881
Paid Claims thru 6/23/14
Year 1 Actual

Correlation of Charges and Birthweight

- Example of how DRGs enable increased understanding of Medi-Cal client health status and hospital utilization

![Graph showing average hospital charge per newborn stay, by birthweight. The graph indicates a decrease in charges with increasing birthweight, highlighting the economic argument for prenatal care.](image-url)
Year 2 Update

Year 2 Update – Policy

• Overall goal is stability between Year 1 to Year 2
• Goal is budget neutrality Year 1 to Year 2 in terms of average payment per stay
• Transition hospitals:
  - Hospital-specific Year 2 base rates unchanged from projections sent to hospitals in July 2013
• Non-transition hospitals:
  - Statewide base rate and remote rural base rate unchanged from projections sent to hospitals in July 2013
  - Wage area adjustments made using Medicare hospital-specific wage area index and labor share values for FFY 2014
• No change to pricing logic or policy adjustors
• As we continue with DRG analysis, mid-year changes remain possible
Year 2 Updates

Year 2 Update – Technical

1. APR-DRG groups, relative weights and average length of stay benchmarks V.29→V.31
2. Updated cost-to-charge ratios by hospital
   - Weighted average CCR 24.2% in Year 1 → 23.5% in Year 2
3. Updated wage area index values (affects non-transition hospitals)
   - Most recent Medicare values for FFY 2014 (i.e., as of August 2013 final rule)
   - Almost all CA wage areas have higher values, including 1.2282 to 1.2477 for most of So Cal
   - Wage area labor share increased from 68.8% to 69.6%
4. No additional documentation and coding adjustment for Year 2
5. Cost outlier thresholds increased by 5.1%, reflecting most recent available data on charge inflation (OSHPD, Medi-Cal FFS stays)
6. No change in discharge status values
Year 2 Impacts

APR-DRG Grouper Update V.29 to V.31

• Important to update version to reflect changes in medicine and practice
• Clinical logic changes from V.29 to V.30 were the most significant changes in 10 years; nevertheless, not a major change
  - No logic changes between versions 30, 31 and 32
• Still 314 base DRGs, each with 4 levels of severity
• We compared APR-DRG assignments on 218,638 CA DRG stays that were paid using V.29, then regrouped to V.31 (thru 3/10/14 paid dates)
  - 94% of stays did not change DRG assignment
  - 0.2% of stays changed base APR-DRG
  - 5.5% of stays changed severity of illness within the same base APR-DRG
    • 1.2% increased severity
    • 4.4% decreased severity
• Relative weights calculated by 3M from 15 million stays from the Nationwide Inpatient Sample
# Year 2 Updates

## Key Payment Policy Values

<table>
<thead>
<tr>
<th>Simulation Parameters</th>
<th>Year 1 Value</th>
<th>Year 2 Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Base rates</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG base rate, non-remote rural</td>
<td>$6,223</td>
<td>$6,289</td>
</tr>
<tr>
<td>DRG base rate, remote rural</td>
<td>$10,218</td>
<td>$10,640</td>
</tr>
<tr>
<td>Transition hospital-specific base rates</td>
<td>Year 1 Hospital-specific</td>
<td>Year 2 Hospital-specific</td>
</tr>
<tr>
<td><strong>Technical updates</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG version</td>
<td>V.29 charge-based weights</td>
<td>V.31 charge-based weights</td>
</tr>
<tr>
<td>Inflation factor</td>
<td>N/A</td>
<td>5.1% applied to outlier thresholds and charges</td>
</tr>
<tr>
<td>Documentation &amp; coding adjustment</td>
<td>3.5% in Year 1</td>
<td>No DCC in year 2</td>
</tr>
<tr>
<td>Wage area adjustments</td>
<td>Per Medicare Impact File for FFY 2013, labor share is 68.8%.</td>
<td>Per Medicare Impact File for FFY 2014; labor share is 69.6%.</td>
</tr>
<tr>
<td><strong>Outlier policy factors- Updates</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost to charge ratios</td>
<td>Year 1 values</td>
<td>Year 2- updated to FY2012 w some exceptions</td>
</tr>
<tr>
<td>High side (provider loss) tiers and marginal cost (MC) percentages</td>
<td>i.e.$0 - $40,000: no outlier payment</td>
<td>i.e.$0 - $42,040: no outlier payment</td>
</tr>
<tr>
<td></td>
<td>i.e. $40,000 to $125,000: MC = 0.60</td>
<td>i.e. $42,040 to $131,375: MC = 0.60</td>
</tr>
<tr>
<td></td>
<td>i.e. &gt; $125,000: MC = 0.80</td>
<td>i.e. &gt; $131,375: MC = 0.80</td>
</tr>
<tr>
<td>Low side (provider gain) tiers and marginal cost (MC) percentages</td>
<td>i.e. $0 - $40,000: no outlier reduction</td>
<td>i.e. $0 - $42,040: no outlier reduction</td>
</tr>
<tr>
<td></td>
<td>i.e. &gt; $40,000: MC = 0.60</td>
<td>i.e. &gt; $42,040: MC = 0.60</td>
</tr>
<tr>
<td><strong>Policy adjustors- no change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy adjustor - neonate at designated NICU</td>
<td>1.75</td>
<td>1.75</td>
</tr>
<tr>
<td>Policy adjustor - neonate at other NICU</td>
<td>1.25</td>
<td>1.25</td>
</tr>
<tr>
<td>Policy adjustor - age - pediatric, misc &amp; resp</td>
<td>1.25</td>
<td>1.25</td>
</tr>
<tr>
<td>Pediatric age cutoff</td>
<td>&lt; 21</td>
<td>&lt; 21</td>
</tr>
</tbody>
</table>
Year 2 Updates

Hospital-Specific DRG Base Rates

- To see hospital-specific base rates, go to DRG webpage/DRG Pricing Resources for SFY 2014/15

- Transition hospitals:
  - SFY 14/15 Transition Base Rates

- Non-transition hospitals:
  - SFY 14/15 DRG Pricing Calculator

DRG Pricing Resources for SFY 2014/15

Below is information about DRG Pricing Resources for SFY 2014/15

- SFY 14/15 DRG Pricing Calculator (Excel)
- SFY 14/15 DRG Pricing Calculator (PDF)
- SFY14/15 Hospital Characteristics File (PDF)
- SFY14/15 Transition Base Rates (PDF)

Back to DRG Main Page
Looking Forward
Looking Ahead to Year 2 and Year 3

• For Year 2 (FY 2014-15):
  - Review performance of payment method in Year 1
  - Changes may be made mid-year if necessary or may take effect in Year 3

• For Year 3 (FY 2015-16):
  - Technical update to comprise APR-DRG V.32 groups (ICD-9-CM), relative weights and ALOS benchmarks; CCRs; cost outlier thresholds; wage area index values
  - Policy topics such as base rates, policy adjustors, pricing logic to be reviewed with changes if appropriate

• DRG base rates
  - Funding depends on legislative appropriation and trends in utilization and casemix
  - Transition hospitals: current best estimate is Year 3 transition base rates (from July 2013 notification)
  - Non-transition hospitals: current best estimate is Year 3 statewide base rates (from July 2013 notification) adjusted using FFY 2015 Medicare wage area values

• ICD-10-CM/PCS
  - DHCS to accept and price inpatient hospital claims using ICD-10-CM/PCS as of October 1, 2015 – APR-DRG V.32
More Resources
Stay in Touch

- DHCS webpage devoted to APR-DRG information
  - Reorganized year 1 vs. year 2: www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx

- Join DRG listserve by emailing drg@dhcs.ca.gov

- Policy questions (NOT patient-specific information) to drg@dhcs.ca.gov


- Provider bulletins at files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20872_1.asp

- Medi-Cal Telephone Service Center 1-800-541-5555 from 8 a.m. to 5 p.m.
For Further Information

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With thanks to HFMA and:
- DHCS: Maria Jaya, Belinda Rowan, Beverly Yokoi
- Xerox: Bud Davies, Darrell Bullocks, Mikal Moore, Kevin Quinn, Andrew Townsend

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Review of DRG Basics

Appendix
**DRG Basics**

**Structure of APR-DRGs**

**DRG 002-4**

*Base DRG - SOI*

<table>
<thead>
<tr>
<th>APR-DRG</th>
<th>APR-DRG Description</th>
<th>Relative Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>002-1</td>
<td>Heart &amp;/Or Lung Transplant</td>
<td>9.0557</td>
</tr>
<tr>
<td>002-2</td>
<td>Heart &amp;/Or Lung Transplant</td>
<td>10.0846</td>
</tr>
<tr>
<td>002-3</td>
<td>Heart &amp;/Or Lung Transplant</td>
<td>13.0086</td>
</tr>
<tr>
<td>002-4</td>
<td>Heart &amp;/Or Lung Transplant</td>
<td>21.2277</td>
</tr>
<tr>
<td>141-1</td>
<td>Asthma</td>
<td>0.3450</td>
</tr>
<tr>
<td>141-2</td>
<td>Asthma</td>
<td>0.5100</td>
</tr>
<tr>
<td>141-3</td>
<td>Asthma</td>
<td>0.7777</td>
</tr>
<tr>
<td>141-4</td>
<td>Asthma</td>
<td>1.4124</td>
</tr>
<tr>
<td>560-1</td>
<td>Vaginal Delivery</td>
<td>0.3027</td>
</tr>
<tr>
<td>560-2</td>
<td>Vaginal Delivery</td>
<td>0.3445</td>
</tr>
<tr>
<td>560-3</td>
<td>Vaginal Delivery</td>
<td>0.5115</td>
</tr>
<tr>
<td>560-4</td>
<td>Vaginal Delivery</td>
<td>1.7983</td>
</tr>
</tbody>
</table>
Hospital Characteristics

- **“Designated NICU”** as determined by California Children’s Services based on neonatal surgical capacity
- **“Designated remote rural hospital”** - rural per OSHPD list and at least 15 miles from the nearest hospital with a basic emergency room
- **Cost-to-charge ratio** used for calculating outlier payments – from the FY 2013 cost report with some exceptions
- **Wage area** - from Medicare impact file for FFY14, including reclassifications where appropriate
DRG Basics
Calculating the Allowed Amount

1. Group each stay to APR-DRG and use relative weight
   - Relative weights from a national database that fits CA well
   - For electronic claims, CA-MMIS will use up to 25 diagnoses and procedure codes; for paper claims, 18 diagnoses and 6 procedure codes are accommodated

2. Hospital-specific base rate
   - Higher base rate for remote rural hospitals
   - Transition rates in effect SFY13/14, SFY 14/15, SFY15/16
   - Adjust by Medicare Wage Area

3. Incorporate specific payment adjustments
   - Age adjustor, NICU adjustor, outlier payments, transfers
DRG Basics

Straight DRG

- 314 base APR-DRGs, each with four levels of severity
- DRG base rate = statewide base rate adjusted for wage area
  - L.A. area: ($6,289 \times 69.6\% \times 1.2477) + ($6,289 \times 30.4\%) = $7,373
- Individual hospitals will have different base rates due to the transition and Medicare wage index for non-transition hospitals

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>Rel Wt</th>
<th>DRG Base Rate</th>
<th>DRG Base Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>139-1</td>
<td>Oth Pneumonia</td>
<td>0.3915</td>
<td>$7,373</td>
<td>$2,887</td>
</tr>
<tr>
<td>139-2</td>
<td>Oth Pneumonia</td>
<td>0.5640</td>
<td>$7,373</td>
<td>$4,158</td>
</tr>
<tr>
<td>139-3</td>
<td>Oth Pneumonia</td>
<td>0.9394</td>
<td>$7,373</td>
<td>$6,926</td>
</tr>
<tr>
<td>139-4</td>
<td>Oth Pneumonia</td>
<td>1.8747</td>
<td>$7,373</td>
<td>$13,822</td>
</tr>
<tr>
<td>166-1</td>
<td>Coronary Bypass w/o Cath</td>
<td>2.6441</td>
<td>$7,373</td>
<td>$19,495</td>
</tr>
<tr>
<td>166-2</td>
<td>Coronary Bypass w/o Cath</td>
<td>3.0517</td>
<td>$7,373</td>
<td>$22,500</td>
</tr>
<tr>
<td>166-3</td>
<td>Coronary Bypass w/o Cath</td>
<td>4.0194</td>
<td>$7,373</td>
<td>$29,635</td>
</tr>
<tr>
<td>166-4</td>
<td>Coronary Bypass w/o Cath</td>
<td>7.0219</td>
<td>$7,373</td>
<td>$51,772</td>
</tr>
</tbody>
</table>
DrG Basics

Pediatric Adjustor

- Illustrates the Straight DRG modified for a pediatric patient
- Pediatric adjustor of 1.25 is applied

<table>
<thead>
<tr>
<th>Straight DRG</th>
<th>Description</th>
<th>Casemix Rel. Wt.</th>
<th>DRG Base Rate</th>
<th>DRG Base Payment</th>
<th>Pediatric Adjustor</th>
<th>Payment Rel. Wt.</th>
<th>DRG Base Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>139-1</td>
<td>Oth Pneumonia</td>
<td>0.3915</td>
<td>$7,373</td>
<td>$2,886</td>
<td>1.25</td>
<td>0.4893</td>
<td>$3,608</td>
</tr>
<tr>
<td>139-2</td>
<td>Oth Pneumonia</td>
<td>0.5640</td>
<td>$7,373</td>
<td>$4,158</td>
<td>1.25</td>
<td>0.7050</td>
<td>$5,198</td>
</tr>
<tr>
<td>139-3</td>
<td>Oth Pneumonia</td>
<td>0.9394</td>
<td>$7,373</td>
<td>$6,926</td>
<td>1.25</td>
<td>1.1743</td>
<td>$8,658</td>
</tr>
<tr>
<td>139-4</td>
<td>Oth Pneumonia</td>
<td>1.8747</td>
<td>$7,373</td>
<td>$13,822</td>
<td>1.25</td>
<td>2.3434</td>
<td>$17,278</td>
</tr>
</tbody>
</table>
DRG Basics

Transfer Cases

• Payment adjustment follows Medicare model

• Applies to short-stay patients transferred from acute care to acute care; (“Transfer” status codes: 02-general hospital, 05-children’s or cancer, 65-psych, 66-critical access)

• Transfer adjustment made only if LOS less than national ALOS - 1 day

• No post-acute transfer policy

Example: DRG 190-3, Heart-attack
LOS= 2 days; Transferred to Another General Hospital

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG base payment</td>
<td>$7,373 x 1.1342</td>
<td>$8,362</td>
</tr>
<tr>
<td>Transfer case</td>
<td>Discharge status = 02</td>
<td>Yes</td>
</tr>
<tr>
<td>National ALOS</td>
<td>Look up from DRG table</td>
<td>5.18</td>
</tr>
<tr>
<td>Tsf adjustment</td>
<td>($8,362/5.18) * (3+1)</td>
<td>$6,457</td>
</tr>
<tr>
<td>DRG payment</td>
<td>$6,457 &lt; $8,362</td>
<td>$6,457</td>
</tr>
</tbody>
</table>
Transfers

• Same Day Stays- LOS for a same day stay is zero; therefore, the Transfer Payment calculation for same-day stays is as follows:

\[
(DRG \text{ Base Payment}) \cdot (0 + 1)
\]

National ALOS

• If a beneficiary is discharged from one hospital and readmitted to another hospital, there will need to be two TARs, one for each hospital admission.

• If a beneficiary is only transported to another hospital for a procedure and returns to the originating hospital, there only needs to be one Admit TAR for the initial hospital admission.
DRG Basics

Cost Outlier Case: Tier 1

- Cost outlier payments supplement base payments in exceptional cases
- Cost is calculated using billed charges and the CCR
- Same calculation model as Medicare -- 5% of payments as outliers; CA 17%
- Tier 1 Threshold $42,040

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG base payment</td>
<td>$7,373 x 2.8127</td>
<td>$20,738</td>
</tr>
<tr>
<td>Estimated cost</td>
<td>$180,000 x 39%</td>
<td>$70,200</td>
</tr>
<tr>
<td>Estimated loss</td>
<td>$70,200 - $20,738</td>
<td>$49,462</td>
</tr>
<tr>
<td>Cost outlier case</td>
<td>$49,462 &gt; $42,040</td>
<td>Yes</td>
</tr>
<tr>
<td>Est. loss - cost outlier</td>
<td>$49,462 - $42,040</td>
<td>$7,422</td>
</tr>
<tr>
<td>Cost outlier payment</td>
<td>$7,422 x 60%</td>
<td>$4,453</td>
</tr>
<tr>
<td>DRG payment</td>
<td>$20,738 + $4,453</td>
<td>$25,191</td>
</tr>
</tbody>
</table>

Example: DRG 720-4 Septicemia with Charges of $180,000
Cost Outlier Case: Tier 1 & 2

- Example of two-tier cost outlier threshold: $42,040 and $131,375
  - Tier 1 paid at 60% for losses between $42,040 and $131,375
  - Tier 2 paid at 80% for losses greater than $131,375

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG base payment</td>
<td>$7,373 x 2.8127</td>
<td>$20,738</td>
</tr>
<tr>
<td>Estimated cost</td>
<td>$600,000 x 39%</td>
<td>$234,000</td>
</tr>
<tr>
<td>Estimated loss</td>
<td>$234,000 - $20,738</td>
<td>$213,262</td>
</tr>
<tr>
<td>Cost outlier case</td>
<td>$213,262 &gt; $42,040</td>
<td>Yes</td>
</tr>
<tr>
<td>Est. loss - cost outlier</td>
<td>$213,262 - $42,040</td>
<td>$171,221</td>
</tr>
<tr>
<td>Cost outlier payment Tier 1 for loss</td>
<td>($131,375 - $42,040) x 60%</td>
<td>$53,601</td>
</tr>
<tr>
<td>between $42,041 &amp; $131,375</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2 loss over $131,375</td>
<td>$213,262 - $131,375</td>
<td>$81,887</td>
</tr>
<tr>
<td>Cost outlier payment Tier 2</td>
<td>$81,887 x 80%</td>
<td>$65,510</td>
</tr>
<tr>
<td>DRG payment</td>
<td>$20,738 + $53,601 + $65,510</td>
<td>$139,849</td>
</tr>
</tbody>
</table>

Example: DRG 720-4 Septicemia with Charges of $600,000

September 8, 2014
DRG Basics

Interim Claims

- Hospitals are not required to submit interim claims under any circumstances
- Hospitals can choose to submit interim claims if a stay exceeds 29 days
- The Interim per diem amount of $600 is intended to provide cash flow for long stays
- Hospitals should not adjust their final claim based on interim claim payments, void interim payments, or try to return interim payments
- Hospitals should submit the final admit through discharge claim, including all ICD-9-CM diagnosis and procedure codes related to the entire stay
- The system, CA-MMIS, will pay the admit through discharge claim, and deduct previously paid interim claim amounts from the subsequent payment remittance
- Authorization, TAR/SAR is required for the admission before the interim claim will be paid
## DRG Basics

### Interim Claim Payment

**Example: Neonate 1200 G with Respiratory Distress Syndrome (APR-DRG 602-4)**

<table>
<thead>
<tr>
<th>Claim</th>
<th>Type of Bill</th>
<th>Days</th>
<th>Interim Per Diem</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st interim claim</td>
<td>112</td>
<td>30</td>
<td>$600</td>
<td>$18,000</td>
</tr>
<tr>
<td>2nd interim claim</td>
<td>113</td>
<td>30</td>
<td>$600</td>
<td>$18,000</td>
</tr>
<tr>
<td><strong>Final complete claim</strong></td>
<td>111</td>
<td>80</td>
<td></td>
<td><strong>$94,118</strong></td>
</tr>
<tr>
<td>System adjusts next week's remittance</td>
<td></td>
<td></td>
<td></td>
<td><strong>$58,118</strong></td>
</tr>
</tbody>
</table>

**Notes:**
1. APR-DRG 602-4 base rate is $7,373 x 12.7652 = $94,118.
2. $600 is the per diem rate for interim claims.
DRG Basics

Deliveries, Babies, General Acute

• This section brings together billing, TAR/SAR and payment changes for five of the most common billing scenarios:
  – Deliveries
  – Well babies
  – Sick babies
  – General acute care – patients with full benefits
  – General acute care – patients with limited benefits

• Same TAR submission process as in place prior to 7/1/2013, but with modifications to accommodate admission only TAR for a significant number of stays per year
  – Daily TAR remains in effect for:
    • Acute inpatient rehabilitation
    • Restricted aid code-assigned beneficiaries
    • Acute administrative days-Level 1 or Level 2

• Reduction in TAR/SAR requirements:
  – Reduces administrative burden, a major benefit for hospitals
DRG Basics

TAR Process

• Required documentation still needed to establish the medical necessity of the Admission (Admit TAR and Principal Diagnosis)

• Providers can still use:
  – 50-1 TAR for elective non-emergency admission
  – 18-1 TAR for emergency admissions, or
  – The electronic (eTAR)

• Designated public hospitals are unaffected by the DRG-related changes in TAR/SAR
DRG Basics

TAR Process

• Refer to “DRG Hospital Inpatient TAR Requirements” on webpage
  – Use the TAR, 50-1 for elective non-emergency admission
  – Use the 18-1 TAR for emergency admissions
  – For a list of CPT-4 procedures requiring TAR, refer to the TAR and non-Benefit List section in the appropriate Part 2 manual
  – TAR field office addresses are located in the manual

• Required documentation – necessary documentation to establish the medical necessity of the:
  – Admission – admit TAR
  – Each day – current process of authorizing each day as well as the admit
## Deliveries

Deliveries are identified by the presence of specific ICD-9-CM procedure codes on the claim.

<table>
<thead>
<tr>
<th></th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing</strong></td>
<td>Typically billed together with the baby</td>
<td>The mother and baby must be billed on separate claims</td>
</tr>
<tr>
<td><strong>TAR/SAR</strong></td>
<td>No TAR/SAR required for admission. TAR/SAR required for induction days and any days over 2 (vaginal delivery) or 4 (cesarean delivery)</td>
<td>None</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Single payment typically made for both the mother and the baby combined</td>
<td>Separate DRG-based payments to be made for the mother and the baby</td>
</tr>
</tbody>
</table>

### Notes:
1. This information applies to all patients, regardless of aid code.
2. For other obstetric stays (e.g., false labor), see General Acute Care.
## Well Babies

If the only accommodation revenue code is 171, the baby is defined as a well baby.

<table>
<thead>
<tr>
<th></th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing</td>
<td>Almost always billed on the mother’s claim</td>
<td>The mother and baby must be billed on separate claims</td>
</tr>
<tr>
<td>TAR/SAR</td>
<td>None</td>
<td>Same</td>
</tr>
<tr>
<td>Payment</td>
<td>Included within payment for the mother</td>
<td>Separate DRG-based payments to be made for the mother and the baby</td>
</tr>
</tbody>
</table>

**Notes:**

1. DRG-based payment will reflect the baby’s diagnoses and procedures, regardless of the revenue codes billed on the claim. The revenue codes are used only to determine the applicability of TAR/SAR requirements.
2. This information applies to all patients, regardless of aid code.
Sick Babies

If accommodation revenue codes 172, 173 or 174 appear on the claim, the baby is defined as a sick baby. This is true even if the claim also includes revenue code 171.

<table>
<thead>
<tr>
<th></th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing</td>
<td>Typically billed separately</td>
<td>The baby should continue to be billed separately from the mother</td>
</tr>
<tr>
<td>TAR/SAR</td>
<td>Admission and each day</td>
<td>Admission only</td>
</tr>
<tr>
<td>Payment</td>
<td>Typically paid separately</td>
<td>Separate DRG-based payments to be made for the mother and the baby</td>
</tr>
</tbody>
</table>

Notes:
1. DRG-based payment will reflect the baby's diagnoses and procedures, regardless of the revenue codes billed on the claim. The revenue codes are used only to determine the applicability of TAR/SAR requirements.
2. This information applies to all patients, regardless of aid code.
General Acute Care—Full Benefits

This information applies to all stays except deliveries and newborns.

<table>
<thead>
<tr>
<th></th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing</strong></td>
<td>Following standard practice</td>
<td>Admission through discharge claim</td>
</tr>
<tr>
<td><strong>TAR/SAR</strong></td>
<td>Admission and each day</td>
<td>Admission only</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>For authorized days, per diem or at percent of charges</td>
<td>By DRG for the entire stay</td>
</tr>
</tbody>
</table>
DRG Basics

General Acute Care—Restricted Benefits

TAR will continue to be reviewed as they are today

- Claim payment process:
  - As long as there is at least one approved day, the claim will pay via the DRG grouper
  - After payment is made, stays with at least one denied day will be reviewed, verifying diagnosis and procedures occur on approved days; if not, those diagnoses and procedures will be removed for DRG reassignment
  - Claim will be run through the grouper for DRG reassignment, this reassigned DRG will determine if there is a reduction in payment
  - The department will recoup payment difference

<table>
<thead>
<tr>
<th>Billing</th>
<th>Previous Payment Method</th>
<th>Effective July 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAR/SAR</td>
<td>Admission and each day</td>
<td>Same</td>
</tr>
</tbody>
</table>

Payment: For authorized days, per diem or at percent of charges

By DRG for the entire stay. Payment for stays with unauthorized services may be recalculated to remove the impact of the unauthorized services.
DRG Basics

Related Outpatient Services

- No change to the Medi-Cal outpatient “window” for inpatient stays
- No change to separate payment for newborn hearing screening
- Blood factors and bone marrow search and acquisition services are the only services separately payable from the inpatient stay

<table>
<thead>
<tr>
<th>Specialized Services That Can be Billed on an Outpatient Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bone Marrow Search and Acquisition Costs</strong></td>
</tr>
<tr>
<td>Management of recipient hematopoietic progenitor cell donor search and cell acquisition</td>
</tr>
<tr>
<td>Unrelated bone marrow donor</td>
</tr>
<tr>
<td><strong>Blood Factors</strong></td>
</tr>
<tr>
<td>Blood Factor XIII</td>
</tr>
<tr>
<td>Blood Factor Von Willebrand - Injection</td>
</tr>
<tr>
<td>Blood Factor VIII</td>
</tr>
<tr>
<td>Blood Factor VIII / Von Willebrand</td>
</tr>
<tr>
<td>Blood Factor Von Willebrand</td>
</tr>
<tr>
<td>Blood Factor VIIa</td>
</tr>
<tr>
<td>Blood Factor IX</td>
</tr>
<tr>
<td>Blood Factor Antithrombin III</td>
</tr>
<tr>
<td>Blood Factor Antiinhibitor</td>
</tr>
</tbody>
</table>