

Medi-Cal DRG Project

Frequently Asked Questions

Please note that changes remain possible before the implementation date.

Revised or added since the July 27, 2011 release: FAQs 4-6, 8-11, 18-22, 29-33, 38-41

OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project?

As directed by the California legislature, the Department of Health Care Services (DHCS) is developing a new method of paying for hospital inpatient services in the fee-for-service Medicaid program. This FAQ document is intended to provide interested parties with periodic updates on the project. **Please note that no decisions have been finalized about how the new payment method will work.**

2. How are hospitals currently paid?

Since 1983, hospitals have been paid under the Selective Provider Contracting Program (SPCP). “Contracted” hospitals negotiate a per diem payment rate with the California Medical Assistance Commission. Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process, but only for emergency services or services that are not available at a contracted hospital. (Note: designated public hospitals have a separate payment method.)

3. What change is being made?

The legislature directed the department to replace the SPCP with payment by diagnosis related group (DRG). The reference is to Senate Bill 853, passed in October 2010, which added Sections 14105.28 and 14105.281 to the California Welfare and Institutions Code.

4. What is the timeframe?

A workgroup of staff from DHCS and other state agencies is developing the new method, in consultation with a group of hospital managers and other stakeholders convened by the California Hospital Association. The workgroup is scheduled to finish its work in February 2012, at which point DHCS will review all recommendations and make final decisions. The original target date to implement payment by DRG was July 1, 2012; it is now January 1, 2013.

5. Will there be a transition period?

Yes. For at least one year, and possibly additional years, the DRG-based payment method will be phased in. Claims will be paid using the DRG payment method but some hospitals will see DRG base prices higher or lower than they otherwise would have been. The intention is that individual hospitals will not experience sharp changes (either up or down) in payment levels. The transitional DRG base prices would be set so that statewide payments would be budget-neutral relative to what they otherwise would have been. Further details on the transition mechanism are now being developed.

6. How much money will be affected?

In FY 2009, approximately \$4.5 billion was paid to hospitals for fee-for-service inpatient acute care. Of that, approximately \$1 billion was paid to designated public hospitals that are outside the scope of DRG payment method. Another significant portion—estimated at \$800 million—was paid for beneficiaries who likely will be enrolled in managed care by 2013. Total payments in 2013 to be made by DRG will depend on the total number of people in fee-for-service Medi-Cal at that time and on legislative appropriations.

7. What providers will be affected?

The new method will apply to general acute care hospitals, including out-of-state hospitals and hospitals designated by Medicare as critical access hospitals.

Psychiatric hospitals, alcohol and drug rehabilitation facilities, and designated public hospitals are outside the scope of the project. These facilities will continue to be paid as they are today. With regard to rehabilitation hospitals and services, please see Question 10.

8. What services will be affected?

For affected hospitals, the new DRG method will apply to all inpatient hospital fee-for-service claims except the following, for which the current payment method will continue to be in effect:

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Rehabilitation stays (see Question 10)
- Managed care stays (see Question 11)
- Inpatient hospice days
- Administrative days
- Subacute days
- Other services as may be determined by DHCS

9. Will DRGs affect CCS and GHPP patients?

The impact on claims for clients who do not have Medi-Cal coverage but do have coverage under the California Children's Services (CCS) or Genetically Handicapped Person Program (GHPP) is under review and has not been determined. Claims for clients who have Medi-Cal coverage plus CCS or GHPP coverage will be priced using the new DRG method.

10. What impact will there be on rehabilitation care?

Rehabilitation services—either within a general hospital or a specialty rehabilitation facility—are currently paid under the SPCP, that is, either at a negotiated hospital-specific per diem rate or, for non-contract hospitals, at 100% of allowable cost. At this time, we do not expect rehabilitation services to be paid by DRG. Instead, the workgroup is exploring the option of a statewide per diem rate, with all days subject to the treatment authorization request (TAR) process.

11. Will the change affect payments by Medicaid managed care plans?

The statutory language about DRG payment applies only to fee-for-service Medi-Cal. Managed care plans may or may not choose to adopt the DRG payment method in whole or in part.

When managed care beneficiaries receive emergency care from out-of-network hospitals, the managed care plan currently pays the hospital the “Rogers Rate,” which reflects fee-for-service rates calculated under the SPCP. With the SPCP being discontinued, we are now analyzing the implications for payment for out-of-network emergency services.

12. Will Medicare crossover claims be affected?

This remains to be decided. On “crossover” claims, the patient has dual eligibility for Medicare and Medi-Cal. Medicare is the primary payer and Medi-Cal is the secondary payer.

DRG PAYMENT

13. How do DRG payment methods work?

In general, every complete inpatient stay is assigned to a single diagnosis related group using a computerized algorithm that takes into account the patient’s diagnoses, age, major procedures performed, and discharge status. Each DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that DRG relative to the hospital resources needed to take care of the average patient. For example, if a DRG has a relative weight of 0.50 then that patient is expected to be about half as expensive as the average patient.

The DRG relative weight is multiplied by a DRG base price to arrive at the DRG base payment. For example, if the DRG relative weight is 0.50 and the DRG base price is \$8,000 then the payment rate for that DRG is \$4,000.

14. Who uses DRG payment?

The Medicare program implemented payment by DRG on October 1, 1983. About two-thirds of state Medicaid programs use DRGs, as do many commercial payers and various other countries. Many hospitals in the U.S. use DRGs for internal management purposes.

15. What are the characteristics of DRG payment?

- DRG payment defines “the product of a hospital,” thereby enabling greater understanding of the services being provided and purchased.
- Because payment does not depend on hospital-specific costs or charges, this method rewards hospitals for improving efficiency.
- Because DRGs for sicker patients have higher payment rates, this method encourages access to care across the full range of patient conditions.
- DRG payment rewards hospitals that provide complete and detailed diagnosis and procedure

codes on claims, thereby giving payers and data analysts better information about services provided.

16. What other payment policies are typically included in DRG payment methods?

For over 90% of stays, it is likely that payment will be made using a “straight DRG” calculation—that is, payment equals the DRG relative weight times the DRG base price, as described in Question 13. In special situations, payment may also include other adjustments, for example:

- **Transfer pricing adjustment.** Payment may be reduced when the patient is transferred to another acute care hospital.
- **Cost outlier adjustment.** Medicare and other DRG payers typically make additional “outlier” payments on stays that are exceptionally expensive for a hospital. Some payers also have a payment reduction if a stay is exceptionally profitable for a hospital. Nationally, outlier adjustments typically affect 1% to 2% of all stays and a somewhat higher percentage of all DRG payments.
- **Partial eligibility.** In some situations, a patient may have Medicaid eligibility for only part of the stay. In these situations, payment is typically prorated. For example, if a patient has coverage for 50% of the length of stay then the payment might be 50% of the calculated amount.
- **Other health coverage and patient cost-sharing.** The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct payments for which a third party (e.g., workers’ compensation) is liable as well as copayments or other amounts owed by the patient. In a Medicaid program, these amounts are typically minor.

17. How will the DRG be assigned?

DHCS plans to use All Patient Refined Diagnosis Related Groups (APR-DRGs). See the next section.

18. Where do the DRG relative weights come from?

DHCS plans to use APR-DRG relative weights calculated from the Nationwide Inpatient Sample. An analysis found very close correlation between the national weights and a set of weights calculated specifically from Medi-Cal fee-for-service data. The national weights are updated annually by 3M Health Information Systems.

19. What will be the DRG base price?

This question remains under discussion. Some states use a single statewide DRG base price for all hospitals. The Medicare program adjusts its base price (or “standard amount”) to reflect regional differences in wage levels, e.g., between the Los Angeles and San Francisco areas. It is also possible to use different base prices for different types of hospitals.

20. How will transfers be paid?

We expect that Medi-Cal will follow the Medicare model for transfers to another acute care hospital. For these stays, the transferring hospital would be paid the lesser of:

- The DRG base payment

- A per diem amount times the actual length of stay plus one day (to recognize the up-front costs of admission). The per diem amount would be the DRG base payment divided by the DRG-specific average length of stay.

The effect would be to reduce payment if the actual length of stay at the transferring hospital is less than overall average length of stay minus one day. The receiving hospital would receive the full DRG payment. Medi-Cal would define a transfer as UB-04 discharge status values 02, 05, 65 and 66. The tentative recommendation is that Medi-Cal, unlike Medicare, would not have a post-acute transfer policy.

21. How will hospital stays with partial eligibility be paid?

This question is under review.

22. How will decisions be made about the new payment method?

A baseline dataset was created using actual data from DHCS extracted from the CA-MMIS Medi-Cal claims payment system. This data was matched to OSHPD data to increase the number of diagnosis and procedure codes available for DRG pricing. 2009 claims data was selected by discharge date, interim claims were chained together, and many other claim validation and improvement techniques were used to create a baseline dataset for analysis. This dataset is then used to simulate results by applying policy adjusters, age adjusters, outlier limits, etc. Using this process, DHCS is able to model the impact of policy decisions on claims data overall and by hospital. These results are shared within the CHA consultation group.

ALL PATIENT REFINED DRGs

23. Why were APR-DRGs chosen? Why not the same DRG algorithm as Medicare uses?

APR-DRGs were chosen because they are suitable for use with a Medicaid population, especially with regard to neonatal, pediatric and obstetric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

MS-DRGs—the algorithm now used by Medicare—were designed for a Medicare population using only Medicare claims. In Medicare, fewer than 1% of stays are for obstetrics, pediatrics, and newborn care. In the Medi-Cal fee-for-service population, these categories represent about two-thirds of all stays.

24. Who developed APR-DRGs? Who uses them?

APR-DRGs were developed by 3M Health Information Systems and the National Association of Children’s Hospitals and Related Institutions (NACHRI). According to 3M, APR-DRGs have been licensed by over 20 state and federal agencies and by 1,600 hospitals. APR-DRGs have been used to adjust for risk in analyzing hospital performance; examples are state “report cards” such as www.floridahealthfinder.gov and analysis done by organizations such as the Agency for Healthcare Research and Quality and the Medicare Payment Advisory Commission.

APR-DRGs are also in use or planned for use in calculating payment by the State of Maryland; Medicaid programs in Colorado, Montana, New York, North Dakota, Pennsylvania, Rhode Island, South Carolina, and Texas; and Wellmark, the BlueCross BlueShield plan in Iowa.

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

No. The Medicaid claims processing system will assign the APR-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 at www.3m.com/us/healthcare/his/products/coding/refined_drg.html. DHCS and ACS, A Xerox Company (which is advising the Department) have no financial interest in APR-DRG software or in any business arrangements between hospitals and their vendors who license APR-DRGs.

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

The Department intends to implement V.29 of APR-DRGs, which was released October 1, 2011. Version 30 will be released October 1, 2012, but the Department plans to implement V.29 because all policy decisions and impact simulations are being done using V.29. Version 29 will accept all diagnosis and procedure codes effective in 2013.

27. What is the APR-DRG format?

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. Severity depends on the number, nature and interaction of complications and comorbidities. For example, APR-DRG 139-1 is pneumonia, severity 1, while APR-DRG 139-2 is pneumonia, severity 2. Unlike MS-DRGs, there are no universal lists of complications and comorbidities.

For hospitals that choose to acquire APR-DRG software, staff should note that the software outputs the base APR-DRG and the severity of illness as two different fields. Medi-Cal would concatenate these fields for purposes of calculating payment. The APR-DRG is therefore four bytes (ignoring the hyphen), in contrast to the three-byte MS-DRG field.

CODING AND BILLING

28. Would the hospital have to submit the APR-DRG on the UB-04 paper form or the 837I electronic transaction?

No. DHCS would assign the APR-DRG based on the diagnoses, procedures, patient age, and patient discharge status, all as submitted by the hospital on the claim. The UB-04 field for "PPS Code" (Form Locator 71) is not read by the Medicaid claims processing system. The PPS Code field is used when, for example, the hospital needs to advise a commercial insurer of the DRG for a stay. This situation would not apply to Medi-Cal.

29. How many diagnoses and procedures will be used in DRG assignment?

Currently, the California claims processing system (CA-MMIS) stores two diagnoses and two procedure codes. Enhancements will be made to the system to accept at least ten diagnosis codes, at least six ICD-9-CM procedure codes, and possibly more.

30. How will ICD-10 affect the DRG payment method?

Effective with the October 1, 2013, national implementation date for ICD-10, the Medi-Cal claims processing system will accept ICD-10 diagnosis and procedure codes and crosswalk them to ICD-9-CM codes that the system will use for internal processing. The replacement claims processing system that is now being built will utilize ICD-10 codes for internal processing. In both situations, hospitals should follow national guidelines in submitting ICD-10 codes to Medi-Cal.

31. Will the present-on-admission indicator be used?

Yes. Hospitals should submit valid values of the POA indicator. The claims processing system will be enhanced to accept, edit and store these values.

32. Will outpatient services related to the inpatient stay be bundled?

In general, there will be no change to the Medi-Cal distinction between outpatient and inpatient services (e.g., when a patient receives outpatient emergency or diagnostic services on the day of admission).

One exception is that under the SPCP a few hospitals can bill for specialized, high-cost services (e.g., organ acquisition and blood factors) on an outpatient claim even for an inpatient. For these situations, appropriate payment under a DRG method is under review.

33. How does this affect contracted SPCP rates that bundled the physician component of hospital services with the hospital component?

The physician component will become separately billable on a professional (e.g., CMS-1500) claim. This situation only affects a few hospitals that had negotiated bundled physician/hospital payments for specific services.

34. Will there be changes in billing requirements?

Some changes in billing requirements are expected, such as those listed below. Hospitals should wait for official notification from DHCS before making any changes in claims submission.

- Interim claims and claims for late charges would not be accepted, possibly with very limited exceptions for exceptionally long stays. This change would affect bill types 112, 113, 114 and 115.
- Separate claims would be submitted for a newborn and a mother. (Currently, there is no separate newborn claim except in specific circumstances.)
- Administrative days and subacute days would be submitted on a claim separate from the claim for the acute care stay.

OTHER QUESTIONS

35. What changes, if any, will be made to supplemental payments?

Medi-Cal has several programs under which it makes supplementary payments to hospitals, e.g., for medical education and disproportionate share hospitals. We expect that most of these payments will continue to be made separately from payment on the claim, but it is possible that some payments may be

combined with DRG payment if the results are simpler and more transparent than the current situation. No decisions have been made.

36. How will this affect the overall payment level?

The change to DRGs is a change in payment *method*, not payment *level*. The overall payment level will continue to be determined each year through the legislative appropriation process.

37. How will the change affect funding to each hospital?

Because there will be a major change in the payment method, we do expect some hospitals to see decreases in payments while other hospitals will see increases. The impacts will depend on decisions that have not yet been made, most importantly whether there are policy-based adjustments to certain care categories and whether the DRG base price varies by wage area or by type of hospital. There will be a transition period of at least one year; see Question 5.

DHCS will work with the hospital consultation group on the most effective way to advise hospitals on the expected impacts of the change, while maintaining the confidentiality of previous hospital-specific payment levels under the Selective Provider Contracting Program.

38. Will payments be subject to adjustment after cost reports have been submitted?

No. Payment based on DRG will be final.

39. Will hospitals still have to submit cost reports?

Yes. The Department also uses cost reports in calculating hospital utilization fees and in reviewing hospital payments overall.

40. Will there be changes to the Treatment Authorization Request (TAR) Process?

Yes. Simplification of the TAR process is expected to be a major benefit of DRG payment. With the caveat that no final decisions have been made, DHCS is reviewing the following draft recommendations.

- For stays paid by DRG:
 - Continuation of the current TAR requirements on the admission. That is, authorization would be required for all admissions except for deliveries and normal newborns.
 - Discontinuation in almost all cases of the current TAR requirement on the length of stay, affecting an estimated 1.7 million days of care per year.
 - Discontinuation of the current TAR requirement for days of care related to induction of labor.
 - Continuation of the current TAR requirement for a short list of specific procedures for all beneficiaries.
 - Continuation of the current TAR requirement for procedures for beneficiaries with restricted Medicaid eligibility. (In practice, the most common example is a cholecystectomy for cholecystitis where medical management might be sufficient according to federal guidelines.)
 - A new requirement for TAR on extremely lengthy or costly stays is under consideration but no recommendation has been drafted.

- For stays not paid by DRG:

- Continuation of current TAR requirements on both the admission and the length of stay for administrative days, subacute days, and rehabilitation (see Question 10).

41. How will payment be affected if a hospital-acquired condition is present on the claim?

Medicaid programs nationwide are required by federal law to demonstrate that they are not paying for “health care acquired conditions (HCACs),” as defined specifically by CMS. The list is virtually identical to the Medicare hospital-acquired condition (HAC) list that hospitals are already familiar with. Although an analysis of Medi-Cal data has not yet been completed, based on results from Medicare and other states we expect payment to be reduced on fewer than 1% of stays. (This figure could change if CMS expands the list of HCACs.)

The Medi-Cal claims processing system would identify HCACs from the diagnosis, procedure and POA information on the claim and disregard the HCAC in assigning the APR-DRG. Payment for the stay would therefore only be affected if the presence of the HCAC would otherwise have pushed the stay into a higher-paying APR-DRG.

42. Where can I go for more information?

- **FAQ.** Updates of this document will be available on the DHCS website at www.dhcs.ca.gov.
- **DRG Grouping Calculator.** 3M Health Information Systems has agreed to provide all California hospitals with access to an APR-DRG Grouping Calculator at no charge. The calculator is a web application that enables the user to enter diagnosis, procedure and other claims data and then shows the step-by-step assignment of the APR-DRG. For the web address and login information, CHA members can go to the “members” section of the CHA website at www.calhospital.org. Hospitals that are not CHA members may contact Jack Ijams at jhijams56@mmm.com.
- **DRG Pricing Calculator.** DHCS plans to publish a DRG Pricing Calculator spreadsheet on our website at www.dhcs.ca.gov. It will not assign the APR-DRG but it will show how a given APR-DRG will be priced in different circumstances. The calculator will include a complete list of APR-DRGs and related information for use in California. We expect it to be posted in the spring of 2012.
- **Hospital training sessions.** Hospital trainings will be held across the state, most likely in the fall of 2012.
- **Hospital provider manual.** The hospital provider manual will be updated to show details of the DRG based payment method.

For Further Information

DRG project management questions	Mark Sanui Safety Net Financing Division California Department of Health Care Services mark.sanui@dhcs.ca.gov 916-327-8256
Technical questions re DRG payment, relative weights, outlier calculations etc.	Kevin Quinn Vice President, Payment Method Development Government Healthcare Solutions ACS, A Xerox Company kevin.quinn@acs-inc.com 406-457-9550
Hospital consultation process	Matt Absher Vice President, Reimbursement Programs California Hospital Association mabsher@calhospital.org 916-552-7669