

# Medi-Cal DRG Project

## *Frequently Asked Questions*

### 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 project is in the initial stages. 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 when a Medi-Cal beneficiary requires emergency care 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 November 2011, at which point DHCS will review all recommendations and make final decisions. The target date to implement payment by DRG is July 1, 2012.

#### 5. 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, rehabilitation hospitals (including alcohol and drug rehabilitation facilities) and designated public hospitals are outside the scope of the project. These hospitals will continue to be paid as they are today.

#### 6. What services will be affected?

For affected hospitals, the new 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, regardless of whether they are in a distinct-part unit or not
- Managed care stays (see Question 7)
- Swing bed stays (i.e., beds used for nursing care pending availability of a bed in a nursing facility)
- Other services as may be determined by DHCS

#### **7. Will the change affect payments from Medicaid managed care plans?**

The statutory language about DRG payment applies only to fee-for-service Medi-Cal.

#### **8. Will Medicare crossover claims be affected?**

This question 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**

#### **9. 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.

#### **10. 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.

#### **11. 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.

#### **12. What other payment policies are typically included in DRG payment methods?**

For over 90% of stays, payment is typically made using a “straight DRG” calculation—that is, payment

equals the DRG relative weight times the DRG base price, as described above. In special situations, payment may also include other adjustments, e.g.,

- **Transfer pricing adjustment.** Payment may be reduced for some stays where 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. Outlier adjustments typically affect 1% to 2% of all stays.
- **Partial eligibility.** In rare 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 would be 50% of the calculated amount.
- **Third party liability and patient liability.** The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct amounts 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.

### **13. How will the DRG be assigned?**

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

### **14. Where do the DRG relative weights come from?**

The two options are to use relative weights calculated from the Nationwide Inpatient Sample or relative weights calculated from Medi-Cal data. The project workgroup will evaluate the advantages and disadvantages of each option.

### **15. What will be the DRG base price be?**

This question has not yet been discussed in depth. Some states use a single statewide DRG base price for all hospitals. The Medicare program adjusts its base price 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.

## **ALL PATIENT REFINED DRGs**

### **16. 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.

## **17. 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](http://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, Montana Medicaid, New York Medicaid, Pennsylvania Medicaid, Rhode Island Medicaid, Colorado Medicaid, North Dakota Medicaid, South Carolina Medicaid, and Wellmark, the BlueCross BlueShield plan in Iowa.

## **18. 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](http://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.

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

The Department intends to implement V.29 of APR-DRGs, which will be released October 1, 2011. Simulation calculations for the new payment method are being done using V.28, which was released October 1, 2010. V.28 and V.29 are extremely similar. Simulations and other analyses will be updated to V.29 when it is released.

## **20. 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.

## **21. 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.

## OTHER QUESTIONS

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

This has not yet been discussed in depth. 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.

### 23. 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.

### 24. 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, whether the DRG base price varies by wage area or by type of hospital, and whether there is a transitional period before the new payment rates are fully implemented.

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.

### 25. Will there be changes in billing requirements?

Some changes in billing requirements are expected. For example, DRG payers make separate payments for a newborn baby and the mother. Therefore, the hospital would submit two claims, whereas the baby is often now included on the mother's claim. As well, DRG payers typically do not accept interim claims or claims for late charges. (Instead of late charges, a hospital would submit an adjusted claim.)

The list of billing changes is currently in process. It will be reviewed in detail with the hospital consultation group as the new payment method is developed.

### 26. Where can I go for more information?

- **FAQ.** Updates of this document will be available on the DHCS website.
- **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](http://www.calhospital.org). Hospitals that are not CHA members may contact Jack Ijams at [jhijams56@mmm.com](mailto:jhijams56@mmm.com).
- **DRG Pricing Calculator.** Once tentative recommendations have been made about the structure of the DRG payment method, DHCS plans to make a DRG Pricing Calculator available at no charge on our website. 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. It is expected to be posted to the website in the fall of 2011.

- ***Hospital training sessions.*** Hospital trainings will be held across the state, most likely in the spring of 2012.
- ***Hospital provider manual.*** The hospital provider manual will be updated to show details of the DRG based payment method.

### **For Further Information**

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