STATUS REPORT TO THE LEGISLATURE

NEW INPATIENT HOSPITAL PAYMENT METHODOLOGY: DIAGNOSIS-RELATED GROUPS

Department of Health Care Services
Safety Net Financing Division
April 1, 2013
# TABLE OF CONTENTS

I. Background Information ........................................................................................................3

II. Purpose of the Update ............................................................................................................3

III. Key Milestones and Objectives. ..........................................................................................3

IV. Key Implementation Issues and Challenges .........................................................................5

Appendices:

- Attachment 1
- Attachment 2
I. Background Information

SB 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010) requires the Department of Health Care Services (DHCS) to implement a new payment methodology for fee-for-service (FFS) inpatient hospital care in the Medi-Cal program based upon diagnosis-related groups (DRGs).

California currently pays hospitals for FFS care based upon one of three methodologies:

- Hospitals that contract through the Selective Provider Contracting Program (SPCP) negotiate a per diem rate through confidential negotiations.
- Hospitals that do not contract through the SPCP are reimbursed for their allowable costs. Non contract hospitals can only provide emergency services unless they operate in an open area.
- Designated Public Hospitals receive federal funding based on their certified public expenditures (CPEs). Pending federal approval, Non-Designated Public Hospitals will also be reimbursed based on their CPEs. Since these hospitals do not receive state reimbursement, they are excluded from the provisions of SB 853.

Roughly two-thirds of Medicaid programs around the country have adopted some form of a DRG payment methodology. A DRG payment methodology reimburses hospitals based on a patient’s clinical characteristics, grouping these characteristics into diagnosis groups. Instead of receiving higher reimbursement by providing more services or having longer stays, hospitals are paid based on patient acuity.

II. Purpose of the Update

SB 853 requires DHCS to submit a status report to the Legislature on the implementation of the DRG payment system on April 1, 2011; April 1, 2012; April 1, 2013; and April 1, 2014. This report provides the status update due to the Legislature for the reporting periods of April 1, 2012 and April 1, 2013.

III. Key Milestones and Objectives

DHCS briefed legislative staff on the status of the project through two in-person briefings in 2011 and 2012. DHCS held a legislative briefing in May 2011 (Attachment 1) and a follow-up presentation in November 2012 (Attachment 2). Those presentations include all updates through those
time periods. This report provides an update on key milestones and objectives since the November 2012 briefing:

- DHCS worked to develop and finalize the simulation data set that serves as the basis for the 2013 base prices by trending the 2009 data to 2013.

- Year one base prices were mailed to hospitals on January 31, 2013. The base price mailings included an attachment that provided information on projected payments under the current methodology; projected DRG payments based on the transition prices; and projected DRG payment based on the statewide base price that goes into effect July 1, 2016, (Year 4 of DRG implementation).

- DHCS hosted two webinars the week of February 4, 2013, to discuss the rate setting process. Over 170 hospital representatives attended the webinars. The PowerPoint presentation used for the webinars and a link to the recording of the webinars are available at the DRG website: http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx

- DHCS hosted two webinars the week of February 11, 2013, to provide general training on changes in claims submission, treatment authorization and claims pricing. Over 300 hospital representatives attended the webinars. The PowerPoint presentation used for the webinars and a link to the recording of the webinars are available at the DRG website cited above.

- DRG training will now be a part of ongoing provider training offered by the DHCS fiscal intermediary, Xerox State Healthcare, LLC. In addition to a monthly webinar series that started in April, in-person trainings are also available. In-person trainings were provided on February 20, 2013, in Ontario, March 14, 2013, in Sacramento, and April 17, 2013, in Anaheim. Individual hospitals can request additional training by contacting DHCS at DRG@dhcs.ca.gov, or Xerox at 1-800-541-5555.

- DHCS finalized per diem rates for rehabilitation services and per diem rates for the new administrative day level II (subacute) level of care. On March 27, 2013, DHCS notified hospitals who render rehabilitation services of their specific rate. The rates were published in a provider bulletin and are also available in the “Hospital Characteristic File” on the DRG website.
DHCS began issuing monthly provider bulletins to notify hospitals of pending changes with the DRG transition. Here is a description of the recent bulletins:

- **January 2013 Bulletin – DRGs: Executive Summary and Requested 2009 Data.** DHCS requested providers to read the Executive Summary that contains important information about the upcoming DRG payment methodology. DHCS continues to accept requests for hospital-specific data that shows how claims from calendar year 2009 would have been paid under the DRG methodology. The bulletin also explains how hospitals can request this information.

- **February 2013 Bulletin – DRGs: Billing for Obstetric (OB) and Newborn Services.** The DRG payment methodology requires a separate claim for services provided to the mother and newborn. Separate claims and separate payments are consistent with the fact that the mother and newborn are distinct patients with separate diagnoses, treatments, charges, lengths of stay and discharge status codes. The bulletin also advises hospitals on how to submit claims for newborn services.

- **March 2013 Bulletin – DRGs: Claim Completion and Billing Tips.** Effective for admissions on or after July 1, 2013, providers may submit up to 18 diagnosis codes and 6 procedure codes on paper claims and up to 25 diagnosis and/or procedure codes on electronic claims. This detailed coding, along with other information on the claim such as the patient's age and discharge status, will be used to assign the claim to an All Patient Refined (APR) DRG group.

A DRG “Frequently Asked Questions (FAQ)” document is posted on the DRG website and has been updated as of March 2013. A second DRG Provider Billing FAQ document was posted on the webpage that provides answers to the most common technical billing, coding, and treatment authorization questions asked in the trainings provided to date.

**IV. Key Implementation Issues and Challenges - UPDATE**

There are multiple key implementation issues DHCS is currently working through to ensure a successful transition July 1, 2013. These issues include:
- Preparing for improved documentation and coding of diagnoses and procedures that is likely to occur once payment is based on patient acuity.
- Securing enhanced federal reimbursement for necessary system changes.
- Meeting the deadlines for system changes, including testing, to the Legacy CA-MMIS which will require a concerted effort from DHCS and its fiscal intermediary. The system changes are on track for a July 1 implementation.
- Preparing the State Plan Amendment.
- Updating the Provider Manual.
Diagnosis–Related Groups (DRG) Hospital Inpatient Payment System

May 25, 2011

Meeting Schedule

› Design of New Methodology
   - April 2011 – November 2011
     - Finish the payment methodology
     - December 2011 ACS provides Final Policy Design Document (PDD)

› Design and Implementation of New Payment System
   - June 2011 – June 2012

Hospital Inpatient Services (cont.)

- Hospitals that do not contract through the SPCP are reimbursed for their allowable costs and can only provide emergency services if they operate in an area that was deemed open by CMAC. In 2009/10 there were 168 non-contract hospitals (excluding psychiatric).
- Designated Public Hospitals (DPH) receive federal funding based upon their Certified Public Expenditures (CPE). There are 21 of these hospitals, but due to these hospitals not receiving State reimbursement, they have been excluded by Statute.

Key Components

› What does DRG do?
   - Distributes a set pot of money to hospitals providing general acute care services

› Who’s Affected
   - All hospitals with General Acute Care

› Who’s Excluded
   - Public Hospitals
   - Psychiatric Hospitals
   - Rehabilitation Hospitals
   - Alcohol and Drug Rehabilitation
Key Components (cont.)

- Benefits of DRGs
  - Provides a price for the product
    - Transparent
  - Rewards Efficiency
  - Flexible
    - Unique situations

Keys to Success

- Transparent Process
  - 2 Workgroups
    - All input will be considered and valued:
      - Internal → Department of Health Care Services (DHCS), Office of Statewide Health Planning and Development (OSHPD), and CMAC
      - External → Led by California Hospital Association (CHA)
    - Everyone has a chance to participate in the development

Medi–Cal DRG Project

Briefing for Legislative Staff
Sacramento—May 25, 2011

Government Healthcare Solutions
Payment Method Development

Medicaid’s Market Share Nationwide

CONTEXT

Medicare
Medicaid
Private & Other
Uninsured

Neonates Obstetrics Pediatric MH Pediatric misc. Adult MH Adult respiratory circulatory Adult circulatory Adult misc. Total


“A Very Short History of Payment Methods

- “Pay More to Those Who Do More”
  - In the beginning:
    - More = more charges, more cost
  - Fee for service philosophy:
    - More = more services
  - The DRG revolution:
    - More = treat sicker patients
  - The next revolution:
    - More = better results
A Win-Win in the Early Years of Medicare DRGs

Prospective Payment System is the most effective cost-containment program ever enacted, successful beyond anyone’s expectations
— Michael Bromberg, Federation of American Hospitals, 1985

Chart 2.2.3.3

How Medicare Pays for Hospital Inpatient Care

Per Stay — CMS-DRGs

Per Stay — AP or Tricare DRGs

Per Stay — MS-DRGs

Per Stay — Other

Per Diem

Cost Reimbursement

AL, AR, CT, ID, ME, SC

Other (Regulated Charges)

MO*

Notes

1. ADRG Description
2. Stays
3. Days
4. Charges
5. Cost
6. ALOS
7. Avg Chg
8. Avg Cost

Per Diem

Medicare Overall

1980-83

1984-87

Per Stay -- CMS-DRGs

Per Stay -- AP or Tricare DRGs

Per Stay -- MS-DRGs

Per Stay -- Other (Regulated Charges)

Notes

1. Growth in Medicare Spending, 1980-87

2. Medicare hospitals went from

3. Other (Regulated Charges)

4. Payment per stay, with higher rates for sicker patients as

5. Requires

6. To be evened out for patients of different severity

7. Payment per stay, with higher rates for sicker patients as

8. Per Diem

9. Cost Reimbursement

10. Per Stay -- CMS-DRGs

11. APR-DRGs

12. All Patient Refined DRGs (3M)

13. Per Diem

14. Per Stay -- APR-DRGs

15. Per Stay -- MS-DRGs

16. Per Stay -- Other

17. Per Diem

18. Cost Reimbursement

19. Other (Regulated Charges)

20. MO*

21. APR-DRG Description

22. Stays

23. Days

24. Charges

25. Cost

26. ALOS

27. Avg Chg

28. Avg Cost

Notes

1. Growth in Medicare Spending, 1980-87

2. Medicare hospitals went from

3. Other (Regulated Charges)

4. Payment per stay, with higher rates for sicker patients as

5. Requires

6. To be evened out for patients of different severity

7. Payment per stay, with higher rates for sicker patients as

8. Per Diem

9. Cost Reimbursement

10. Per Stay -- CMS-DRGs

11. APR-DRGs

12. All Patient Refined DRGs (3M)

13. Per Diem

14. Per Stay -- APR-DRGs

15. Per Stay -- MS-DRGs

16. Per Stay -- Other

17. Per Diem

18. Cost Reimbursement

19. Other (Regulated Charges)

20. MO*

21. APR-DRG Description

22. Stays

23. Days

24. Charges

25. Cost

26. ALOS

27. Avg Chg

28. Avg Cost

Notes

1. Growth in Medicare Spending, 1980-87

2. Medicare hospitals went from

3. Other (Regulated Charges)

4. Payment per stay, with higher rates for sicker patients as

5. Requires

6. To be evened out for patients of different severity

7. Payment per stay, with higher rates for sicker patients as

8. Per Diem

9. Cost Reimbursement

10. Per Stay -- CMS-DRGs

11. APR-DRGs

12. All Patient Refined DRGs (3M)

13. Per Diem

14. Per Stay -- APR-DRGs

15. Per Stay -- MS-DRGs

16. Per Stay -- Other

17. Per Diem

18. Cost Reimbursement

19. Other (Regulated Charges)

20. MO*

21. APR-DRG Description

22. Stays

23. Days

24. Charges

25. Cost

26. ALOS

27. Avg Chg

28. Avg Cost

Notes

1. Growth in Medicare Spending, 1980-87

2. Medicare hospitals went from

3. Other (Regulated Charges)

4. Payment per stay, with higher rates for sicker patients as

5. Requires

6. To be evened out for patients of different severity

7. Payment per stay, with higher rates for sicker patients as

8. Per Diem

9. Cost Reimbursement

10. Per Stay -- CMS-DRGs

11. APR-DRGs

12. All Patient Refined DRGs (3M)

13. Per Diem

14. Per Stay -- APR-DRGs

15. Per Stay -- MS-DRGs

16. Per Stay -- Other

17. Per Diem

18. Cost Reimbursement

19. Other (Regulated Charges)

20. MO*

21. APR-DRG Description

22. Stays

23. Days

24. Charges

25. Cost

26. ALOS

27. Avg Chg

28. Avg Cost

Notes

1. Growth in Medicare Spending, 1980-87

2. Medicare hospitals went from

3. Other (Regulated Charges)

4. Payment per stay, with higher rates for sicker patients as

5. Requires

6. To be evened out for patients of different severity

7. Payment per stay, with higher rates for sicker patients as

8. Per Diem

9. Cost Reimbursement

10. Per Stay -- CMS-DRGs

11. APR-DRGs

12. All Patient Refined DRGs (3M)
**HOW DRG PAYMENT WORKS**

**Medicare DRGs vs APR-DRGs**

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Medicare patients only</th>
<th>All patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>No separate logic</td>
<td>Separate logic for Pediatrics</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>15 DRGs, not updated since 1980s, no specific severity logic</td>
<td>12 DRGs, severity logic adapted for obstetric cases</td>
</tr>
<tr>
<td>Newborns</td>
<td>7 DRGs, not updated since 1980s, no use of birthweight</td>
<td>112 DRGs, reflects birthweight</td>
</tr>
</tbody>
</table>

**Severity of Illness**
- Captured through use of complication/comorbidity (CC) and major CC
deferred severity logic, which depends on number, nature and interaction of CCs

**Structure**
- 314 base DRGs, each with 4 levels of severity = 1,256 severity levels

**Note:**
ACS has no financial interest in any DRG algorithm

**Based on clinical data**

<table>
<thead>
<tr>
<th>DRG</th>
<th>Hospital</th>
<th>Case Rate</th>
<th>Relative Weight</th>
<th>Policy Adjustor</th>
<th>Payment Relative Weight</th>
<th>DRG Base Price</th>
<th>DRG Base Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Heart Failure Level 1</td>
<td>Hospital 1</td>
<td>0.95</td>
<td>1.00</td>
<td>0.95</td>
<td>4,000</td>
<td>$3,800</td>
</tr>
<tr>
<td>002</td>
<td>Heart Failure Level 2</td>
<td>Hospital 2</td>
<td>1.25</td>
<td>1.00</td>
<td>1.00</td>
<td>5,000</td>
<td>$6,250</td>
</tr>
<tr>
<td>003</td>
<td>Newborn &gt; 2000 G</td>
<td>Hospital 1</td>
<td>0.50</td>
<td>1.25</td>
<td>0.63</td>
<td>4,000</td>
<td>$2,500</td>
</tr>
<tr>
<td>004</td>
<td>Newborn &lt; 2000 G</td>
<td>Hospital 2</td>
<td>1.75</td>
<td>1.25</td>
<td>2.19</td>
<td>5,000</td>
<td>$10,938</td>
</tr>
</tbody>
</table>

**Example is for illustration only**

**CHART 2.1.1**

**Typical Mechanics of DRG Payment**

- Set by payer to hit budget target—can be statewide base-price or hospital-specific
- Calculated from dataset

- **Based on clinical data**
- **Policy Adjustor**
- **Payment Relative Weight**
- **DRG Base Price**
- **DRG Base Payment**

- **Example is for illustration only**

**PROCESS**

**DRG Payment Method Development**

- Based on experience nationwide, this method may be in place for 15, 20 or more years
- Internal DMCS workgroup meets monthly from April to November
- Consultation meeting convened monthly by CHA
- Process culminates in “policy design document” due in November

**Key points in developing recommendations**
- Data-driven decision-making wherever possible
- Work to build understanding and trust
- Nothing is final until everything is final
- Keep focus on payment policy criteria
- One-on-one discussions are discouraged
- Final review and approval by DHCS only after PDD is complete

**FAQ and other tools to be used to inform broader audience**

**PROCESS**

**Major Payment Policy Considerations**

- Excluded from the project: psych and rehab hospitals, psych and rehab stays in general hospitals, designated public hospitals
- DRGs are a method of allocating a funding pool among inpatient stays; the size of the funding pool is a separate question
- No discussion yet on several key financial topics:
  - Whether to use policy adjustors to boost payment for certain categories of care
  - Whether to have a single statewide DRG base price, or vary it geographically, or vary it by hospital type
  - Whether to have a transition period before the new method is fully effective
  - Interaction of DRG payment and supplementary payments
- Target date for implementation is July 1, 2012

**PROCESS**

**Suggested Criteria for Payment Policy**

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>User payment is expected resource cost</td>
<td>Adjust payment for patient acuity</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Reward lower cost for same care</td>
<td>Set prospective rates that do not depend on individual provider costs or charges</td>
</tr>
<tr>
<td>Policy control</td>
<td>Overall and for specific priorities</td>
<td>Set up method so Medicaid sets payment levels</td>
</tr>
<tr>
<td>Admin ease</td>
<td>For Medicaid and providers</td>
<td>Think carefully before adding complexity, work through operational implementation</td>
</tr>
<tr>
<td>Data integrity</td>
<td>Base calculations on good data</td>
<td>Avoid reliance on vague or hard-to-verify six, Px, charge or cost values</td>
</tr>
<tr>
<td>Purchasing clarity</td>
<td>Enable understanding of services</td>
<td>Use clinically meaningful groupings and pooled data on rates and utilization</td>
</tr>
<tr>
<td>Fairness</td>
<td>Similar payment for similar care</td>
<td>Standardize rates for services</td>
</tr>
<tr>
<td>Quality</td>
<td>Specifiically facilitate improvement</td>
<td>Few current methods inherently promote quality</td>
</tr>
</tbody>
</table>

**PROCESS**

**Keys to Success in DRG Projects**

- Genuine collaboration between Medicaid and hospitals
- Close collaboration between policy staff and systems staff
- Extensive analysis of claims dataset in order to set budget target and simulate impacts
- Think twice before adding complexity
- Early start on state and federal approvals
- Extensive MMIS testing
- Strong provider education efforts
ACS, A Xerox Company

- ACS is part of Xerox’s $22 billion global enterprise with over 140,000 employees serving our clients in 160 countries
- ACS Government Healthcare Solutions serves Medicaid programs across the U.S.
- ACS is the new Medi-Cal fiscal intermediary, taking over operations in September 2011 and building a new claims processing system
- ACS payment method development team helps Medicaid programs analyze, design and implement methods for purchasing services provided by hospitals, nursing facilities, physicians and other health care providers
- Major DRG development projects include the District of Columbia, Mississippi, Montana, Rhode Island, South Carolina, and Texas
- More information about ACS is available at www.acs-inc.com

For Further Information

Medi-Cal DRG Project—Policy and Process
- Mark Sanui
  - Safety Net Financing Division
  - California Department of Health Care Services
  - mark.sanui@dhcs.ca.gov
  - 916-327-8278

Medi-Cal DRG Project—Technical Questions
- Kevin Quinn
  - Vice President, Payment Method Development
  - Government Healthcare Solutions
  - ACS, A Xerox Company
  - kevin.quinn@acs-inc.com
  - 406-457-9550

California Hospital Association

- DHCS has asked the California Hospital Association to engage hospitals in a Consultation workgroup
- Workgroup will meet once monthly with DHCS and ACS through November
- DHCS and ACS have asked for hospital input in development of Policy Design Matrix

California Hospital Association

- Hospital Groups Participating Include:
  - Children’s Hospitals
  - District Hospitals
  - Disproportionate Share Hospitals
  - Rural Hospitals
  - Urban Hospitals
  - Teaching Hospitals
  - Tertiary Care Hospitals
  - Cancer Hospitals

Some results in this analysis were produced using data obtained through the use of proprietary computer software created, owned and licensed by the 3M Company. All copyrights in and to the 3MTM Software are owned by 3M. All rights reserved.
Background

- Current payment method:
  - Contracted hospitals: Selective Provider Contracting Program (negotiated confidential per diem rates)
  - Non-contracted hospitals: cost reimbursement
  - In place almost 30 years
- SB 853 (2010) directed DHCS to replace current method with new payment method based on Diagnosis Related Groups
- Affects inpatient claims only – not outpatient
- Affects payment method, not payment level
  - Expected to reward hospital efficiency
  - Future funding levels based on number of stays, casemix, and legislative appropriations

DRG Algorithm: APR-DRGs

- APR-DRGs: All Patient Refined Diagnosis Related Groups
- Developed in early 1990s by 3M and National Association of Children’s Hospitals (NACHRI)
- Intended to be suitable for all-patient population, especially obstetrics, newborns, NICU babies, general pediatrics, and children with complex medical needs
- Widely used for research, analysis and payment
- Medicare MS-DRGs not suitable or intended for Medicaid
  - “We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn and maternity patients.” (FFY 2008 Medicare Final Rule (8.2.07))
Characteristics of DRG Payment

- Payment reform that helps ensure and improve access and rewards efficiency.
- Payment based on patient need by setting payments based on acuity.
- Improves transparency and fairness
- Rewards hospitals that reduce cost
- Rewards complete coding of diagnoses and procedures
- Allows for future implementation of quality factors into payments

Characteristics of DRG Payment

Basic DRG Payment is based on:

Base price \times \text{relative weight}

- Base price is determined by State and may vary based on geography or other characteristics
- Relative weight is determined by DRG algorithm and is based on procedures and diagnoses (acuity)
- Other impacts to the final payment include policy adjustors, outlier payments, and other potential adjustments depending on State policy

Key Policy Decisions

- Transition Period
- Supplemental Payments
- Geographic Adjustment
- Policy Adjustors
- Outlier Policy
- Separately Payable Devices, Supplies and Services

Transition Period

- Implementation is July 1, 2013
- 3 year transition period
  - Similar to Medicare when it moved to DRGs
  - Limits individual hospital’s change from baseline to a +/- 5% in year 1; 10% in year 2; 15% in year 3. Full implementation of methodology in year 4
  - Transition is necessary due to the fundamental change in the payment system, which results in a redistribution of existing funding
  - Will allow hospitals time to make adjustments to systems as needed
  - Intend to provide individual hospital rates by end of 2012
  - Emphasize reducing impact to those adversely affected
- Example:
  - Individual hospital base rate equivalent is $10k; statewide base price is $7k, thus looking at 30% decrease
  - Year 1 rate would be set at $5,500 (-5%); year 2 at $4,900 (-10%); year 3 at $4,500 (-15%); year 4 at $7,000 (full implementation)

Supplemental Payments

- All supplemental payments will remain outside of the DRG payment system
  - Disproportionate Share Hospital Funding
  - Hospital Fee & IGT based payments
  - Private Hospital Supplemental Fund
Geographic Adjustment

• Adjustment to account for differences in wage areas
  – We will follow Medicare’s differential classifications for hospitals
    • Match Medicare on Lugar, Outmigration and other differentials
  – Adjustment to be applied to 68.8% of base price (labor portion)
    • This is based on Medicare and will be updated annually

Rural Hospitals

• Remote Rural Hospital
  – Defined as hospital listed on OSHPD rural hospital list that does not have another hospital, which operates at least a basic level ER, within 15 miles and hospital is not on a combined facility license
    • All Medicare CAH’s fall within this definition
    • Rounded mileage up to the nearest mile (one additional hospital made the list)
  – The base price for remote rural facilities will be set at 95% of cost in aggregate
    • Hospitals may be added or deleted to the extent circumstances change (e.g. hospital closure)
  – Intended to help ensure access in rural areas with sole community providers. DHCS will continue to monitor access and make adjustments as needed

Policy Adjustor – Neonatal Intensive Care Unit (NICU)

• Designated NICU – 1.75 multiplier
  – Defined as facilities whose NICU offers CCS approved Neonatal Surgery
    • Higher costs related to specialists, equipment, and other higher fixed costs
  – All Other NICU – 1.25 multiplier

Policy Adjustor - Pediatrics

• Pediatrics (under 21) receive a 1.25 multiplier for two Medicaid Care categories
  – Pediatric Respiratory
  – Pediatric Miscellaneous
    • These two cover roughly 95% of pediatric stays

Outlier Policy

• High Side Outlier - tiered
  – Threshold 1: >$30,000 but <$100,000 loss: Marginal Cost Factor - 60%
  – Threshold 2: >$100,000 loss: Marginal Cost Factor at 80%
    • Example: If loss is $105,000 then ($70,000 x 60%) + ($5,000 x 80%) = $46,000 outlier payment in addition to DRG base payment
  – Tiered approach addresses concerns regarding very expensive patients

• Low Side Outlier
  – >$30,000 gain: Marginal Cost Factor at 60%

Separately Payable Devices, Supplies, and Services

• Bone marrow transplant search and acquisition costs
• Blood factors
• Potential for future carve outs for new technologies
**DRG Payment Methodology**

**Key Payment Values**

<table>
<thead>
<tr>
<th>DRG Base Price, rural</th>
<th>Medicare ’08</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG Base price, rural</td>
<td>Medicare ’09</td>
</tr>
<tr>
<td>Hospital, rural</td>
<td>Medicare ’09</td>
</tr>
</tbody>
</table>

**Policy Adjustments**

<table>
<thead>
<tr>
<th>Policy adjustment</th>
<th>Base Rural</th>
<th>Rural Statewide</th>
<th>Non-Rural Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age remote</td>
<td>1.25</td>
<td>1.15</td>
<td>1.05</td>
</tr>
<tr>
<td>Age rural</td>
<td>1.25</td>
<td>1.15</td>
<td>1.05</td>
</tr>
</tbody>
</table>

**Transfer Discharge**

<table>
<thead>
<tr>
<th>DRG Category</th>
<th>Rural</th>
<th>Rural Statewide</th>
<th>Non-Rural Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric</td>
<td>0.25</td>
<td>0.20</td>
<td>0.30</td>
</tr>
</tbody>
</table>

**How the Allowed Amount Is Calculated**

1. Group each stay to APR-DRG
2. Look up relative weight by APR-DRG
   - From a national database that fits CA well
   - Some care categories increased by policy
3. Will vary by Medicare wage area
4. Will be higher for remote rural hospitals
6. Incorporate specific payment adjustments
   - Age policy adjustor, outlier payments, transfers

**How Claims Will Be Paid**

1. Straight DRG
   - 314 base APR-DRGs, each with four levels of severity
   - DRG base price in Los Angeles wage area = $5,075 x 1.2282

```
<table>
<thead>
<tr>
<th>DRG Description</th>
<th>Rel. Wt.</th>
<th>DRG Base Price</th>
<th>DRG Base Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>109 A</td>
<td>0.0006</td>
<td>S 6,333</td>
<td>S 7,812</td>
</tr>
<tr>
<td>109 B</td>
<td>0.0007</td>
<td>S 6,333</td>
<td>S 7,892</td>
</tr>
<tr>
<td>109 C</td>
<td>0.0014</td>
<td>S 6,333</td>
<td>S 10,019</td>
</tr>
<tr>
<td>109 D</td>
<td>0.0025</td>
<td>S 6,333</td>
<td>S 12,765</td>
</tr>
<tr>
<td>109 E</td>
<td>0.0038</td>
<td>S 6,333</td>
<td>S 22,210</td>
</tr>
</tbody>
</table>
```

2. Pediatric Adjuctor
   - Illustrates the Straight DRG modified for a pediatric patient

```
<table>
<thead>
<tr>
<th>DRG Description</th>
<th>Rel. Wt.</th>
<th>DRG Base Price</th>
<th>Pediatric adjustor</th>
<th>Pediatric adj. applied</th>
<th>Pediatric adj. applied</th>
<th>Pediatric adj. applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>109 A</td>
<td>0.0006</td>
<td>S 6,333</td>
<td>1.2282</td>
<td>1.25</td>
<td>1.25</td>
<td>1.25</td>
</tr>
<tr>
<td>109 B</td>
<td>0.0007</td>
<td>S 6,333</td>
<td>1.2282</td>
<td>1.15</td>
<td>1.15</td>
<td>1.15</td>
</tr>
<tr>
<td>109 C</td>
<td>0.0014</td>
<td>S 6,333</td>
<td>1.2282</td>
<td>1.05</td>
<td>1.05</td>
<td>1.05</td>
</tr>
<tr>
<td>109 D</td>
<td>0.0025</td>
<td>S 6,333</td>
<td>1.2282</td>
<td>0.80</td>
<td>0.80</td>
<td>0.80</td>
</tr>
<tr>
<td>109 E</td>
<td>0.0038</td>
<td>S 6,333</td>
<td>1.2282</td>
<td>0.60</td>
<td>0.60</td>
<td>0.60</td>
</tr>
</tbody>
</table>
```
3. Transfer Cases
- Payment adjustment follows Medicare model
- Applies to short-stay patients transferred for acute care; ("Transfer" statuses 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

<table>
<thead>
<tr>
<th>Special Topics</th>
<th>Misc pediatric</th>
<th>Revenue</th>
<th>Costs</th>
<th>Net</th>
<th>Percent 1</th>
<th>Percent 2</th>
<th>Percent 3</th>
<th>Percent 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>73%</td>
<td>83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) This simulation is for purposes of illustration only and does not represent Xerox recommendations or DHCS decisions.

<table>
<thead>
<tr>
<th>Medicaid Care Category</th>
<th>Revenue</th>
<th>Costs</th>
<th>Net</th>
<th>Percent 1</th>
<th>Percent 2</th>
<th>Percent 3</th>
<th>Percent 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oakland-Fremont-Hayward Reclass-1</td>
<td>$11,910,925</td>
<td>$11,910,925</td>
<td>$6,857,451</td>
<td>(5,053,474) (-42%)</td>
<td>100%</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>Modesto</td>
<td>$37,956,296</td>
<td>$27,112,106</td>
<td>$29,146,919</td>
<td>$2,034,813 8% 71% 77%</td>
<td>$1,258,204 18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresno</td>
<td>$68,596,624</td>
<td>$70,070,860</td>
<td>$60,806,891</td>
<td>(9,263,969) -13% 102% 89%</td>
<td>$5,214,772 9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Los Angeles-Long Beach-Glendale Reclass</td>
<td>$220,841,857</td>
<td>$179,185,839</td>
<td>$188,642,107</td>
<td>$9,456,268 5% 81% 85%</td>
<td>$20,236,714 11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Santa Ana-Anaheim-Irvine Reclass</td>
<td>$120,947,774</td>
<td>$94,775,995</td>
<td>$84,358,049</td>
<td>(10,417,945) -11% 78% 70%</td>
<td>$4,371,355 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chico</td>
<td>$47,552,129</td>
<td>$45,068,436</td>
<td>$38,722,276</td>
<td>(6,346,160) -14% 95% 81%</td>
<td>$1,193,612 3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Cost Outlier Case: Tier 1 & 2

<table>
<thead>
<tr>
<th>Cost Outlier Case: Tier 1 &amp; 2</th>
<th>Revenue</th>
<th>Costs</th>
<th>Net</th>
<th>Percent 1</th>
<th>Percent 2</th>
<th>Percent 3</th>
<th>Percent 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>77%</td>
<td>77%</td>
<td>28%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example of two-tier cost outlier threshold:
- Tier 1 paid at 60% for losses between $30,000 and $100,000
- Tier 2 paid at 80% for losses greater than $100,000

Wage Area

<table>
<thead>
<tr>
<th>Wage Area – continued</th>
<th>Revenue</th>
<th>Costs</th>
<th>Net</th>
<th>Percent 1</th>
<th>Percent 2</th>
<th>Percent 3</th>
<th>Percent 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>98%</td>
<td>98%</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5/31/2013
Next Steps

- Late 2012: hospitals will receive:
  - Base rates
  - Summarized simulated claims data
  - Hospital-specific claims information available upon request
- Spring 2013 Provider Training
- June 2013 revised Provider Manual published
- Implementation: July 1, 2013

For Further Information
Jon Wunderlich
Assistant Deputy Director, Healthcare Financing
California Department of Health Care Services
jonathan.wunderlich@dhcs.ca.gov  916.440.7800

New DHCS webpage devoted to APR-DRG information:
www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx