STATUS REPORT TO THE LEGISLATURE

NEW INPATIENT HOSPITAL PAYMENT METHODOLOGY: DIAGNOSIS-RELATED GROUPS

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Department of Health Care Services
Safety Net Financing Division

Pursuant to Senate Bill 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010)
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I. Background Information

SB 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010) required 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 previously paid hospitals for FFS care based upon one of three methodologies:

- Hospitals that contracted through the Selective Provider Contracting Program (SPCP) negotiated a per diem rate through confidential negotiations.

- Hospitals that did not contract through the SPCP were reimbursed for their allowable costs. Non contract hospitals can only provide emergency services if they operate in an open area.

- Designated Public Hospitals receive federal funding based on their Certified Public Expenditures. California is able to certify unreimbursed Medicaid eligible costs expended by these hospitals and draw down the applicable federal Medicaid matching funds associated with those costs. This methodology continues in place as these facilities are exempt from DRG reimbursement.

Roughly two-thirds of Medicaid programs nationwide have adopted some form of a hospital DRG payment methodology. A DRG payment methodology reimburses hospitals based on a patient's clinical characteristics grouped 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 is the final report which provides an update for the period April 30, 2013, to April 1, 2014.
III. Key Milestones and Objectives

DHCS successfully transitioned private hospitals to the DRG payment methodology effective July 1, 2013, for general acute care services and transitioned Non-Designated Public Hospitals (NDPHs) to the DRG methodology on January 1, 2014.

In this report DHCS provides an update on additional key milestones and objectives related to the DRG transition and post implementation activities. The following are highlights of key milestones and objectives:

- **DRG Rates** – Hospital specific base price or transitional prices for Years 2, 3 and 4 were mailed to hospitals on July 30, 2013. The letters contained technical attachments providing information on projected payments under DRG methodology, projected case mix acuity at a hospital specific level, projected DRG payments based on the transition or statewide prices for each fiscal year, and projected DRG payment based on the statewide base price that goes into effect July 1, 2016 (Year 4 of DRG implementation).

- **State Plan Amendment (SPA) Approval** – SPA 13-033 was approved by the Centers for Medicare & Medicaid Services on December 5, 2013. SPA 13-033 provides that inpatient hospital services furnished by NDPHs be reimbursed under a DRG payment methodology, for admissions on or after January 1, 2014. NDPHs were successfully integrated into the methodology by the date specified.

- **Training** – DHCS offers statewide DRG provider training, conducted via webinar on a monthly basis and upon request by a provider. Topics include DRG billing, the importance of accurate claim coding, reimbursement calculations, outlier adjustments, and other policy adjustors that impact reimbursements. DHCS also maintains a DRG webpage and an e-mail address to respond to provider questions.

- **Outreach** – DHCS regularly meets with internal and external stakeholders to address any concerns with the change in payment methodology. Major topics include the validation of DRG paid claims data, provider education on DRG payment tools, monitoring payment data in relation to budget neutrality, and accurate claims coding to ensure access to all Medi-Cal beneficiaries. The last meeting was held on June 23, 2014.
• **Bulletins** – DHCS continues to issue provider bulletins to inform hospitals of pending or new changes that impact DRG coding, claims processing and payments. The last bulletin issued April 2014, notified providers that DHCS will be updating to version 31 of the APR-DRG Grouper effective for inpatient admissions on or after July 1, 2014.

• **“Frequently Asked Questions” (FAQ)** – DHCS maintains an FAQ document on the DHCS website which is updated on an as needed basis. The most recent update was posted on April 4, 2014. The FAQ provides answers to the most common questions related to technical billing, coding, and treatment authorization.

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

Prior reports focused on the key points and challenges of DRG implementation including:

- Securing enhanced federal reimbursement for necessary system changes. DHCS received approval on May 22, 2013.

- Meeting the deadlines for system changes, including testing, to the Legacy California Medicaid Management Information System.

- Policy decisions related to the development of the DRG payment system.

- Preparing the SPA and Provider Manual changes.

In 2014, new post implementation monitoring of DRG reimbursement, will include continued data compilations to ensure program integrity. DHCS will also be reviewing and updating all hospital cost-to-charge ratios, processing a new SPA, and preparing for the implementation of International Statistical Classification of Diseases, 10th Revision (ICD-10). DHCS will also be developing new audit procedures relative to DRG reimbursement. These major projects are listed below as DRG Phase 2 Implementation tasks:

- **Claims Monitoring** – DHCS monitors all inpatient FFS claim submissions and payments on a weekly basis. This enables quick identification of potential issues and ensures the earliest possible resolution. A small number of billing and/or system issues have been identified. The DHCS fiscal intermediary has already resolved some and others are in progress. Issues that have been resolved took effect on July 1, 2014, while the remaining issues continue to be researched on an ongoing basis.
- **System Updates and Rates** – System updates include an upgrade to the APR-DRG grouper from version 29 to version 31 to be effective on July 1, 2014, as well as Year 2 hospital-specific rates for all general acute care inpatient providers, hospital specific rehabilitation rates, and updates to administrative day rate per diems. The system updates became effective on July 1, 2014.

- **Annual State Plan Amendments** – DHCS will prepare SPAs annually to identify all technical changes necessary for each year’s base prices beginning with Year 2 base prices effective July 1, 2014. Changes that may be included in future SPAs are adjustments to policy adjustors, outlier thresholds or casemix corridors based on outcomes from DHCS monitoring. The SPA for Year 2 base prices was approved by CMS on June 19, 2014, and became effective on July 1, 2014.

- **Regulations** – In Year 2 of DRG, DHCS will amend the California Code of Regulations Sections 51003 - 51556 to be consistent with DRG bulletins and Provider Manual changes to general acute care inpatient reimbursement for private hospitals and NDPHs.

- **Provider Monitoring** – DHCS will be moving into post-implementation known as Phase 2 Implementation which will focus on more thorough program review of claim analysis, data mining, access monitoring, developing new audit procedures and claim reviews for any abnormalities or questionable billing practices. This phase will be ongoing and as needed to ensure proper DRG reimbursement and program oversight.

- **External Stakeholder Meetings** – DHCS continues to meet with providers upon request, as well as various hospital associations to address inquiries related to DRG reimbursement.