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*Director*

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
*Governor*

DATE: FEBRUARY 12, 2013

ALL PLAN LETTER 13-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RATES FOR EMERGENCY AND POST-STABILIZATION ACUTE INPATIENT SERVICES PROVIDED BY OUT-OF-NETWORK GENERAL ACUTE CARE HOSPITALS BASED ON DIAGNOSIS RELATED GROUPS EFFECTIVE JULY 1, 2013.

The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding a new Fee-For-Service (FFS) acute inpatient rate and payment method known as Diagnosis Related Groups (DRGs). As set forth in greater detail in this APL, DRGs will apply to out-of-network emergency and post-stabilization acute inpatient services provided to MCP beneficiaries by general acute care hospitals.

## **POLICY**

DRGs are scheduled to be applied in FFS starting on or about July 1, 2013, with certain exceptions. First, in FFS, DRGs will only apply to private hospitals. Secondly, acute care rehabilitation services will not be priced by DRGs in FFS. Pursuant to Welfare and Institutions Code (W&I Code) Sections 14105.28 and 14091.3, DRGs will go into effect for Medi-Cal managed care at the same time as FFS, on or about July 1, 2013. MCPs will be required to use DRGs for emergency and post-stabilization services at all out-of-network hospitals, including public and out-of-state hospitals. To the extent acute rehabilitation services are provided at out-of-network hospitals on an emergency or post-stabilization basis, MCPs may not pay more than the statewide per diem rate that the Department of Health Care Services (DHCS) is developing, which should be distributed at least three months prior to the DRG transition. Rehabilitation services are identified as those claims that include revenue codes 118, 128, 138, or 158. For hospital stays that group to the rehabilitation DRG code 860, MCPs will need to work with hospitals to determine appropriate payment. Specifically, MCPs will need to verify if an acute rehabilitation revenue code should have been present and pay the statewide per diem rate, or if the claim incorrectly included rehabilitation as the primary diagnosis. Rehabilitation DRG code 860 will not be used.

The implementation of DRGs for emergency and post-stabilization services does change the Medi-Cal allowed amount for out-of-network crossover claims. The implementation of DRGs does not change any other policy for crossover claims, MCP contracts with network hospitals, or arrangements for elective admissions to out-of-network hospitals.

## **PROCESS**

DHCS is implementing Version 29 of All Patient Refined (APR) DRGs in FFS, which was released October 1, 2011. The DRG software determines the diagnosis group, severity of illness, and other information based on the diagnoses and procedures associated with a hospital stay. With this information, the price of each claim is determined using the pricing calculator found under 'Important Information' on DHCS's DRG website at the following link:

<http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx>.

MCPs are responsible to calculate out-of-network rates consistent with this pricing. Consistent with current policy, MCPs may negotiate a different payment amount with out-of-network hospitals, but that amount may not exceed the DRG FFS equivalent payment amount for that admission.

In FFS, DHCS is utilizing hospital-specific transition prices for the first three years of APR-DRG implementation. Year one spans from July 1, 2013, through June 30, 2014, year two is from July 1, 2014, to June 30, 2015, and year three is from July 1, 2015, to June 30, 2016. A statewide base price will be used in year four that will be effective July 1, 2016. Remote rural hospitals will have a different base price, which will be identified on DHCS's DRG website. Consistent with the current practice of using geographic averages for emergency out-of-network inpatient services, out-of-network rates will be based on a hospital's year four base price (the applicable statewide base price) rather than transition prices. Regional cost differences will be determined by the hospital-specific Medicare wage index. Existing interim and regional rates or related cutbacks will no longer apply.

DHCS is implementing a number of policies in DRG rates, which are reflected in the pricing calculator. These policies include, but are not limited to, transfer rates, increased payment for pediatric and Neonatal Intensive Care Unit (NICU) stays, enhanced NICU payments for hospitals that are certified by DHCS to perform neonatal surgery, and outlier payments. For the purposes of emergency and post-stabilization out-of-network reimbursement by MCPs, the list of hospitals eligible for enhanced NICU payments will be expanded from the FFS list to include qualifying public hospitals. MCPs may refer to the 'Hospital Characteristics File' on the DRG webpage for lists of

remote rural hospitals, NICU certified hospitals, statewide and remote rural base prices, and Medicare wage indexes.

The DHCS Safety Net Financing Division (SNFD) is available to provide technical assistance and answer any questions MCPs may have about this new FFS reimbursement method. Future reimbursement changes in the DRG program in FFS will impact reimbursement for emergency out-of-network admissions. Those changes will be communicated to hospitals through provider bulletins and to the MCPs through APLs.

More information about the DRG program is available on the DRG website at <http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx>. If you have any questions regarding this APL, please contact the SNFD, through the DRG general mailbox at [drg@dhcs.ca.gov](mailto:drg@dhcs.ca.gov).

Sincerely,

ORIGINAL SIGNED BY MARGARET TATAR

Margaret Tatar  
Chief, Medi-Cal Managed Care Division