

## **Medi-Cal All Patient Refined Diagnosis Related Groups (APR-DRG) Project**

### **PROJECT ORIGINS**

In 2010, Senate Bill 853 was enacted into law, directing the Department of Health Care Services (DHCS) to develop a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program utilizing a diagnosis related group (DRG) methodology.

Since 1983, private hospitals have been paid under the Selective Provider Contracting Program (SPCP) or received cost-based reimbursement. "Contracted" hospitals negotiated a per diem payment rate with the California Medical Assistance Commission; that role has now been taken on by DHCS in the period before the new method is implemented. Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. Designated public hospitals and non-designated public hospital have a separate payment method and therefore are not included in the DRG project.

### **GOALS OF THE PROJECT**

In implementing the new DRG payment method for hospital inpatient services provided to Medi-Cal beneficiaries, the Department's goals are to:

- Engage in payment reform to help drive California towards the goals of health care reform, including driving payment towards quality and reducing the cost trend.
- Promote efficiency, improve transparency, and improve fairness by paying similarly across hospitals for similar care.
- Promote access to care by paying more for patients who require more care.
- Simplify the payment process, encourage administrative efficiency and base payments on consistent and credible data.

### **PROJECT BACKGROUND**

#### ***Timeframe***

DHCS began work on the DRG project in April of 2011. During the project development, DHCS received input from hospitals and other stakeholders. Although originally targeted to be implemented on July 1, 2012, the implementation date was moved to July 1, 2013 to ensure sufficient time was given to fully develop the methodology. DHCS work will continue and DRGs will be implemented as scheduled on July 1, 2013.

#### ***Fiscal Impacts***

Upon implementation, the DRG methodology is intended to be budget neutral to the state compared to the prior reimbursement system. Over time, DRGs are expected to reduce the cost trend of inpatient services in Medi-Cal.

#### ***Affected Hospitals***

The new method will apply to private 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, designated public hospitals, and non-designated public hospitals are outside the scope of the DRG based payment method.

## ***Affected Claims***

For affected hospitals, DRG pricing 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 unless otherwise noted:

- Psychiatric stays, regardless of whether they are in a distinct-part unit or not
- Rehabilitation stays; however, because contract and cost-based reimbursement will no longer continue, DHCS will establish a per diem rate for rehabilitation services.
- Managed care stays. However, DRG pricing will be used for out-of-network stays for emergency and post-stabilization services (Roger's rates).
- Administrative days (except that two new levels will be added with rates to be established by DHCS).
- Other services as may be determined by DHCS

DRG billing will affect special populations. Claims for clients who have coverage under the California Children's Services (CCS) or Genetically Handicapped Person Program (GHPP) will be priced using the new DRG method. This is true for all CCS or GHPP clients regardless of whether they also have Medi-Cal coverage.

## ***APR-DRG***

DHCS chose to utilize APR-DRGs 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.<sup>1</sup>

The Medi-Cal claims processing system will assign the APR-DRG and calculate payment without any need for the hospital to determine the DRG and put the DRG on the claim. In general, every complete inpatient stay is assigned to a single APR-DRG using a computerized algorithm that takes into account the patient's diagnoses, age, procedures performed, and discharge status. Each APR-DRG has a relative weight that reflects the typical hospital resources needed to care for a patient in that APR-DRG, relative to the hospital resources needed to take care of the average patient.

## ***DRG Pricing***

For over 90% of stays, it is likely that payment will be made using a "straight DRG" calculation—that is, payment will equal the DRG relative weight times the DRG base price times any policy adjustors.

In special situations, payment will include other adjustments, for example:

- ***Transfer pricing adjustment.*** Payment will be reduced when the patient is transferred to another acute care hospital if the length of stay in the first hospital is less than the average length of stay for the DRG.

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<sup>1</sup> 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.

- **Other health coverage and patient cost-sharing.** The calculations described above determine the allowed amount. From the allowed amount, payers typically deduct payments from other health coverage (e.g., workers' compensation) as well the patient's share of cost. No changes are planned to current Medi-Cal policies or procedures on other health coverage or share of cost.

The Department has also decided on a number of policies that will impact payment as described in the Policy Decisions section:

### ***Treatment Authorization Request (TAR) changes***

Simplification of the Treatment Authorization Request (TAR) process is expected to be a major benefit of DRG payment as, in general, a TAR will only be done to determine the medical necessity of the admission. Further detail on the TAR changes is available on the DRG website

### **MAJOR DRG POLICY DECISIONS**

Several major policy decisions were needed to finalize the DRG payment methodology. DHCS developed these decisions after significant data analysis and receiving input from hospital stakeholders. These policy decisions were made with a focus on the goals of the project which include promoting efficiency, access, transparency and fairness. DHCS will monitor access on an ongoing basis and make adjustments to these policies or add other policies as necessary to ensure access and appropriate reimbursement.

### ***Transition Period***

In order to ensure that the transition to DRGs does not negatively impact access, DHCS has determined that DRG base prices will be phased in over four years. In year one, hospitals will receive a base price that is within 5 percent of the base price that would maintain their funding level compared to the prior methodology. The increase or decrease limit will be 10 percent in year two and 15 percent in year 3. In year four, all hospitals that have not already done so will transition to their appropriate base price.

### ***Policy Adjustors***

To ensure access to particular services, DHCS has decided to implement two policy adjustors to the DRG payment method.

- *NICU:* Payment for NICU stays will receive a 25 percent increase over what payment otherwise would have been. In recognition that the overall cost structure for certain NICU facilities is higher, DHCS determined that payment for NICU stays in a designated NICU (capable of neonatal surgery as defined by DHCS) will receive a 75 percent increase.
- *Pediatric services:* Given the need to ensure access to pediatric services, payment for pediatric stays will receive a 25 percent increase. Pediatric stays for purposes of this adjustor are defined as stays for beneficiaries under 21, but excluding obstetric and newborn stays. This makes the pediatric and NICU policy adjustors mutually exclusive.

### ***Geographic Adjustment***

Similar to other DRG reimbursement programs, DHCS recognizes that there are geographic differences in cost. Therefore, DHCS has determined that the Medicare wage

index will be utilized to adjust DRG payments as it is done in the Medicare program.

### ***Rural Access***

DHCS recognizes that access in rural areas is critical to the Medi-Cal program. Therefore, it was determined that hospitals that meet the definition of a “remote rural” hospital would receive a higher, separate base price. Remote rural hospitals are defined as hospitals that are at least 15 miles in driving distance from the nearest general acute care hospital that has at least a basic level emergency room. The hospitals will still receive reimbursement based on DRGs to continue to promote the goals of DRGs; however, they will have a higher base price that sets reimbursement for these hospitals as a group at 95 percent of cost.

### ***Cost Outliers***

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. DHCS has developed a tiered outlier adjustment for high-cost stays in recognition that highly expensive cases are rare but can have a more significant negative impact on a hospital. The outlier adjustment for Medi-Cal will pay hospitals 60 percent of any loss between \$30,000 and \$100,000 and 80 percent for any loss above \$100,000. Profits above \$30,000 will be reduced by 60 percent.

### ***Separately Payable Devices, Supplies & Services***

While DRGs, particularly APR-DRGs, are intended to appropriately capture the typical cost of inpatient services, there are cases in which specific devices, supplies or services may not be appropriately priced by DRGs. In the development of the DRG payment method, DHCS determined that the need existed for a separately payable carve-out in two instances: blood factors and bone marrow transplant search & acquisition costs.

DHCS intends to continue to monitor and receive input for potential future separately payable devices, supplies & services as new technologies are developed that may not, at least for a period of time, be accurately reflected in the DRG relative weights.

### ***Documentation and Coding Adjustment***

Based on the experience of other payers (Medicare and other state Medicaid programs), DHCS expects documentation and coding to improve with the transition to DRGs. To ensure budget neutrality, DHCS plans to reduce payments by 3.5 percent to account for improved documentation and coding. This is consistent with other payers, and DHCS will monitor documentation and overall payment to determine if this amount should be reduced or increased.

### **FOR MORE INFORMATION**

DHCS has created a DRG website for key documents related to DRG pricing. Please refer to [www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx). The following documents are available or will be made available on the website:

- FAQ. The Frequently Asked Questions document.
- PDD. The Policy Design Document (PDD) provides more detail on the change in payment methodology to APR-DRG. This is available on the DRG website.

- DRG Pricing Calculator. The DRG Pricing Calculator shows how a given APR-DRG is priced in different circumstances.
- DRG Summary (this document)
- Provider bulletins
- Legislative report