Medi-Cal Year 5
DRG Payment
May 23 & June 1, 2017
Provider Training
Contents

- DRG Background
- Years 1 - 3 Experience
- Year 5 Updates
- Billing Points
- Cost Report Training
- Provider Education

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DRG Background

DRG Refresher Training

DRG Recorded Webinars on the Medi-Cal Learning Portal

Provider Recorded Webinars

Allied Health Common Denials Recorded Webinar

Operations Recorded Webinars

DRG Training for TAR Field Offices Recorded Webinar

Diagnosis Related Group Year 4 Recorded Webinar (05/26/2016 or 06/02/2016)
https://learn.medical.ca.gov/ivdetail/tabid/64/listingkey/614/diagnosis_related_group_year_4_recorded_webinar.aspx

Diagnosis Related Group Year 3 Recorded Webinar (06/11/2015 or 06/15/2015)
https://learn.medical.ca.gov/ivdetail/tabid/64/listingkey/432/diagnosis_related_group_year_3_recorded_webinar.aspx

Diagnosis Related Group Year 2 Recorded Webinar 07/2014
https://learn.medical.ca.gov/wcbrj9/diagnosis_related_group_year_2_recorded_webinar.aspx

Diagnosis Related Group Year 1 Overview Recorded Webinar 12/2013
https://learn.medical.ca.gov/_ngcdfvw/diagnosis_related_group_overview_recorded_webinar.aspx

DRG Training For TAR Field Offices Recorded Webinar 06/2013
https://learn.medical.ca.gov/.hz1gkqi/drg_training_for_tar_field_offices_recorded_webinar.aspx

Diagnosis Related Group Year 1 Ratesetting Recorded Webinar 02/2013
https://learn.medical.ca.gov/_m07kbnh/diagnosis_related_group_ratesetting_recorded_webinar.aspx

Diagnosis Related Group Billing Recorded Webinar July 2013
https://learn.medical.ca.gov/_fl55izi/diagnosis_related_group_billing_recorded_webinar.aspx

May 23 & Jun 1, 2017 W17-874 Medi-Cal Year 5 DRG Payment Provider Training
DRG Background

First, the Headlines

- FFS Medi-Cal DRG payment is budget neutral overall
- Actual FFS spending depends upon actual utilization and casemix
- Increase in non-remote rural base rate and pediatric adjustor; one tier outlier policy
- Hospitals:
  - Not required to change their systems or billing practices
  - Do not need to put the DRG on the claim
  - Should use appropriate year’s grouper settings to replicate DRG assignment and pricing
  - Should submit accurate cost reports
- APR-DRGs is an acuity-based payment method that adjusts payment according to the illness severity of each patient.
- Protecting the integrity of this acuity adjustment is critical.
A majority of states, and the District of Columbia, use or will use APR-DRGs for FFS Medicaid.

All the largest states have implemented APR-DRGs.

APR-DRGs account for 67% of the FFS inpatient Medicaid dollars.
Principles of DRG Payment

- **Value purchasing**: DRGs define “the product of a hospital,” enabling greater understanding of the services provided and purchased
  - DRGs reward better diagnosis and procedure coding, which should be complete, accurate and defensible
- **Fairness**: Statewide base rates with outlier policy for expensive patients
- **Efficiency**: Because payment does not depend on hospital-specific costs or charges, hospitals are rewarded for improving efficiency, such as reductions in lengths of stay
- **Access**: Higher DRG payment for sicker patients encourages access to care across the range of patient conditions
- **Transparency**: Payment methods and calculations on the DRG webpage
- **Administrative ease**: Day-by-day TAR no longer required (except some limited-benefit beneficiaries)
- **Quality**: Sets foundation for improvement of outcomes
History of the DRG Project

• Timeline:
  – Authorized by Senate Bill 853 in October 2010
  – 2011-2012: Policy development and consultation with hospitals
  – 2012-2013: Systems implementation and provider training
  – July 1, 2013: DRG Year 1 (first year of transition)
  – January 1, 2014: NDPHs implemented; Medicaid expansion implemented
  – July 1, 2014: DRG Year 2 (second year of transition)
  – July 1, 2015: DRG Year 3 (third year of transition)
  – October 1, 2015: ICD-10 Implementation
  – July 1, 2016: DRG Year 4 (statewide rates fully implemented)
  – July 1, 2017: DRG Year 5

• Programs: Medi-Cal fee-for-service, CCS only, GHPP only
• Hospitals: General acute care hospitals, including out-of-state; Medicare-designated CAHs and LTACs
• Excluded hospitals: Designated public hospitals, psychiatric hospitals (county financed)
• Excluded services: Rehabilitation (per diem), admin days (per diem), psychiatric care
Years 1 - 3 Experience
Impact: Medicaid Expansion/MC Transition

- Published FY 2013-14 Utilization and Payment Report
- Noticeable increase in Year 3 ACA Medi-Cal FFS volume
  - Year 1 contains only 6 months of ACA claims (Jan – June 2014)
  - Increased revenue for hospitals, assuming these patients were previously uninsured
  - Average casemix is higher than pre-existing FFS population
- Effect on FFS volumes and payments going forward depends on interaction of three trends:
  - Pace of new Medi-Cal enrollees under ACA Medicaid expansion
  - Pace of transition from FFS to managed care
  - Actual casemix and utilization
# Dataset Claims

## Medi-Cal DRG Years 1-3 Claims Dataset Completion

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year 1 (SFY 2013-14)</th>
<th>Year 2 (SFY 2014-15)</th>
<th>Year 3 (SFY 2015-16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admit dates</td>
<td>Admit dates</td>
<td>Admit dates</td>
</tr>
<tr>
<td>Payments</td>
<td>100%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Stays</td>
<td>100%</td>
<td>100%</td>
<td>99.1%</td>
</tr>
</tbody>
</table>

**Notes:**

1. Year 1 budget analysis included NDPH non-DRG claims from 7/1-12/31/13.
3. All data exclude designated public hospitals.
4. Includes all stays except interim claims, rehabilitation, and administrative days.
5. "Payment" refers to the paid amount, which equals about 98% of the allowed amount.
Years 1-3 Experience

Actual Stays, Paid by 2/27/17

- Overall decline in stays
- Non-ACA population 13% annual decrease
- ACA stays stable in Year 2, 11% increase in Year 3

Notes:
- Year 1 ACA stays only include 6 months, beginning Jan 2014
- Years 1 and 2 stays are 100% complete
- Year 3 stays are 99% complete
Years 1-3 Experience

Actual Payment, Paid by 2/27/17

• Overall volume and payment decreased
  – 12% from Year 1 to 2
  – 7% from Year 2 to 3

• Non-ACA payment decreased (most likely due to managed care transition)
  – 12% from Year 1 to 2
  – 7% from Year 2 to 3

• High-acuity ACA volume and payment increased in Year 3 after drop in utilization from Year 1 to 2
  – 11% increase in volume
  – 15% increase in payment
  – Increase in enrolled patient casemix and length of stay

Notes:
• Years 1 and 2 payment are 100% complete
• Year 3 payment is 98% complete
Years 1-3 Experience

Claims Analysis

• ACA included
  – Year 1 data only includes six months of ACA claims beginning January 1, 2014

• Includes NDPH facilities 1/1/2014 forward (DRG claims only)
  – Previous slides include NDPH paid claims back to 7/1/2013, though payment by DRG for NDPHs was implemented as of 1/1/2014

• Utilization analysis
  – MIS-DSS paid through 2/27/2017
Years 1-3 Experience

ACA vs. Non-ACA Utilization Trends

- ACA population has higher casemix, longer length of stay and higher average payment per stay
  - Aid codes: M2 = undocumented, M1 & 7U = adults; L1 = MCE transition
- Year 3 non-ACA average payment and length of stay are trending up in the final quarter of the year
- Casemix measurement changed from Year 2 to Year 3 so the trend isn’t perfectly comparable
Years 1-3 Experience

How Claims Were Paid

- Claims payment categories stable for Years 1-3; new Obstetrics adjustor applied in Year 3
- Increase in percent of claims that hit outlier status as well as payment in Year 3
  - Year 1: 3.6% of claims categorized as outliers; Year 2 at 3.4% and Year 3 at 3.8%
  - Yet outlier payments grow from Year 1 -17%, Year 2- 18%, Year 3- 22%* (incomplete)

*Year 3 data is incomplete. Outliers as a percentage of payment is expected to increase when the dataset is complete and longer, more expensive stays are captured.
Years 1-3 Experience

Stays by Medicaid Care Category (MCC)

- Medicaid care categories stable for Years 1-3

**Year 1 Stays by MCC**
- Total stays: 418,246
- Paid claims through 2/27/17

**Year 2 Stays by MCC**
- Total stays: 406,585
- Paid claims through 2/27/17

**Year 3 Stays by MCC**
- Total stays: 364,489
- Paid claims through 2/27/17

Year 3 stays are estimated to be 90% complete.
Years 1-3 Experience

Payment by Medicaid Care Category

- Similar payment distribution across MCCs for Years 1-3
- Obstetrics (OB) adjustor applied starting in Year 3; contributed to increased OB payment though OB volume decreased
Years 1-3 Experience

Concentration of Spending

- 5% of stays account for almost half of payments across the three years
- Spending concentration remains consistent from Year 1 through Year 3

Concentration of Spending -- Hospital Inpatient Care

Year 1 totals exclude NDPH stays prior to 1/1/14.
Outlier Percentage

- Outlier payments for neonates increased from 18% in Year 1 to 32% in Year 3, so far
- Adult circulatory and respiratory outlier payments decreased
- Total outlier payment continues to increase from 17% in Year 1 to 22% in Year 3 (final Year 3 results are expected to increase as data becomes more complete)
ACA vs. Non-ACA Age Groups

- Very sick adults comprise majority of ACA stays
- Note: Non-ACA results reflect population that is heavily obstetric and newborn
Years 1-3 Experience

ACA vs. Non-ACA Gender

- Nearly two-thirds of ACA stays are by males
- Nearly two-thirds of non-ACA stays are by females
- Gender mix stable from Year 1 to Year 3
Year 5 Updates
Year 5 Updates

Year 5 Policy Summary

Budget neutral overall and no changes in pricing structure

Regular annual updates:
- APR-DRG software, HSRV relative weights
- National wage areas
- CCRs
- Wage area neutrality factor

Policy changes from Year 4 to 5
- Non-remote rural base rate (includes border hospitals): $6,760
  - $440 (7%) increase
- All outlier payment calculations are based on a single tier; tier 2 threshold no longer applies as of July 1, 2017
  - Outlier threshold of $60,000
  - Marginal cost percentage 50%
- Pediatric policy adjustor increased to 1.45

Impacts on individual hospitals will depend on actual utilization and casemix

*Subject to federal approval
Year 5 Updates

Rationale to Decrease Outlier Percentage

• **Background:**
  - DRG payment was implemented 7/1/13 with generous outlier safeguards to maintain access during the change to DRG payment
  - As we enter Year 5, claims data and the payment method are stable; access is monitored

• **Issue:** Outlier payments as a percentage of DRG payments are high, rising, and far in excess of the outlier percentages seen in Medicare and other Medicaid programs

• **Challenge:** Shift money from outlier payments to non-remote rural DRG base payments (7% increase, $250M) in a way that minimizes impact on hospitals and access

• **Benefits of decreasing outlier payments:**
  1. **Reward efficiency** to be consistent with the original purpose of DRG payment nationwide
  2. **Reduce vulnerability** to CCR volatility (year to year and between submitted and audited CCRs) and efforts to supplement outlier payments with targeted charge increases
  3. **Improve fairness** to efficient hospitals and those that report accurate CCRs and minimize charge increases
  4. **Reduce administrative burden** on DHCS and hospitals associated with outlier audits and recalculation, and retroactive changes to payment levels for services years earlier
Year 5 Updates

Update to V.34 APR-DRG

- V.34 Grouper:
  - 3 deleted DRGs; 7 new DRGs
  - Changes to the description of 20 DRGs
  - Adjustments to the HSRV weights
  - Measured casemix changes using Year 3 stays (10/1/2015 through 3/31/2016), comparing V.33 and V.34
    - Overall measured casemix decreased from 0.88 to 0.87
    - Changes in casemix by MCC were varied
    - Total estimated payments decreased 1.24%
- V.34 HAC upgrade will include up to five HACs identified and used, minor impact
- Include procedure date for DRG assignment

### V.34 DRG Code Updates

<table>
<thead>
<tr>
<th>Deleted</th>
<th>Replacements</th>
</tr>
</thead>
<tbody>
<tr>
<td>173 Other Vascular Procedures</td>
<td>181 Lower extremity vascular procedures</td>
</tr>
<tr>
<td></td>
<td>182 Other peripheral vascular procedures</td>
</tr>
<tr>
<td>460 Renal Failure</td>
<td>469 Acute kidney injury</td>
</tr>
<tr>
<td></td>
<td>470 Chronic kidney disease</td>
</tr>
<tr>
<td>693 Chemotherapy</td>
<td>695 Chemotherapy for acute leukemia</td>
</tr>
<tr>
<td></td>
<td>696 Other chemotherapy</td>
</tr>
<tr>
<td></td>
<td>322 Shoulder &amp; elbow joint replacement</td>
</tr>
</tbody>
</table>

### Notes:
1. Three DRG codes are deleted and each replaced with two new DRG codes.
2. There is one new DRG.
Year 5 Updates

Coding Analyses

- **Transition to ICD-10**
  - Only minor changes in measured casemix
    - Multi-factorial decomposition analysis. Used widely accepted economic analysis method (Paasche), with cross-validation (Laspeyres)
    - After accounting for the increasing number of ACA patients, casemix increased by 3% after ICD-10 implemented

- **Years 1-3**
  - Documentation, coding and capture improvement noticeable in Year 1 compared to 2009 analytical dataset, as expected
    - Newborn and obstetric claims were originally combined; newborn claims were inferred in the analytical dataset
    - Negligible change between Years 1 and 3

No documentation and coding adjustment at this time; continued monitoring recommended

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![Total Avg. Diagnosis and Procedure Codes Per Stay by MCC](chart)

**Legend**

- **Analytical Dataset**
- **Year 1**
- **Year 2**
- **Year 3**
## 5 Years of DRG Payment Policy

### Summary of Five Years of DRG Payment Policies

<table>
<thead>
<tr>
<th>Payment Policy</th>
<th>Year 1 Values (SFY 2013 14)</th>
<th>Year 2 Values (SFY 2014 15)</th>
<th>Year 3 Values (SFY 2015 16)</th>
<th>Year 4 Values (SFY 2016 17)</th>
<th>Year 5 Values (SFY 2017 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRG Base Rates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRG base rate, statewide</td>
<td>$6,223</td>
<td>$6,289</td>
<td>$6,289</td>
<td>$6,320</td>
<td>$6,760</td>
</tr>
<tr>
<td>DRG base rate, statewide (remote rural hospitals)</td>
<td>$10,218</td>
<td>$10,640</td>
<td>$12,768</td>
<td>$12,832</td>
<td>$12,832</td>
</tr>
<tr>
<td><strong>Payment to non-transition hospitals</strong></td>
<td>Statewide DRG base rate adjusted for Medicare FFY 2013 wage area values</td>
<td>Statewide DRG base rate adjusted for Medicare FFY 2014 wage area values</td>
<td>Statewide DRG base rate adjusted for Medicare FFY 2015 wage area values and 0.9797 wage area neutrality factor</td>
<td>Statewide DRG base rate adjusted for Medicare FFY 2016 wage area values and 0.9690 wage area neutrality factor</td>
<td>Statewide DRG base rate adjusted for Medicare FFY 2017 wage area values and 0.9792 wage area neutrality factor</td>
</tr>
<tr>
<td><strong>Payment to transition hospitals</strong></td>
<td>Hospital-specific, as shown in separate document¹</td>
<td>Hospital-specific, as shown in separate document²</td>
<td>Hospital-specific, as shown in separate document³</td>
<td>Transition has ended as expected; all hospitals at non-remote rural and remote rural statewide rates</td>
<td>Transition has ended as expected; all hospitals at non-remote rural and remote rural statewide rates</td>
</tr>
<tr>
<td><strong>Adjustment for wage area values</strong></td>
<td>Similar to Medicare, reflecting a labor share of 68.8%</td>
<td>Similar to Medicare, reflecting a labor share of 69.6%</td>
<td>Similar to Medicare, reflecting a labor share of 69.6%, then adjusted by 0.9797 to neutralize CA changes compared to U.S.</td>
<td>Similar to Medicare, reflecting a labor share of 69.6%, adjusted by 0.9690 to neutralize CA changes compared to U.S.</td>
<td>Similar to Medicare, reflecting a labor share of 69.6%, adjusted by 0.9792 to neutralize CA changes compared to U.S.</td>
</tr>
<tr>
<td><strong>Adjustment for improved documentation, coding and capture of diagnoses and procedures</strong></td>
<td>-3.50%</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
## 5 Years of DRG Payment Policy (Continued)

### Summary of Five Years of DRG Payment Policies

<table>
<thead>
<tr>
<th>Payment Policy</th>
<th>Year 1 Values (SFY 2013-14)</th>
<th>Year 2 Values (SFY 2014-15)</th>
<th>Year 3 Values (SFY 2015-16)</th>
<th>Year 4 Values (SFY 2016-17)</th>
<th>Year 5 Values (SFY 2017-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRG Grouper</strong></td>
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<tr>
<td>DRG version</td>
<td>APR-DRG V.29</td>
<td>APR-DRG V.31</td>
<td>APR-DRG V.32</td>
<td>APR-DRG V.33</td>
<td>APR-DRG V.34</td>
</tr>
<tr>
<td>DRG relative weights</td>
<td></td>
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<td></td>
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<tr>
<td>APR-DRG V.29 national, charge-based</td>
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<tr>
<td>APR-DRG V.31 national, charge-based</td>
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<td>APR-DRG V.32 national hospital-specific relative value (HSRV) weights</td>
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<tr>
<td>APR-DRG V.33 national HSRV weights are unchanged from V.32</td>
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<tr>
<td>APR-DRG V.34 national HSRV weights</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National average length of stay benchmarks (used in calculating transfer adjustments)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APR-DRG V.29 (arithmetic, untrimmed)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>APR-DRG V.31 (arithmetic, untrimmed)</td>
<td></td>
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</tr>
<tr>
<td>APR-DRG V.32 (arithmetic, untrimmed)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>APR-DRG V.33 (arithmetic, untrimmed), unchanged from V.32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APR-DRG V.34 (arithmetic, untrimmed)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Outlier Policy Factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital-specific cost-to-charge ratios (CCR)</td>
<td>Most recent CCR available for Year 1, as determined by DHCS</td>
<td>FYE 2012 cost report (some exceptions may apply)</td>
<td>FYE 2013 cost report (some exceptions may apply)</td>
<td>FYE 2014 cost report (some exceptions may apply)</td>
<td>FYE 2015 cost report (some exceptions may apply)</td>
</tr>
<tr>
<td>High side (provider loss) tiers and marginal cost (MCost) percentages</td>
<td>$0-$40,000: no outlier payment</td>
<td>$0-$42,040: no outlier payment</td>
<td>$0-$45,000: no outlier payment</td>
<td>$0-$46,800: no outlier payment</td>
<td>$0-$60,000: no outlier payment</td>
</tr>
<tr>
<td>$40,001 to $125,000: MCost = 0.60</td>
<td>$42,041 to $131,375: MCost = 0.60</td>
<td>$45,001 to $145,000: MCost = 0.60</td>
<td>$46,801 to $150,800: MCost = 0.60</td>
<td>&gt;60,000: MCost = 0.50</td>
<td>No tier 2 outlier</td>
</tr>
<tr>
<td>&gt;$125,000: MCost = 0.80</td>
<td>&gt;$131,375: MCost = 0.80</td>
<td>&gt;$145,000: MCost = 0.80</td>
<td>&gt;$150,800: MCost = 0.80</td>
<td>&gt;$60,000: MCost = 0.50</td>
<td></td>
</tr>
<tr>
<td>Low side (provider gain) tiers and marginal cost percentages</td>
<td>$0-$40,000: no outlier reduction</td>
<td>$0-$42,040: no outlier reduction</td>
<td>$0-$45,000: no outlier reduction</td>
<td>$0-$46,800: no outlier reduction</td>
<td>$0-$60,000: no outlier reduction</td>
</tr>
<tr>
<td>&gt;$40,000: MCost = 0.60</td>
<td>&gt;$42,040: MCost = 0.60</td>
<td>&gt;$45,000: MCost = 0.60</td>
<td>&gt;$46,800: MCost = 0.60</td>
<td>&gt;$60,000: MCost = 0.50</td>
<td></td>
</tr>
<tr>
<td><strong>Other Payment Policies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy adjustor – neonate at designated NICU</td>
<td>1.75</td>
<td>1.75 (No change)</td>
<td>1.75 (No change)</td>
<td>1.75 (No change)</td>
<td>1.75 (No change)</td>
</tr>
<tr>
<td>Policy adjustor – neonate at other NICU</td>
<td>1.25</td>
<td>1.25 (No change)</td>
<td>1.25 (No change)</td>
<td>1.25 (No change)</td>
<td>1.25 (No change)</td>
</tr>
<tr>
<td>Policy adjustor – obstetric</td>
<td>n/a</td>
<td>n/a</td>
<td>1.06</td>
<td>1.06 (No change)</td>
<td>1.06 (No change)</td>
</tr>
<tr>
<td>Policy adjustor – pediatric miscellaneous, pediatric resp</td>
<td>1.25</td>
<td>1.25 (No change)</td>
<td>1.25 (No change)</td>
<td>1.25 (No change)</td>
<td>1.45</td>
</tr>
</tbody>
</table>
### Summary of Five Years of DRG Payment Policies

<table>
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<tr>
<th>Payment Policy</th>
<th>Year 1 Values (SFY 2013 14)</th>
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<th>Year 4 Values (SFY 2016 17)</th>
<th>Year 5 Values (SFY 2017 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric age cutoff</td>
<td>&lt;21</td>
<td>&lt;21 (No change)</td>
<td>&lt;21 (No change)</td>
<td>&lt;21 (No change)</td>
<td>&lt;21 (No change)</td>
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<tr>
<td>Discharge status values for the transfer adjustment</td>
<td>02, 05, 65, 66</td>
<td>02, 05, 63, 65, 66, 82, 85, 91, 93, and 94</td>
<td>02, 05, 63, 65, 66, 82, 85, 91, 93, and 94</td>
<td>02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 (No change)</td>
<td>02, 05, 63, 65, 66, 82, 85, 91, 93, and 94 (No change)</td>
</tr>
</tbody>
</table>

#### Notes:

1. For SFY 2013-14 hospital-specific DRG base rates, see “SPCP Contract Rates” at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

2. For SFY 2014-15 hospital-specific DRG base rates, see “SFY 14/15 Hospital Characteristics File” for non-transition hospitals and “SFY 14/15 Transition Base Rates for Admissions” for transition hospitals at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

3. For SFY 2015-16 hospital-specific DRG base rates, see “SFY 15/16 Hospital Characteristics File” for transitional and non-transitional hospitals base rates at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

4. For SFY 2016-17 hospital-specific DRG base rates, see SFY 16/17 Hospital Characteristics File for California, border, and Asante hospitals at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

5. For SFY 2017-18 hospital-specific DRG base rates, the SFY 17/18 Hospital Characteristics File is available at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

6. DRG out-of-state border hospital policy per SPA 15-020 and Asante court judgement changed during Year 4; some changes were retroactive and affected Year 3. Current policy is reflected in the table.

7. Outlier thresholds have been increased annually to reflect the latest available data on hospital charge inflation.

8. Discharge status values 82, 85, 91, 93, and 94 became effective nationally October 1, 2013. They became effective for Medi-Cal inpatient FFS stays September 21, 2015, retroactive to July 1, 2014. These values parallel the other values that indicate a transfer adjustment, with the difference being a planned acute care readmission. Discharge status value 70 became effective nationally in 2008, but implemented for Medi-Cal inpatient FFS stays September 21, 2015, retroactive to July 1, 2014. Note that discharge status value 70 will not trigger a transfer pricing adjustment.

9. For details of the pricing logic, APR-DRG groups, and relative weights, see the DRG Pricing Calculators specific to each year of DRG payment at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.
Year 5 Updates

Year 5 Grouper Software Settings

- Hospitals do not need to buy APR-DRG software or put the DRG on the claim
- Hospitals that try to mimic Medi-Cal DRG pricing must be sure to use the appropriate software settings based on the admission date of the hospital stay
- Year 5 settings are similar to Year 4 settings
- For ease of use, a CSV file is available for import on the DRG webpage:
  - Instructions for importing the CSV file into the 3M core grouping software will be available as well
  - The CSV file will expedite installation of the new settings, instead of adding them manually
- The October mapper update date is to be determined; please watch provider bulletins for when this upgrade is effective.
Year 5 Updates

Year 5 Grouper Settings Software

• For claims with admission dates on or after July 1, 2017, use:
  – Grouper V.34
  – HAC V.34 for California Medicaid
  – Entered Code Mapping: No code mapping is required until V.35 Mapper is implemented
  – Mapping Type: None until V.35 Mapper is implemented
  – Grouper ICD Version Qualifier: The ICD Version Qualifier should be set to “0 ICD-10” in the grouper

• ICD version indicator should be set to “0” on the claim record for ICD-10 claims

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Admit Date</th>
<th>Mapping</th>
<th>ICD Version</th>
<th>Comments</th>
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<tr>
<td>A</td>
<td>On or after 7/1/17</td>
<td>No mapping required</td>
<td>ICD-10 (0)</td>
<td>Grouper V. 34 and HAC V.34 for California Medicaid</td>
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<tr>
<td>B</td>
<td>To be determined</td>
<td>Historical mapping</td>
<td>ICD-10 (0)</td>
<td>Admission dates after the V.35 mapper is installed will require historical mapping</td>
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</table>
Year 5 Updates

Year 5 Grouper Software Settings

Year 5 CA DRGs SFY 2017-18 Admit date on or after 7/1/17

Note: After the October 2017 V.35 mapper is installed:
- The end date in this screenshot will be updated
- Another screenshot will be added for claims submitted after the update

The complete Year 5 Grouper Software Settings document is available on the DRG webpage.
Billing Points
Billing Points

Billing Pearls

- Diagnosis and procedure coding must be accurate, complete and defensible; continue to include POA codes as appropriate
- Hospitals need not buy DRG pricing software or submit the DRG on the claim
  - If you use commercially available software, be sure grouper settings and pricing elements match the policy defined in this presentation as applied in the DRG Pricing Calculator
- Reference the Hospital Characteristics File for your hospital-specific base rate and CCR
- Use the year-specific pricing resources such as the DRG Pricing Calculators and FAQs to understand pricing and predict payment
- Meet treatment authorization requirements
- Be informed by your Medi-Cal Provider Manual
- Be alert to provider bulletins regarding claims processing
- Reference the Medi-Cal Inpatient Claims Processing document for DRG billing updates
Billing Points

Inpatient Claims Processing Information

See provider bulletins for claims instructions

http://www.dhcs.ca.gov/provgovpart/Pages/DRG-Provider-Edu.aspx

Provider Bulletins

- DRG Billing and Reimbursement Update for AHIP Services  February 2017 (PDF)
- Costwitect Policy Adjustor on DRG Claims Will Be Reprocessed  June 2016 (PDF)
- Update DRG Claims Denied with RAD Code 0314 May Be Reprocessed  May 2016 (PDF)
- Medi Cal Inpatient Claims Processing Update  April 2017 (PDF)
- Update to Emergency Services and Inpatient Admission Reimbursement Policy  May 2016 (PDF)
- Fee-For-Service Eligibility Determines DRG Inpatient Service Dates  May 2016 (PDF)
- Final and Interim Claim Update for Hospitals  April 2016 (PDF)
- Update to Timeliness Date Extended for Resubmission of DRG Claims Over 22 Lines  August 2016 (PDF)
- DRG Claims Erroneously Denied with RAD Code 9953 Resolved January 2016 (PDF)
- Reimbursement Instructions for DRG Claims with New Patient Status Codes January 2016 (PDF)
- Update DRG Claims Erroneously Grouping to APR-DRG 951 and 952  September 2016 (PDF)
- Update RTDs for DRG Organ Procurement Claims November 2015 (PDF)
- MCP and Fee-For-Service Billing for Inpatient Stays at DRG Hospitals September 2015 (PDF)
- DRG Claims Erroneously Denied with RAD Code 0314 August 2015 (PDF)
- Rehabilitation and Admin Level 2 (PDF)
- CCAs and SAGs May 2013 (PDF)
- Updates to Web Page April 2013 (PDF)
- OB/Newborn Services February 2013 (PDF)
- 2009 Datasets January 2013 (PDF)
- Contract/WIPA Changes 11/2012 (PDF)
Billing Points

Medi-Cal Inpatient Claims Processing Update

The Medi-Cal Inpatient Claims Processing document for DRG billing updates is posted on the DRG webpage http://www.dhcs.ca.gov/provgovpart/Documents/DRG/Medi-Cal_DRG_Inpatient_Claims_Processing_Update-17-05-12ADA.pdf

<table>
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<tr>
<th>Reference</th>
<th>Initial Bulletin</th>
<th>RAD Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
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<tr>
<td>C. 1</td>
<td>NA</td>
<td>NA</td>
<td>Claims billed with invalid ancillary codes are denied because some revenue codes are NOT allowed by Medi-Cal, but still used by other payers.</td>
<td>This issue is being reviewed by the Department and being discussed within related divisions.</td>
</tr>
<tr>
<td>C. 2</td>
<td>NA</td>
<td>NA</td>
<td>Due to system limitations, the Appeal/CIF process has to drop to paper claim format, causing claims with over 22 revenue lines to limit the amount of procedure and diagnosis codes processed for payment.</td>
<td>The Department and State Fiscal Intermediary, Conduent, are aware of the limitations of the CA-MMIS system. We continue to brainstorm work around solutions, if possible.</td>
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<tr>
<td>C. 3</td>
<td>NA</td>
<td>NA</td>
<td>Issue 1- Baby using mom's ID, the SOC is being taking out twice from mom's claims and baby's claims. Issue 2- Claim with a From and Through date longer than 30 days (final) claim is only deducting the 1st month SOC.</td>
<td>The Department is aware of this issue and has notified providers via Newsflash published 11/14/2016. This issue is being researched by the Department and State Fiscal Intermediary, Conduent.</td>
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<tr>
<td>C. 4</td>
<td>NA</td>
<td>NA</td>
<td>Provider bills for Acute days, however there are no billing instructions on how to bill for acute transfer's.</td>
<td>This issue is being reviewed by the Department and billing instruction updates are being discussed within related divisions.</td>
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May 23 & Jun 1, 2017 W17-874 Medi-Cal Year 5 DRG Payment Provider Training
Cost Report Training
### Cost Report Submission Requirements

<table>
<thead>
<tr>
<th>Hospital Submits</th>
<th>Comments by DHCS' ARAS</th>
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</thead>
<tbody>
<tr>
<td>Cover letter</td>
<td>Detail special circumstances, contact personnel, etc.</td>
</tr>
<tr>
<td>Signed copy of CMS 2552-10</td>
<td>FQHCs must have “Provider Based” status approved by CMS to be included on CMS 2552-10</td>
</tr>
<tr>
<td>Signed copy of DHCS 3092</td>
<td>If applicable</td>
</tr>
<tr>
<td>Audited financial statements</td>
<td></td>
</tr>
<tr>
<td>Working papers used to support A-6 and A-8 adjustments</td>
<td>If the hospital participated in the Medi-Cal Quality Assurance Fee Program, any payments made must be removed on A-8</td>
</tr>
<tr>
<td>Cost-to-charge ratio (CCR)</td>
<td>If change is greater than 5%, indicate cause</td>
</tr>
</tbody>
</table>

**Notes:**
1. Email cost report submissions to [Acute.Submissions@dhcs.ca.gov](mailto:Acute.Submissions@dhcs.ca.gov).
2. DHCS' Audit and Review Analysis Section (ARAS).
CCR Review and Correction

- CCR (cost-to-charge ratio) calculation
  - Total Medi-Cal Costs (E-3 VII Line 7) / Total Medi-Cal Charges (E-3 VII Line 12)
- CCRs for FYE 2016 are provided to SNFD in October 2017 and used for rate setting for SFY 18/19
- Review of CCR changes from the prior year
  - < 5% difference – No further review
  - > 5% difference – CCR narrative should be completed to identify cause such as:
    - Reporting error in prior or current year.
    - Changes in services provided
    - Changes in utilization
- If reporting error(s), ARAS may request resubmission of cost report to correct the error(s); applies to already accepted prior year cost report as well
  - If resubmitted by December 31, ARAS will forward revised CCR to SNFD for inclusion in the rate setting for the next fiscal year
Provider Education
Looking Ahead

1. Year 6 policy review and technical changes (APR-DRG V.35)
   • Update system changes
   • Re-evaluate policy
   • Detailed study of rehab per diem
2. Monitor legislation
3. Continued monitoring and reporting of DRG payment
4. Review evidence on hospital documentation and coding change
5. Quality: potentially preventable readmissions and complications
6. DRG payment integrity
   • DRG validation
   • DRG outlier recalculation
   • High-dollar claim review
1. DHCS DRG webpage devoted to APR-DRG information; Reorganized Years 1-5 key documents
   www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx
   - Provider bulletins at http://files.medicl.ca.gov/pubsdoco/prevarticles_home.asp
2. Join DRG listserve by emailing drg@dhcs.ca.gov
3. Policy questions (DO NOT email patient-specific information) to drg@dhcs.ca.gov
5. Medi-Cal Telephone Service Center 1-800-541-5555 from 8 a.m. to 5 p.m.
For Further Information

To find out about DRG specific information, please select from the pages below.

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Pricing Resources: SFY 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important Information</td>
<td>Pricing Resources: SFY 2014/15</td>
</tr>
<tr>
<td>Provider Education and Bulletins</td>
<td>Pricing Resources: SFY 2015/16</td>
</tr>
<tr>
<td>Billing and TAR Changes</td>
<td>Pricing Resources: SFY 2016/17</td>
</tr>
<tr>
<td></td>
<td>Pricing Resources: SFY 2017/18</td>
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</table>

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Chief, DRG Section  
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DHCS  
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Maria.Jaya@dhcs.ca.gov

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With Thanks To:  
**DHCS:** Brie-Anne Sebastien, Cyrus Sanchez, Jim Mason, Joanna Lin, Karen del Gallego, Loni Anderson, Nzinga Griffin, Richard Luu, Matthew Wong  
**Conduent:** Christine Bredfeldt, Bud Davies, Elizabeth Gillette, Coley Hembree, Kevin Quinn, Lisa Nelson, Angela Sims, Andrew Townsend
Appendix
Appendix

Update Wage Area and Index Values

- Medi-Cal policy is to follow Medicare; updates posted by Medicare in August of one year are implemented by Medi-Cal the following July 1
- Starting in Year 4, applies to all hospitals, including border hospitals
- Labor portion of cost (69.6% for wage index > 1.0000) unchanged from Year 4 to Year 5; labor share of cost for wage index value ≤ 1.0000 is 62%
- Each year, the Medicare Impact File updates wage area assignments and index values for Medicare prospective payment hospitals
  - [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html)
  - For children’s hospitals, Medicare critical access hospitals and others not listed on the Medicare Impact file, we assign wage areas and index values by geographic location
- Wage area neutrality adjustor applied to remove impact of changes in CA wage areas relative to rest of U.S.
  - Year 3: applied CA wage area neutrality adjustor of 0.9797
  - Year 4: applied CA wage area neutrality adjustor of 0.9690
  - Year 5: applied CA wage area neutrality adjustor of 0.9792
## Wage Area Index Values

<table>
<thead>
<tr>
<th>CBSA Number</th>
<th>CBSA Name</th>
<th>FFY 2015 Wage Index</th>
<th>CA Neutral Adj. Wage Index (0.9797)</th>
<th>FFY 2016 Wage Index</th>
<th>CA Neutral Adj. Wage Index (0.9690)</th>
<th>FFY 2017 Wage Index</th>
<th>CA Neutral Adj. Wage Index (0.9792)</th>
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## Wage Area Index Values (Continued)

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<th>CA Neutral Adj. Wage Index (0.9797)</th>
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<th>CA Neutral Adj. Wage Index (0.9690)</th>
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<th>CA Neutral Adj. Wage Index (0.9792)</th>
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</tr>
</tbody>
</table>

**Notes:**

1. **CBSA** = Core Based Statistical Area.
2. The wage index values Medi-Cal uses to calculate DRG base rates are derived from the current federal fiscal year's Medicare Impact File.
3. The California wage area neutrality factor was calculated because wage index values in California increased relative to the rest of the U.S. In SFY 2015-16 (DRG Year 3), Medi-Cal adjusted wage index values by a factor of 0.9797. Wage area index values were adjusted by 0.9690 in SFY 2016-17 (DRG Year 4). Wage area index values will be adjusted by 0.9792 in SFY 2017-18 (Year 5).
4. For hospitals with a wage index above 1.0000, 69.6% of the base rate is adjusted for labor share. For hospitals with a wage index equal to or less than 1.0000, 62% of the base rate is adjusted for labor share. Labor share of cost is determined before the neutrality factor is applied.
## Acronyms/Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Patient Protection and Accountable Care Act</td>
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<tr>
<td>A&amp;I</td>
<td>DHCS Audits and Investigation</td>
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<tr>
<td>APR-DRG</td>
<td>All Patient Refined Diagnosis Related Groups</td>
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<tr>
<td>ARAS</td>
<td>Audit Review and Analysis Section</td>
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<td>DHCS</td>
<td>CA Department of Healthcare Services</td>
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<td>Diagnosis Related Groups</td>
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<td>CAH</td>
<td>Critical Access Hospital</td>
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<td>CBSA</td>
<td>Core Based Statistical Area</td>
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<td>Cost-to-Charge Ratio</td>
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<td>California Children’s Services</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>Comma Separated Values</td>
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