

Medi-Cal DRG Project

Briefing on Hospital DRG Base Prices

February 6 and 8, 2013

Kevin Quinn
Government Healthcare Solutions
Payment Method Development



Topics

1. Overview of DRG payment
2. Walk-through of base price notification
3. Other topics

Scope of DRG Payment

- As directed by the legislature (SB 853, October 2010)
- Replaces Selective Provider Contracting Program and cost reimbursement
- Developed in consultation with hospitals
- Patients:
 - Medi-Cal fee-for-service, CCS only, GHPP only. Not managed care.
- Hospitals:
 - Excluded: designated public hospitals, non-designated public hospitals, psychiatric hospitals
 - Included: all other general hospitals, including out-of-state, Medicare-designated CAH, Medicare-designated LTAC
- Services:
 - APR-DRGs to be used for almost all care except psych (counties), rehabilitation (per diem), admin days (per diem)

Aspects 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
- **Efficiency:** Because payment does not depend on hospital-specific costs or charges, hospitals are rewarded for improving efficiency
 - Reductions in length of stay, where appropriate, generate savings
- **Access:** Higher DRG payment for sicker patients encourages access to care across the full range of patient conditions.
 - Non-contract hospitals in closed areas may increase Medi-Cal volume
- **Transparency:** Payment methods and calculations on the Internet
 - But note Slide 21 re SPCP confidentiality before DRG implementation
- **Administrative burden:**
 - Day-by-day TAR no longer required (except some limited-benefit beneficiaries)

Training on DRG Payment

- Webinars
 - Wednesday, February 6, 12:30-1:30 Rate Setting Overview
 - Friday, February 8, 2:00-3:00 Rate Setting Overview
 - Monday, February 11, 1:00-4:00 General DRG Training
 - Thursday, February 14, 9:00-12:00 General DRG Training
 - www.dhcs.ca.gov/provgovpart/pages/DRG.aspxinfo, “Webinar Information”
- In-person seminars – General DRG Training
 - Ontario Provider Seminar, February 19-20 (DRG Feb. 20)
 - Sacramento Provider Seminar, March 13-14
 - Anaheim Provider Seminar, April 16-17
 - <https://learn.medi-cal.ca.gov/Training/TrainingCalendar.aspx>
- Additional trainings to be scheduled

DRG Payment

Key Resources

- New DHCS webpage devoted to APR-DRG information
 - www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx
- Questions to drg@dhcs.ca.gov
- Join DRG listserve by emailing drg@dhcs.ca.gov



DRG Payment Base Prices: Background Documents

Medi-Cal DRG Project Frequently Asked Questions

Please note that changes remain possible before the implementation date.

Changes have been made since the May 3, 2012 version was published on the DHCS website.

OVERVIEW QUESTIONS

1. What is the Medi-Cal DRG project?

As directed by the California legislature, the Department of Health Care Services (DHCS) is developing a new method of paying for hospital inpatient services in the fee-for-service Medi-Cal program. This FAQ document is intended to provide interested parties with periodic updates on the project.

2. How are hospitals currently paid?

Since 1983, hospitals have been paid under the Selective Provider Contracting Program (SPCP). "Contracted" hospitals negotiate a per diem payment rate with the California Medical Assistance Commission. Non-contracted hospitals are reimbursed based on interim rates using a cost-to-charge ratio and subject to a cost settlement process. (Note: designated public hospitals have a separate payment method).

3. What change is being made?

The California Legislature directed the department to replace the current reimbursement methodology for hospital acute care inpatient services (both negotiated contract rates and non-contract cost reimbursement) with payment by diagnosis related group (DRG). This would eliminate the current contract and non-contract status designation once payments are based upon DRGs. The reference is to Senate Bill 853, passed in October 2010, which added Section 14105.28 to the California Welfare and Institutions Code.

4. What is the timeframe?

A workgroup of staff from DHCS and other state agencies developed the new method, in consultation with a group of hospital managers and other stakeholders convened by the California Hospital Association (CHA). The consultation workgroup finished its work in February 2012. The original target date to implement DRG payment was July 1, 2012; as part of the 2012 Budget Act, implementation is now set for July 1, 2013.

5. Will there be a transition period?

Yes. The DRG-based payment method will be phased in over a three-year period with the changes fully implemented in the fourth year, similar to what Medicare does with major payment changes. Claims will be paid using the DRG payment method, but some hospitals will see transition DRG base prices higher or lower than they would have been without the transition. In the first year of the transition, the intention is that average payments per stay for an individual hospital will increase or decrease by no more than 5% relative to what they otherwise would have been. In the second year the range would widen to plus or minus 10% and in the third year to 15%.

September 14, 2012 Please note that changes remain possible before implementation 1

DRG Pricing Calculator

Medi-Cal DRG Pricing Calculator		
Make: This calculator does not reflect final decisions on the structure of the Medi-Cal fee-for-service DRG payment method that will be implemented July 1, 2013. Errors for administrative days and rehabilitation services will not be priced via the DRG method.		
Indicates information to be input by the user.		
Indicates payment policy parameters set by Medicaid		
INFORMATION FROM THE HOSPITAL--TO BE INPUT BY THE USER		
7. Total charges	\$100,000.00	UB-04 Form Locator: 42
8. Hospital-specific cost-to-charge ratio	95.0%	Used to estimate the hospital's cost of this stay.
9. Length of stay	41	Used for transfer pricing adjustment.
10. Patient discharge status - 02, 05, 06 or 687 (parallel)	02	Used for transfer pricing adjustment.
11. Patient age (in years)	15	Used for age adjuster.
12. Other health coverage	\$300.00	UB-04 Form Locator 54 for payments by third parties.
13. Patient share of cost	\$300.00	Includes spend-down or copayment.
14. Is discharge status equal to 30?	Yes	Indicates an interim claim.
15. Designated HCU facility	No	Policy adjuster for designated HCU facilities.
16. APR-DRG	011.1	From separate APR-DRG grouping software.
APR-DRG INFORMATION		
18. APR-DRG description	LIVER TRANSPLANT SICR RESTRUCTURAL TRANSPLANT	Look up from DRG base.
19. Case mix relative weight - unadjusted	7.0839	Look up from DRG base.
20. Service adjuster - hospital with designated HCU	1.0000	Look up from DRG base.
21. Service adjuster - all other hospitals	1.0000	Look up from DRG base.
22. Age adjuster	1.2500	Look up from DRG base.
23. Payment relative weight	8.8549	If E1+E2, then if (E15="Yes"), then (E19*(E21/E22)), else (E19*(E21/E22)), else (E19*(E21/E22)), else (E19*(E21/E22)), else (E19*(E21/E22)).
24. Average length of stay for this APR-DRG	6.93	Look up from DRG base.
PAYMENT POLICY PARAMETERS SET BY MEDICAID--SUBJECT TO CHANGE		
25. DRG base price	\$7,200	Used for DRG base payment--see DRG base price tab.
27. Cost outlier threshold 1	\$40,000	Used for cost outlier adjustments.
28. Cost outlier threshold 2	\$120,000	Used for cost outlier adjustments.
29. Marginal cost percentage_1	80%	Used for cost outlier adjustments.
30. Marginal cost percentage_2	80%	Used for cost outlier adjustments.
31. Medicaid adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
32. Interim claim threshold	29	Used for pricing interim claims.
33. Interim claim amount	\$600	Used for pricing interim claims.
IS THIS AN INTERIM CLAIM?		
35. Is discharge status equal to 30?	Yes	Look up E14.
36. Is length of stay > interim claim threshold?	Yes	If E30="Yes", then if (E8 > E32), "Yes", else "No", else "NA".
37. Skip to E25 for final interim claim payment amount	\$24,600.00	If E36="Yes", (E37/E19) rounded to 2 places, else 0.
WHAT IS THE DRG BASE PAYMENT?		
38. DRG base payment for this claim	\$68,411.56	E26*(E23/E21)
IS A TRANSFER PAYMENT ADJUSTMENT MADE?		
41. Is a transfer adjustment potentially applicable?	No	Look up E15.
42. Calculated transfer payment adjustment	N/A	If E15="Yes", then (E30*(E41/E19-1)) rounded to 2 places, else "NA".
43. Is transfer payment adjustment allowed amount so far?	N/A	If E42="NA", then "NA", else if (E42-E39), then "Yes" else "No".
44. Allowed amount after transfer adjustment	\$68,411.56	If E43="Yes", then E42, else E39.
IS A COST OUTLIER ADJUSTMENT MADE?		
46. Estimated cost of this case	\$33,000.00	E7 * E8
47. Is estimated cost > allowed amount	Yes	If E46 > E44, then "Yes", else "No".
48. High-Side Outlier Payment When Payment is Much Lower than Cost	N/A	If E47 = "Yes", then (E46-E44), else "NA".
49. Estimated loss on this case	N/A	If E47 = "Yes", then if (E48 > E37), then "Yes", else "No", else "NA".
50. Is loss > outlier threshold lower limit	N/A	If E50 = "Yes", then (E48-E38), then (E48-E37/E38), else (E38-E27/E29), else 0.
51. DRG cost outlier payment increase 1	\$0.00	If E50="Yes", then if (E48-E38), then (E48-E37/E38) rounded to 2 places, else 0, else 0.
52. DRG cost outlier payment increase 2	\$0.00	
Low-Side Outlier Payment When Payment is Much Greater than Cost		
54. Estimated gain on this case	\$31,411.56	If E47="Gain", then (E44-E46), else "NA".
55. Is gain > outlier threshold	No	If E47="Gain", then if (E54-E37), then "Yes", else "No", else "NA".
56. DRG cost outlier payment decrease	\$0.00	If E47="Gain", then if (E55="Yes"), then (E54-E37/E38) rounded to 2 places, else 0.
ALLOWED AMOUNT AFTER TRANSFER AND OUTLIER ADJUSTMENTS		
58. DRG payment so far	\$68,411.56	If E47="Loss", then (E44-E51+E52), else (E44-E50).
CALCULATION OF ALLOWED AMOUNT AND REBURSEMENT AMOUNT		
60. Add-in amount	\$0.00	Hospital-specific payment amounts from DRG payment (not used at this time).
61. Allowed amount	\$68,411.56	Allowed amount = E58+E50.
62. Other health coverage	\$300.00	E12.
63. Patient share of cost	\$300.00	E13.
64. Lesser of calculation	\$68,411.56	Dedating policy ensures that payment amount cannot exceed total charges. If E51="E", then E2, else E0.
65. Payment amount	\$68,400.00	If interim claim (E35="Yes"), then interim claim (E37) amount as payment amount. Otherwise, add other health coverage (E12) and patient share of cost (E13) from "Lesser of" (E64) to obtain payment amount.
CAUTION: MATCH VALUES ARE SUBJECT TO CHANGE BEFORE IMPLEMENTATION JULY 1, 2013.		

Medi-Cal DRG Project Summary of Analytical Dataset

Prepared for the California Department of Health Care Services
December 22, 2011



A XEROX Company

- Available at www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx



DRG Payment

Key Payment Values

Payment Policy Parameter	Value
Statewide base price	\$6,223
Statewide base price (remote rural)	\$10,218
APR-DRG algorithm and relative weights	V.29 national
Policy adjustor -- neonate at designated NICU hospital	1.75
Policy adjustor -- neonate at other hospital	1.25
Policy adjustor -- pediatric resp, pediatric misc	1.25
Pediatric age	< 21 years old
Transfer discharge statuses	02, 05, 65, 66
Documentation, coding and capture adjustment	3.50%
Wage area adjustments	Per Medicare Aug 2012
Allowed = lesser of calculated payment or charge	Yes
High-side (provider loss) cost outlier threshold 1	\$40,000
Marginal cost percentage	60%
High-side (provider loss) cost outlier threshold 2	\$125,000
Marginal cost percentage	80%
Low-side (provider gain) cost outlier threshold	\$40,000
Marginal cost percentage	60%
Notes	
1. Policy adjustors are applied to the relative weight for specific DRGs, with the effect of increasing the relative weight used for calculating payment. "Neonate" refers to specific APR-DRGs for sick newborns.	
2. The statewide base price for remote rural hospitals was calculated to equal 95% of cost for remote rural hospitals in aggregate. The statewide base price for all other hospitals was then calculated so that aggregate payments statewide equalled the budget target.	

DRG Payment

Statewide Totals

	Previous Payment Method		DRG Payment	
	CY 2009 Baseline	FY 2013-14 Baseline	FY 2013-14 No Transition	FY 2013-14 Transition
Stays	406,164	406,164	406,164	406,164
Days	1,593,825	1,593,825	1,593,825	1,593,825
Charges	\$ 13,657,896,644	\$ 17,615,955,092	\$ 17,615,955,092	\$ 17,615,955,092
Casemix	0.6219	0.6583	0.6583	0.6583
Payment	\$ 2,412,565,737	\$ 2,627,205,655	\$ 2,627,709,953	\$ 2,627,933,673
Payment per stay	\$ 5,940	\$ 6,468	\$ 6,470	\$ 6,470
Casemix-adj'd pay/stay	\$ 9,551	\$ 9,826	\$ 9,827	\$ 9,828
Outlier payments			\$ 449,963,999	\$ 462,210,254
Outlier payment %			17%	18%

Please Keep in Mind

- Data by hospital are estimates for FY 2013-14
- A hospital's actual experience will depend on volume, casemix, prevalence of outliers, cost per stay, etc.
- In analyzing impacts, averages are more useful than totals
- DRG payments \approx DRG base payments + DRG outlier payments
 - Outlier payments approximately 17% of Medi-Cal DRG payments
 - Other adjustments (e.g., transfers) affect payment but are less important
- In addition to DRG payments on claims, Medi-Cal makes very substantial supplementary payments to hospitals
- The Medi-Cal and Medicare DRG payment methods are different methods for different populations, using different DRG algorithms
- Unlike Medicare, Medi-Cal will not implement the transition by pricing claims under two methods and blending the difference

Base Price Notification

Hospital-Specific Payment Information

- “Designated NICU” as determined by California Children’s Services based on neonatal surgical capacity
- “Designated remote rural hospital” = rural per OSHPD list and at least 15 miles from the nearest hospital with a basic emergency room
- CCR = (1) from the hospital’s most recent cost report accepted by DHCS or, if need be, (2) most recent Provider Master File
- Wage area = from Medicare impact file for FFY 2013, including reclassifications where appropriate

Hospital-Specific Information on DRG Payment			
Line	Item	Value	Comment
1	Hospital	Example Hospital	
2	National provider identifier	0123456789	
3	OSHPD identifier	987654321	
4	Designated NICU		N Affects payment for sick newborns
5	Designated remote rural hospital		N Affects DRG base price
6	Cost-to-charge ratio used in payment simulation	20.00%	Affects outlier payments
7	Wage area used in payment simulation	Los Angeles-Long Beach-Glendale, CA	Same as Medicare for most hospitals
8	Wage area index value used in simulation	1.2282	Same as Medicare for most hospitals

Base Price Notification

Utilization Data

- Simulation dataset = CY 2009 Medi-Cal fee-for-service data based on CA-MMIS, OSHPD, cost reports. Two key adjustments:
 - “Inferred newborn” claims for well babies who will be billed separately
 - Estimates made of patients transitioning to managed care
- Documentation by hospital in *Summary of Analytical Dataset*
- Billed charges trended forward to FY 2013-14 by 28.98%
 - Reflects average annual growth from OSHPD data for Medi-Cal patients
- Casemix trended forward to FY 2013-14 by 5.85%
 - Reflects estimates of real growth and growth due to improved documentation, coding and capture of diagnoses and procedures

9 Stays used in payment simulation (from CY 2009)	1,000	Note 1 (see below)
10 Days used in payment simulation (from CY 2009)	4,000	Includes normal newborns; Note 1
11 Casemix -- CY 2009	0.6200	Note 2
12 Casemix -- trended forward to FY 2013-14	0.6563	Note 3
13 Billed charges -- CY 2009	\$34,000,000	For the stays in Line 9
14 Billed charges -- FY 2013-14	\$43,853,200	Note 4

Base Price Notification

Baseline Payment

- Refers to the allowed amount; excludes supplemental payments
- Contract hospitals
 - CY 2009 reflects SPCP payments
 - Trended forward to 7/1/13 per hospital-specific changes in SPCP rates
- Non-contract hospitals
 - CY 2009 = charges x CCR from 2009 audited cost report (or, if necessary, 2009 reported cost report)
 - Trended forward to 7/1/13 at 17.49% (consistent with the Quality Assurance Fee financial model)
- See *Summary of Analytical Dataset* §§2.4, 2.6 re 2009 methodology
- Data for some hospitals have been updated since then.

15	Baseline payment under previous method -- CY 2009	\$6,000,000	Note 5
16	Baseline payment under previous method -- trended forward to FY 20	\$6,540,000	Note 6
17	<i>Per stay</i>	\$6,540	Line 16 / Line 9
18	<i>Per stay, casemix adjusted</i>	\$9,965	Line 17 / Line 12

Base Price Notification

Determination of Transition Status

- DHCS's primary goal is protecting beneficiary access to care
- In practice, this means buffering the negative financial impacts on hospitals expected to see decreased payments under DRGs
- Transition rates do not apply to hospitals where the financial impact (up or down) is expected to be relatively manageable:
 - Change under 5% (29 hospitals)
 - Change under \$50,000 (17 hospitals)
 - Fewer than 100 stays and Medi-Cal fee-for-service share < 2% (30 hospitals)
 - Out of state hospitals (about 175 hospitals)
 - No Medi-Cal FFS stays in simulation dataset (15 hospitals)
- All other hospitals receive transition base prices in FY 2013-14 with a goal of limiting expected changes to < 5% (211 hospitals).

19 Will this hospital receive a transition base price?

Yes--go to Line 21

20 *Reason why not (if applicable)*

Note 7

Base Price Notification

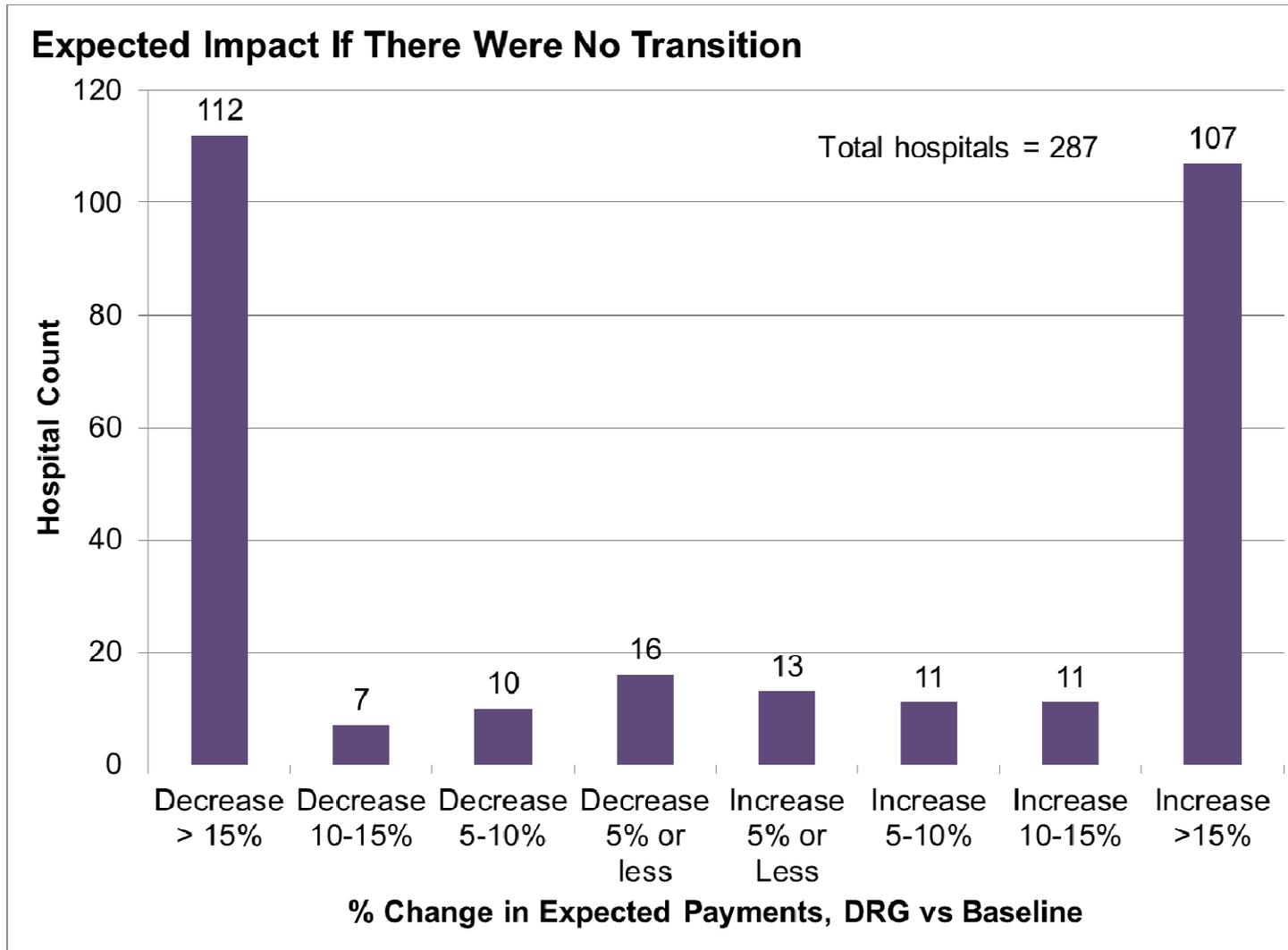
Base Price – No Transition

- DRG base price = statewide base price adjusted for wage area
 - L.A. area: $(\$6,223 \times 68.8\% \times 1.2282) + (\$6,223 \times 31.2\%) = \$7,200$
 - Base prices range from \$7,200 to \$14,413 (including remote rurals)
- DRG payment \approx DRG base payments + DRG outlier payments
 - Policy adjustors, transfer adjustments, lower-of logic also affect payment
 - See DRG Pricing Calculator for detailed pricing logic
- Outlier payments = about 17% of total payments but can be higher for individual hospitals

BASE PRICE – NO TRANSITION

29 DRG base price	\$7,200	Note 11
30 Total DRG payment	\$5,700,000	Note 9
31 <i>Per stay</i>	\$5,700	Line 30 / Line 9
32 <i>Per stay, casemix adjusted</i>	\$8,685	Line 31 / Line 12
33 Total change from baseline payment	-\$840,000	Line 30 minus Line 16
34 Percent change from baseline payment	-13%	Line 33 / Line 16
35 <i>Outlier payments</i>	\$950,000	Note 10
36 <i>Outlier payments as a percentage of total payment</i>	17%	Line 35 / Line 30

Statewide Impact – No Transition



Base Price Notification

Statewide Impact – Transition

Count of Hospitals by Expected Impact in FY 2013-14, Relative to Baseline Under Current Payment Method									
	Decrease				Increase				Total Hospitals
	> 15%	10-15%	5-10%	5% or less	5% or Less	5-10%	10-15%	>15%	
Hospitals Paid Using Statewide Base Price									
Impact <5%				16	13				29
Impact <\$50,000	9	1				1		6	17
<100 stays & <2% Medi-Cal	18	1					1	10	30
Subtotal no transition	27	2	0	16	13	1	1	16	76
Hospitals Paid Using Statewide Base Price									
Expected impact if no transition price = decrease > 15%				85					85
Expected impact if no transition price = decrease 10-15%				5					5
Expected impact if no transition price = decrease 5-10%				10					10
Expected impact if no transition price = decrease 5% or less									0
Expected impact if no transition price = increase 5% or less									0
Expected impact if no transition price = increase 5-10%					10				10
Expected impact if no transition price = increase 10-15%					10				10
Expected impact if no transition price = increase > 15%					77	3	2	9	91
Subtotal hospitals with transition base price	0	0	0	100	97	3	2	9	211
All hospitals with volume in simulation dataset	27	2	0	116	110	4	3	25	287
Hospitals with No Volume									
Hospitals with no volume in simulation dataset									15
Total: All California Hospitals	27	2	0	116	110	4	3	25	302

Note: The table includes only DRG hospitals, i.e., designated and non-designated public hospitals are excluded

Base Price Notification

Transition Base Price

- Calculated iteratively using hospital-specific claims
 - Excluding extreme outliers (i.e., outlier payment > \$100,000, which is unusual)
 - Transition base price then applied to all stays, including extreme outliers
 - Floor set so that transitional base price = at least 50% of no-transition price
- Hospitals that would see lower payment: expected decrease 5% or less
- Hospitals that would see higher payment: expected increase 2%-3%
 - To ensure budget neutrality
 - Some expected increases > 2-3% if transition base price at floor
 - **Most will see further increases in FY 2014-15**

TRANSITION BASE PRICE

21 DRG base price	\$8,500	Note 8
22 Total DRG payment	\$6,200,000	Note 9
23 <i>Per stay</i>	\$5,504	Line 22 / Line 9
24 <i>Per stay, casemix adjusted</i>	\$10,767	Line 23 / Line 12
25 Total change from baseline payment	-\$340,000	Line 22 – Line 16
26 Percent change from baseline payment	-5%	Line 25 / Line 16
27 <i>Outlier payments</i>	\$650,000	Note 10
28 <i>Outlier payments as a percentage of total payment</i>	10%	Line 27 / Line 22

Future Year DRG Base Prices

- Intention:
 - FY 2013-14: Impact -5% to +5%
 - FY 2014-15: Impact -10% to +10%
 - FY 2015-16: Impact -15% to +15%
 - FY 2016-17: Full implementation
- We're evaluating expected impacts in FY 2014-15 and FY 2015-16 using the simulation dataset
- Hospitals will be advised before July 1 of expected base prices for FY 2014-15 and FY 2015-16
- Actual future base prices may differ, based e.g., on changes in appropriations, Medicare wage areas, or other factors.

Confidentiality Under SPCP

- Applies to contract hospitals paid under the Selective Provider Contracting Program in CY 2009.
- Hospital-specific per diem rates are confidential under the SPCP.
- Because the transition DRG base prices are based in part on baseline payments that reflect SPCP rates, the confidentiality requirements of the contracting program apply to DRG transition base prices.
- The contractual confidentiality provisions apply so long as the SPCP remains in place.

Other Topics

For More Information

- To request detailed data by hospital: drg@dhcs.ca.gov
 - Level 1 data, at DRG level, requires email from hospital email address from authorized hospital representative (e.g., CFO)
 - Level 2 data, at claim level, requires signed DHCS data use agreement. A DUA previously signed is sufficient, so long as no changes are needed.
- Check www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx for updates
 - Webinars and in person trainings (Ontario, Sacramento, Anaheim)
 - Provider bulletins and educational tools (FAQ, pricing calculator)
- Sign up for DRG-specific listserve through drg@dhcs.ca.gov
- Updated provider manual to be released in June 2013

Some results in this presentation 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 3M™ Software are owned by 3M. All rights reserved. 3M has no role in the development of the Medi-Cal DRG payment method or the calculation of DRG base prices.

