

Medi-Cal DRG Payment

Provider Training

February / March 2013

Kevin Quinn & Dawn Weimar
Government Healthcare Solutions
Payment Method Development



Topics

- 1. Introduction**
2. Background: Why and How
3. DRG Grouping Logic
4. Claims Pricing under DRG Payment
5. Hospital Impacts
6. Provider Education

Introduction

First, the Headlines

- Payment by APR-DRG to start with dates of admission 7/1/13
- Rates to be phased in over four years
- 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)
- Major simplification in TAR requirements
- Important changes in billing (e.g., separate claims for mom and baby claims, limitations on interim claims, requirements for admin/rehab)

Introduction

Medi-Cal DRG Webpage

- 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



Introduction

Two Very Helpful 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 3% 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

Medi-Cal DRG Pricing Calculator

Note: 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. Stays for administrative days and rehabilitation services will not be priced via the DRG method.

Indicates information to be input by the user.

Information from the Hospital - TO BE INPUT BY THE USER	Value	Medicare Payment Policy Parameters set by Medicare
1. Top charge	\$100,000.00	US-04 Form Locator 47
2. Hospital-specific cost-to-charge ratio	35.00%	Used to estimate the hospital's cost of this stay
3. Length of stay	41	Used for transfer pricing adjustment
4. Patient discharge status = Q2, Q4, Q5 or Q6? (transfer)	No	Used for age adjuster
5. Patient age (in years)	15	US-04 Form Locator S4 for payments by third parties
6. Other health coverage	Yes	Includes append-down or co-payment
7. Patient state of stay	9300.00	Includes an interim claim
8. Discharge status equal to 307	\$350.00	Policy indicator for emergency NCU activities
9. Designated NCU facility	Yes	From separate APR-DRG grouping software
10. APR-DRG	No	
11. APR-DRG description	LIVER TRANSPLANT W/O INTERSTITIAL TRANSPLANT	
12. Case mix relative weight - designated	7.0830	Look up from DRG table
13. Service adjuster - hospital with designated NCU	1.0000	Look up from DRG table
14. Service adjuster - at other hospitals	1.0000	Look up from DRG table
15. Age adjuster	1.2500	Look up from DRG table
16. Payment relative weight	8.4540	Look up from DRG table
17. Average length of stay for this APR-DRG	5.93	IF E11+E21, then 0 (E18+E19), then (E19+E20+E21), else (E14+E21+E22), else (E16+E21)
18. DRG base price	\$7,500	Look up from DRG table
19. Cost outlier threshold 1	\$40,000	Used for cost outlier adjustments
20. Cost outlier threshold 2	\$120,000	Used for cost outlier adjustments
21. Marginal cost percentage, 1	60%	Used for cost outlier adjustments
22. Marginal cost percentage, 2	80%	Used for cost outlier adjustments
23. Casemix adjustment factor	1.30	Used to adjust DRG relative weights should a need arise, else leave set to 1.00
24. Interim claim threshold	28	Used for pricing interim claims
25. Interim claim amount	\$600	Used for pricing interim claims
26. IS A TRANSFER PAYMENT MADE?	Yes	LOOK UP E14
27. If length of stay > interim claim threshold?	Yes	IF E35="Yes", then 0 (E18+E19), "Yes", else "No", else "NA"
28. If E14="Yes", then interim claim payment amount	\$24,000.00	IF E35="Yes", then 0 (E18+E19), "Yes", else "No", else "NA"
29. WHAT IS THE DRG BASE PAYMENT?	926,411.56	E26+E23+E21
30. IS A TRANSFER PAYMENT ADJUSTMENT MADE?	No	LOOK UP E10
31. Calculated payment adjustment	N/A	IF E41="Yes", then (E36E24)/(E36-1) rounded to 2 places, else "NA"
32. Allowed amount after transfer adjustment	366,411.05	IF E42="NA", then "NA", else IF (E42+E27)+E29, then "Yes", else "No"
33. IS A COST OUTLIER ADJUSTMENT MADE?	\$35,000.00	IF E43="Yes", then E42, else E30
34. Estimated cost of this case	\$35,000.00	E7 * E9
35. High-Side Outlier Payment When Payment is Much Lower than Cost	0.00	IF E46 = E24 then "Loss" else "Gain"
36. Estimated loss in this case	0.00	
37. Is low > outlier threshold (lower limit)	N/A	IF E47 = "Loss", then (E48-E44), else "NA"
38. DRG cost outlier payment increase 1	80.00	IF E47 = "Loss", then 0 (E48-E27), then "Yes", else "No", else "NA"
39. DRG cost outlier payment increase 2	30.00	IF E50 = "Yes", then 0 (E48-E27)+E29, else (E28-E27)+E29, else 0
40. Low-Side Outlier Payment When Payment is Much Greater than Cost	\$31,411.56	IF E49="Yes", then 0 (E48-E28), then (E49-E28)+E30, rounded to 2 places, else 0
41. Estimated gain in this case	0.00	
42. Is gain > outlier threshold	No	IF E47="Gain", then (E44-E46), else "NA"
43. DRG cost outlier payment decrease	0.00	IF E47="Gain", then 0 (E54+E27), then "Yes", else "No", else "NA"
44. ALLOWED AMOUNT AFTER TRANSFER AND OUTLIER ADJUSTMENTS	\$65,411.56	IF E47="Gain", then 0 (E54+E27), then "Yes", else "No", else "NA"
45. DRG payment to be	\$65,411.56	IF E47="Gain", then 0 (E54+E27), then "Yes", else "No", else "NA"
46. ALLOCATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT	\$0.00	IF E48="Loss", then (E44+E14+E22), else (E44-E26)
47. Inpatient amount	\$65,411.56	Hospital-specific payments separate from DRG payment (not used at the time)
48. Other health coverage	\$300.00	Allowed amount = E58-E50
49. Net share of cost	\$300.00	E14
50. Total of calculation	\$65,411.56	E13
51. Net amount	\$65,411.56	Scaling policy ensures that payment amount cannot exceed total charges (if E10+E7, then E7, else E11)
52. Final amount	\$24,600.00	If interim claim (E35="Yes"), then interim claim (E33) amount as payment amount. Otherwise, subtract other health coverage (E22) and patient share of cost (E23) from "Loser of" (E44) to obtain payment amount.

CALCULATOR VALUES ARE SUBJECT TO CHANGE BEFORE IMPLEMENTATION JULY 1, 2013.



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>
- Presentations at www.dhcs.ca.gov/provgovpart/pages/DRG.aspxinfo
- Additional trainings to be scheduled – check webpages above

Topics

1. Introduction
- 2. Background: Why and How**
3. DRG Grouping
4. Claims Pricing under APR-DRGs
5. Hospital Impacts
6. Provider Education

Background

Previous Payment Method

- In CY 2009, \$4.5 billion was paid for Medi-Cal FFS inpatient care
 - Generally referred to as Selective Provider Contracting Program (SPCP)
 - In place almost 30 years
1. Contract hospitals
 - Signed contracts with California Medical Assistance Commission
 - Flat-rate per diem rates for all care (with some exceptions)
 - Rates confidential
 2. Non-contract hospitals
 - Paid at 100% of allowed cost, with cost settlement process
 - In closed areas, could only accept emergency patients
 3. Designated public hospitals
 - Separate method outside the SPCP

Background

New Payment Method

- Authorized by Senate Bill 853 in October 2010
- To be based on Diagnosis Related Groups (DRGs)
- Included hospitals: all general acute care hospitals in and out of state, including Medicare-designated CAHs and LTACs
- Excluded hospitals: designated public hospitals and non-designated public hospitals, psychiatric hospitals
- Excluded services within included hospitals:
 - Psychiatric stays, regardless of distinct-part location
 - Managed care stays
 - Rehabilitation stays and administrative days are outside the scope of DRG payment, but inside scope of this project (to be paid per diem)
- Based on experience nationwide, this method may be in place for 15, 20 or more years

Background

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
- **Fairness:** Moving toward 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
 - 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 ease:** Day-by-day TAR no longer required (except some limited-benefit beneficiaries)
- **Quality:** Sets foundation for improvement of outcomes

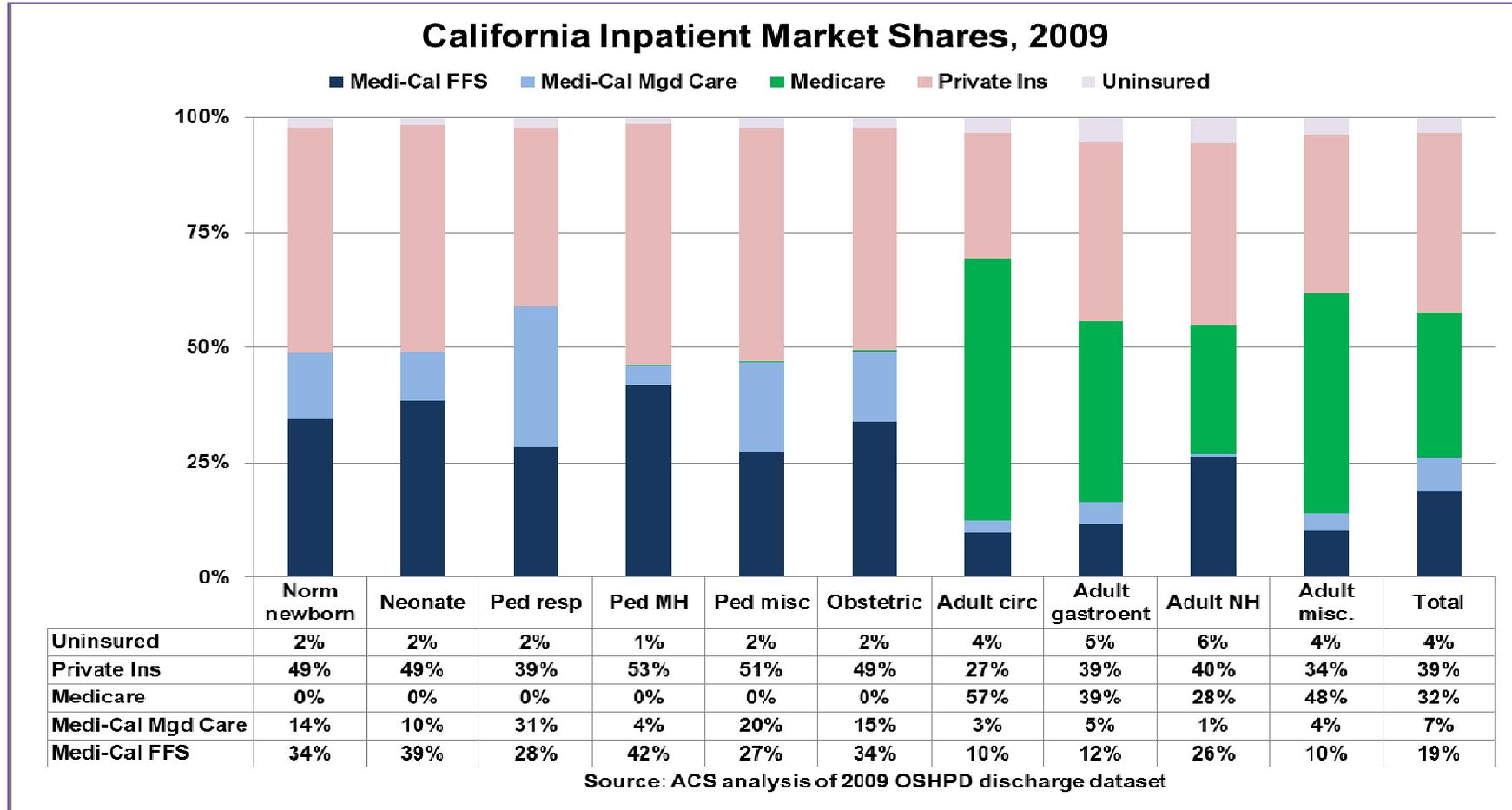
Background

Policy Development Process

- DHCS instructions: an open, transparent process
- April 2011 to February 2012
 - Monthly meetings of state workgroup, hospital consultation group
- “Policy design document (PDD)” was key document
 - Set the structure of the payment method
- July 1, 2012: Contracting program transferred from CMAC to DHCS
- Early February 2013: Hospital-specific base prices sent effective 7/1/13
 - Sent by U.S. mail to hospital CFO
 - For explanation, see sample and presentation on DRG webpage
- July 1, 2013: DRG implementation (by date of admission)

Background

Medi-Cal's Role as a Purchaser



Medi-Cal FFS data include designated public hospitals and do not take into account the transition to managed care since 2009

Topics

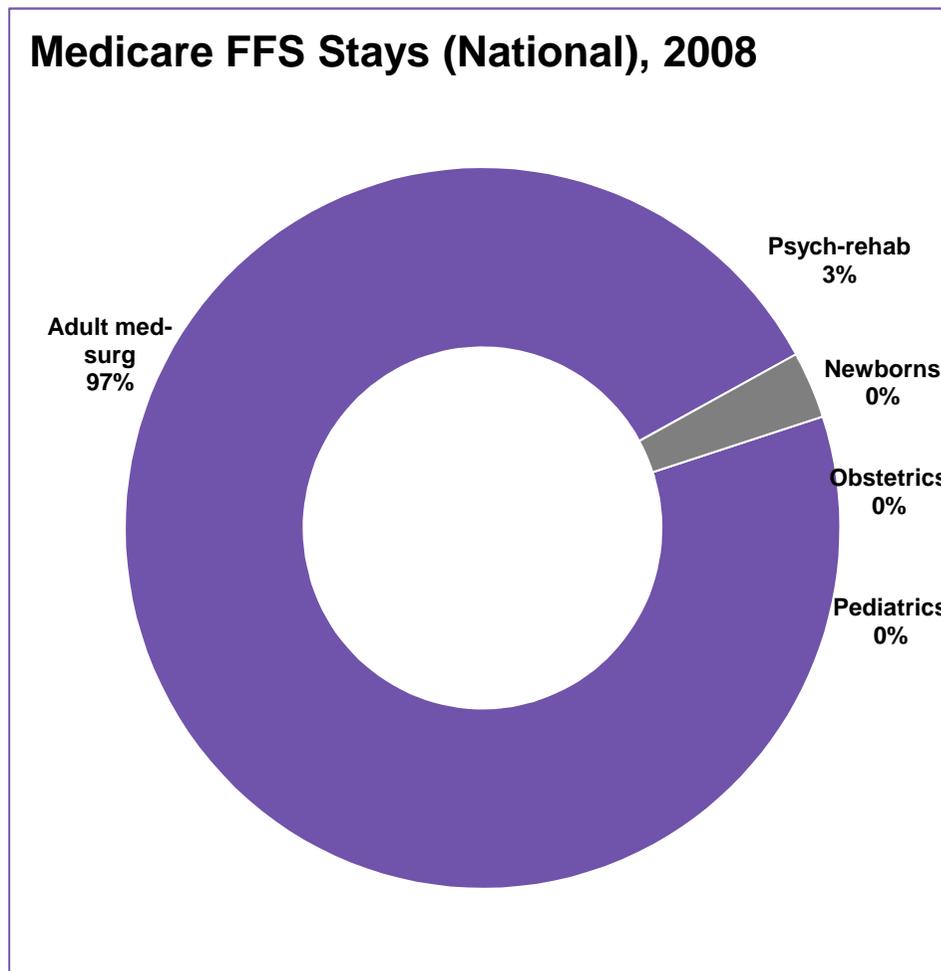
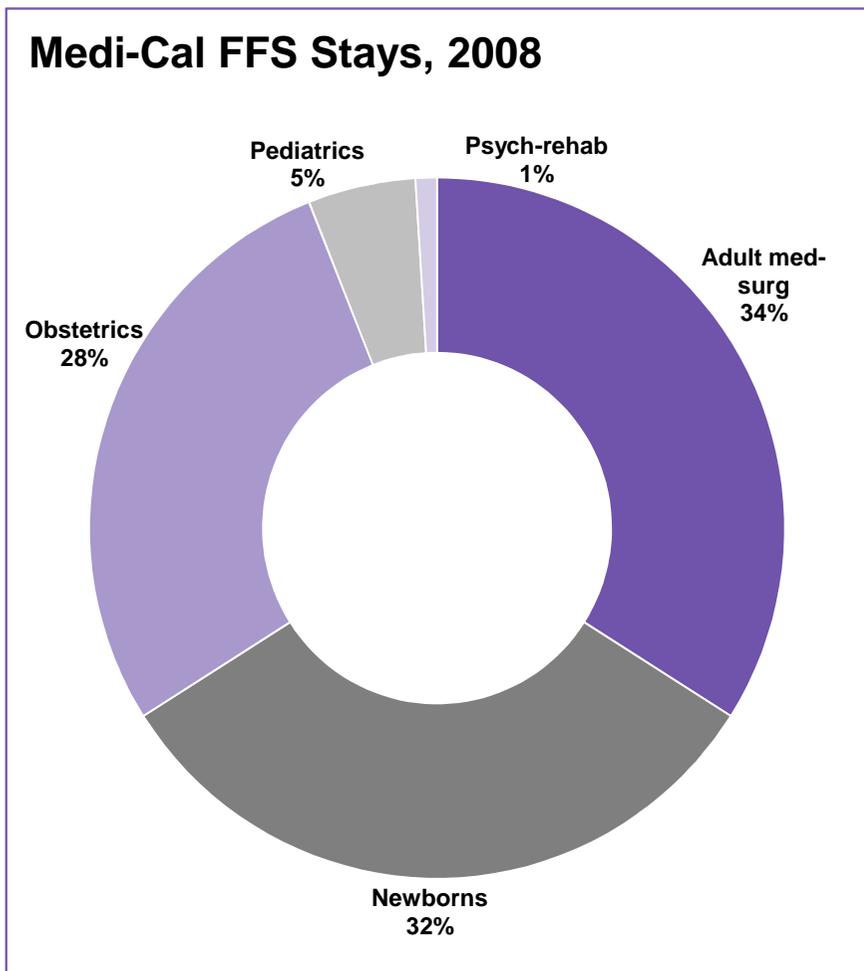
1. Introduction
2. Background: Why and How
- 3. DRG Grouping**
4. Claims Pricing under APR-DRGs
5. Hospital Impacts
6. Provider Education

How States Pay for Inpatient Care

As of December 2012	
<p>Per Stay -- CMS-DRGs CO*, IA, IL*, KS**, KY, MN, NC**, ND*, OH*, UT, VT, WV**</p> <p>* Moving to APR-DRGs ** Moving to MS-DRGs</p>	<p>Per Stay -- AP or Tricare DRGs DC, GA, IN, NE, NJ, VA, WA</p>
<p>Per Stay -- MS-DRGs MI, NH, NM, OK, OR, SD, WI</p>	<p>Per Stay -- Other DE, MA*, NV, WY</p> <p>* Casemix adjustment based on APR-DRGs</p>
<p>Per Stay -- APR-DRGs MT, NY, PA, RI, MS, TX</p>	<p>Per Diem AK, AZ, CA*, FL*, HI, LA, MO, TN</p> <p>* Moving to APR-DRGs</p>
<p>Cost Reimbursement AL, AR, CT, ID, ME, SC*</p> <p>* Interim payment using APR-DRGs</p>	<p>Other (Regulated Charges) MD*</p> <p>* Casemix adjustment based on APR-DRGs</p>

DRG Grouping

Very Different Populations



Source: OSHPD 2008 data

DRG Algorithm: APR-DRGs

- Developed in early 1990s by 3M and National Association of Children's Hospitals (formerly NACHRI)
- Intended to be suitable for all patients, especially obstetrics, newborns, NICU babies, general pediatrics, and medically complex children
- Widely used for research, analysis and payment
- Medicare MS-DRGs not suitable or intended for Medicaid
 - “We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn and maternity patients.” (FFY 2008 Medicare IPPS Final Rule (8.2.07))
- Hospitals do not need to buy APR-DRG software
 - DRG grouping and pricing will be done by Medi-Cal
- California hospitals can access 3M DRG grouping webpage at no charge
 - CHA members may go to the “members” section at www.calhospital.org. Hospitals that are not CHA members may contact Jack Ijams at jhijams56@mmm.com

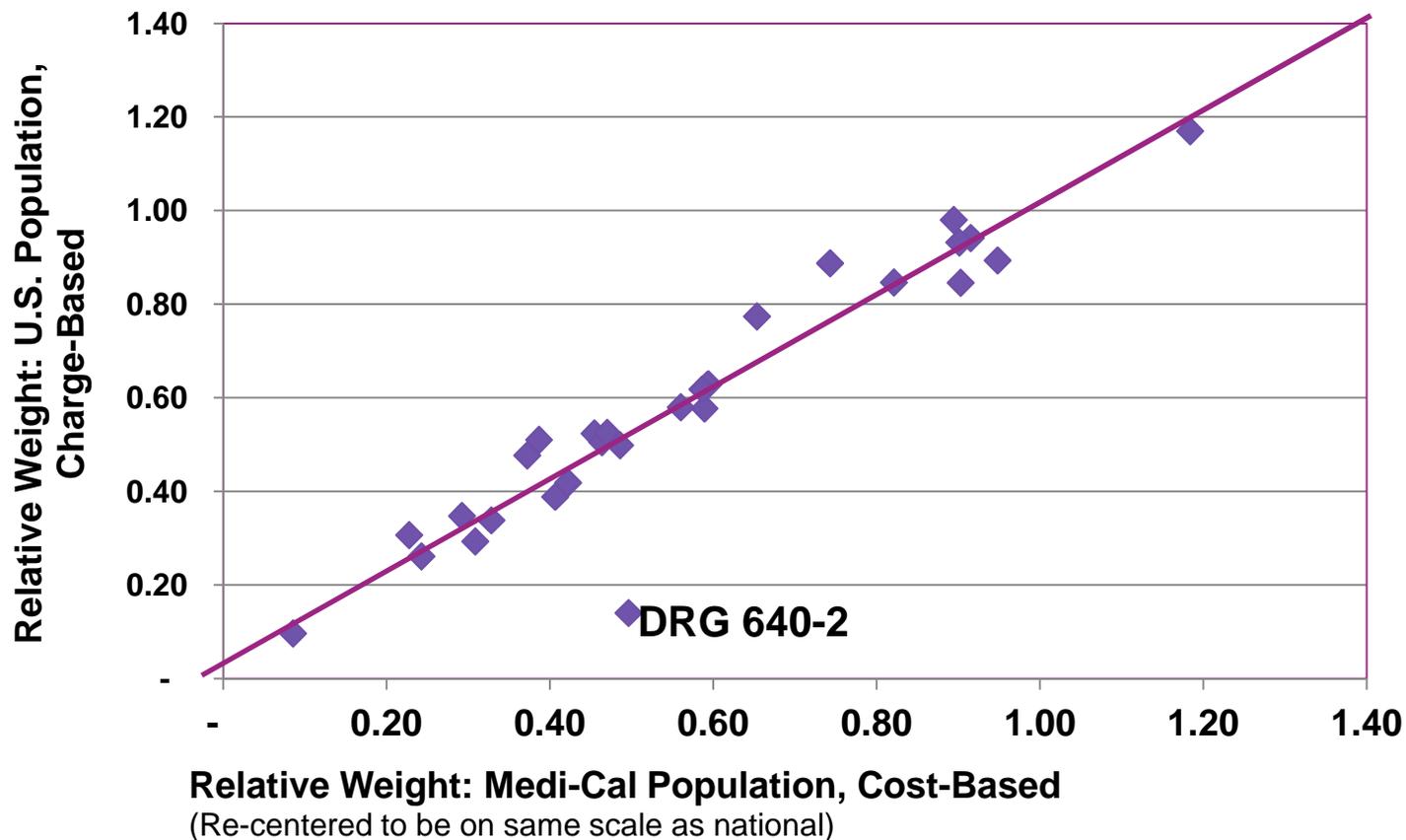
DRG Grouping

Comparing MS-DRGs and APR-DRGs

	Medicare MS-DRGs	Medi-Cal APR-DRGs
Developer	Medicare (3M contractor)	3M and National Association of Children's Hospitals
Genesis	2007--adaptation of CMS-DRGs to improve capture of complications and comorbidities (CC)	Early 1990s--new model
Patient population	Medicare only	All-patient, using the Nationwide Inpatient Sample (NIS)
Total DRGs	751	1,258
DRG Structure	334 base DRGs; many conditions split "with CC" or "with major CC"	316 base DRGs, each with 4 severity of illness (SOI) levels. No CC list.
Newborn DRGs	7 DRGs; birthweight not used	28 x 4 = 112 DRGs; birthweight used
Obstetric DRGs	Unchanged since 1983	4 x 4 = 16 delivery DRGs, plus other obstetric DRGs
Pediatric DRGs	Previous CMS-DRG logic discontinued; now, pediatric age not considered	Pediatric age reflected in base DRGs (e.g., RSV) and severity
Version	V.30 for federal fiscal year 2013	V.29 for state fiscal year 2013-14
Relative weights	Calculated from Medicare population	Calculated from NIS; validated using Medi-Cal data

Nat'l Relative Weights Fit Medi-Cal

Comparison of National and Medi-Cal Weights
Top 30 DRGs by Volume

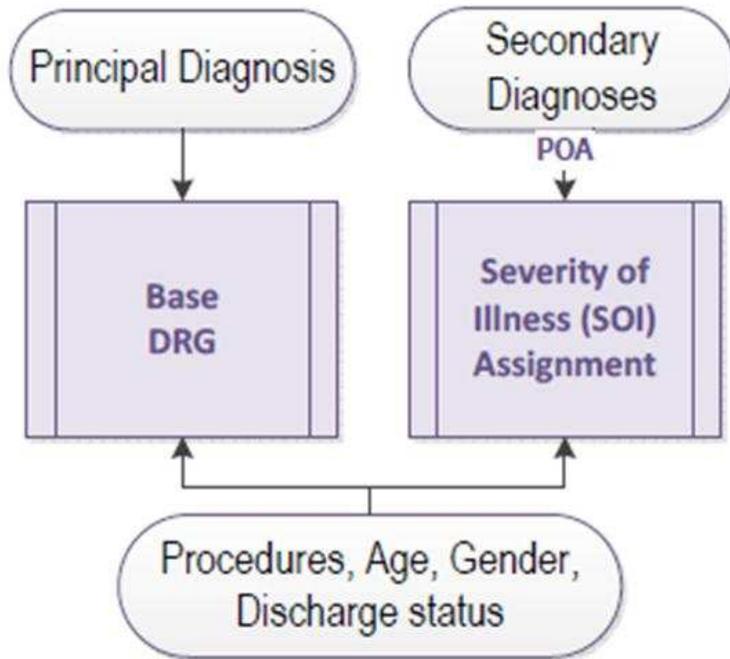


To improve clarity, APR-DRG 720-4 is not shown. Its relative weights are 2.79 national and 2.73 California.

DRG Grouping

Structure of APR-DRGs

DRG 002-4 Base DRG - SOI



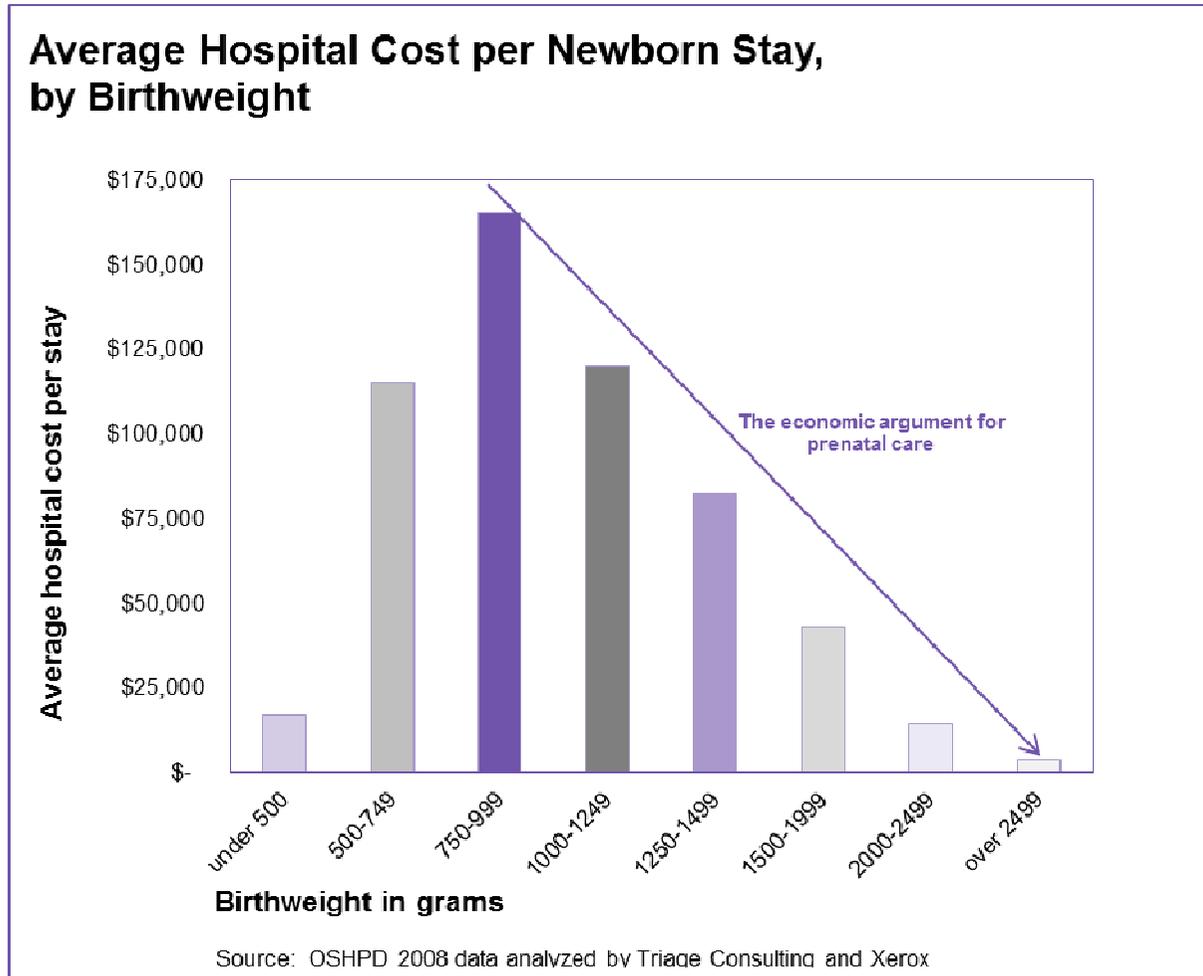
APR-DRG	APR-DRG Description	Relative Weight
002-1	Heart &/Or Lung Transplant	9.5322
002-2	Heart &/Or Lung Transplant	11.3558
002-3	Heart &/Or Lung Transplant	16.027
002-4	Heart &/Or Lung Transplant	24.7273
141-1	Asthma	0.3506
141-2	Asthma	0.4946
141-3	Asthma	0.7464
141-4	Asthma	1.4218
560-1	Vaginal Delivery	0.307
560-2	Vaginal Delivery	0.3477
560-3	Vaginal Delivery	0.5057
560-4	Vaginal Delivery	1.3646

DRG Grouping

Top 20 Medi-Cal Stays by Total Cost 2009

APR-DRG	Description	Stays	Days	Charges	Est. Cost	Casemix	National ALOS	Average Cost per Stay
540-1	Cesarean Del	36,767	116,578	\$895,069,993	\$206,357,005	0.52	3.0	\$5,613
560-1	Vaginal Del	68,222	133,236	\$829,993,929	\$191,713,182	0.31	2.0	\$2,810
720-4	Septicemia & Disseminated Inf	4,855	56,175	\$763,063,878	\$167,482,211	2.73	9.6	\$34,497
640-1	Normal Newborn, Bwt >2499G	139,196	297,543	\$631,929,500	\$146,658,208	0.10	2.1	\$1,054
005-4	Trach, MV 96+ Hrs, w/o Ext Proc	678	33,055	\$475,513,784	\$100,128,923	11.47	34.1	\$147,683
560-2	Vaginal Del	20,946	48,125	\$320,122,814	\$75,595,806	0.35	2.4	\$3,609
540-2	Cesarean Del	8,714	35,322	\$275,245,556	\$63,960,846	0.63	4.1	\$7,340
130-4	Resp Sys Diag w MV 96+ Hrs	878	20,146	\$254,667,446	\$57,615,744	5.39	17.4	\$65,622
710-4	Inf & Parasit Dis Incl HIV w O.R. Proc	720	18,267	\$231,849,292	\$49,418,135	6.09	18.8	\$68,636
634-1	Neo, Bwt >2499G w Maj Resp Cond	1,165	30,436	\$204,226,884	\$44,176,471	0.55	4.5	\$37,920
720-3	Septicemia & Disseminated Inf	2,742	18,924	\$176,718,683	\$40,100,616	1.17	6.3	\$14,625
194-3	Heart Failure	2,945	15,233	\$153,063,934	\$33,288,623	0.94	5.6	\$11,303
139-3	Oth Pneumonia	2,804	15,583	\$144,338,588	\$32,838,843	0.89	5.5	\$11,711
139-2	Oth Pneumonia	3,899	14,941	\$117,597,728	\$28,379,777	0.58	3.8	\$7,279
133-4	Pulmon Edema & Resp Failure	1,175	8,392	\$114,031,279	\$25,568,272	1.97	7.1	\$21,760
460-3	Renal Failure	2,191	11,643	\$108,423,344	\$24,436,578	0.85	5.1	\$11,153
540-3	Cesarean Del	2,163	13,335	\$106,424,329	\$24,081,373	0.93	6.8	\$11,133
194-2	Heart Failure	3,282	11,883	\$108,817,664	\$24,030,415	0.63	3.8	\$7,322
140-3	COPD	2,351	11,628	\$108,543,395	\$23,845,083	0.85	5.2	\$10,143
140-2	COPD	3,266	12,400	\$103,554,831	\$23,665,712	0.62	4.0	\$7,246
Top 20 Total		308,959	922,845	\$6,123,196,853	\$1,383,341,821	0.58	3.9	\$4,477
Top 20 as Percent of All		57%	42%	31%	30%			

Example of Purchasing Clarity



Topics

1. Introduction
2. Background: Why and How
3. APR-DRG Grouping Logic
- 4. Claims Pricing under APR-DRGs**
5. Hospital Impacts
6. Provider Education

Claims Pricing under DRG

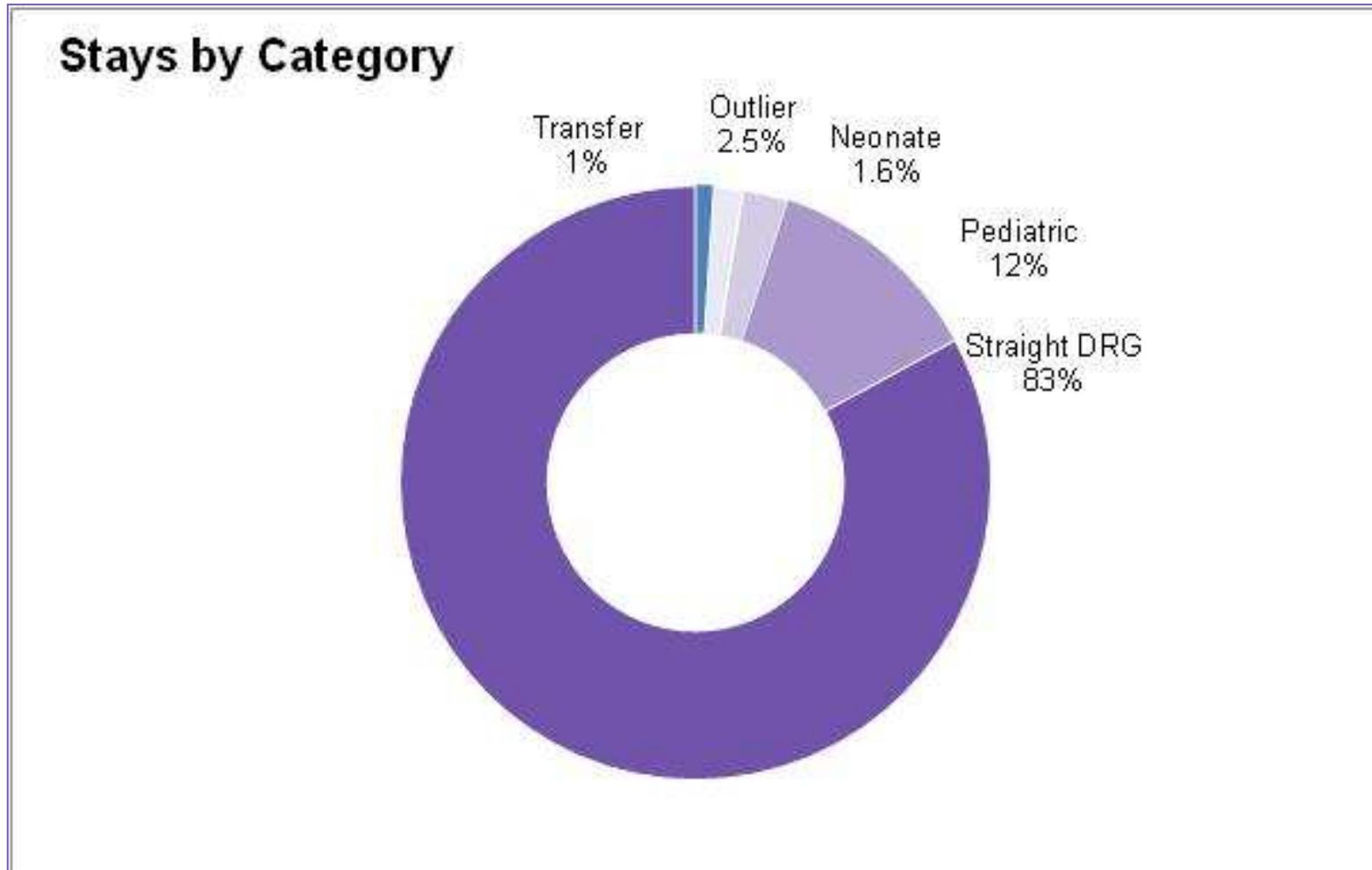
Key Payment Values

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.	

Hospital Characteristics

- **“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
- **Cost-to-charge ratio used for calculating outlier payments** - (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

How Claims Will Be Paid



Calculating the Allowed Amount

1. Group each stay to APR-DRG and use relative weight
 - Relative weights from a national database that fits CA well
2. Hospital-specific base price
 - Higher base price for remote rural hospitals
 - Transition rates in effect 2013-14, 2014-15, 2015-16
 - Adjust by Medicare Wage Area
3. Incorporate specific payment adjustments
 - Age adjustor, NICU adjustor, outlier payments, transfers

Claims Pricing under DRG

DRG Calculator Shows Calcs, Values

Information	Value	Comments or Formula
INFORMATION FROM THE HOSPITAL-- TO BE INPUT BY THE USER		
7 Total charges	\$100,000.00	UB-04 Form Locator 47
8 Hospital-specific cost-to-charge ratio	35.00%	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, 06, 05 or 07 (transfer)	No	Used for transfer pricing adjustment
11 Patient age (in years)	18	Used for age adjustment
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 NICU facility	No	Policy adjuster for designated NICU facilities
16 APR-DRG	001-3	From separate APR-DRG grouping software
APR-DRG INFORMATION		
18 APR-DRG description	LIVER TRANSPLANT SICR INTERNAL TRANSPLANT	Look up from DRG table
19 Casmix relative weight -unadjusted	7.0839	Look up from DRG table
20 Service adjuster - hospital with designated NICU	1.0000	Look up from DRG table
21 Service adjuster - all other hospitals	1.0000	Look up from DRG table
22 Age adjuster	1.0000	Look up from DRG table
23 Payment relative weight	8.9549	IF E14=1, then (E15*Year), then (E19)(E20)(E22), else (E19)(E21)(E22), else IF (E19="Yes"), then (E19)(E23), else (E19)(E23)
24 Average length of stay for this APR-DRG	8.93	Look up from DRG table
PAYMENT POLICY PARAMETERS SET BY MEDICAID-- SUBJECT TO CHANGE		
26 DRG base price	\$7,500	Used for DRG base payment--see DRG base price table
27 Cost outlier threshold 1	\$40,000	Used for cost outlier adjustments
28 Cost outlier threshold 2	\$125,000	Used for cost outlier adjustments
29 Marginal cost percentage_1	30%	Used for cost outlier adjustments
30 Marginal cost percentage_2	30%	Used for cost outlier adjustments
31 Detrended 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 per-claim amount	\$500	Used for pricing interim claims
IS THIS AN INTERIM CLAIM?		
34 Is discharge status equal to 30?	Yes	Look up E14
35 Length of stay > interim claim threshold?	Yes	IF E35="Yes", then E (E3 > E32), "Yes", else "No", else "N/A"
36 Days to 60 for long-term claim payment amount	\$24,600.00	IF E36="Yes", (E30)(E3) rounded to 2 places, else 0
WHAT IS THE DRG BASE PAYMENT?		
38 DRG base payment for this claim	\$68,411.56	E26*(E23)(E3)
IS A TRANSFER PAYMENT ADJUSTMENT MADE?		
40 Is a transfer adjustment ultimately appropriate?	No	Look up E10
41 Calculated transfer payment adjustment	N/A	IF E41="Yes", then (E19)(E24)(E3+1) rounded to 2 places, else "N/A"
42 Is transfer payment adjustment < allowed amount, so far?	N/A	IF E42="N/A" then "N/A", else IF (E40<E38), then "Yes" else "No"
44 Allowed amount after transfer adjustment	\$68,411.56	IF E43="Yes", then E42, else E38
IS A COST OUTLIER ADJUSTMENT MADE?		
46 Estimated cost of this case	\$35,000.00	E7 * E8
47 Is estimated cost > allowed amount?	Yes	IF E40 > E44 then "Yes" else "No"
High Side Outlier Payment When Payment is Much Lower than Cost		
48 Estimated loss on this case	N/A	IF E47 = "Loss", then ((E4-E44)/E4), else "N/A"
49 Is loss > outlier threshold above limit	N/A	IF E47 = "Loss", then IF (E48 > E27), then "Yes", else "No", else "N/A"
51 DRG cost outlier payment increase 1	\$0.00	IF E50 = "Yes", then IF (E49<E29), then ((E49-E29)/E29), else 0
52 DRG cost outlier payment increase 2	\$0.00	IF E50="Yes", then IF (E49<E26), then ((E49-E26)/E26) rounded to 2 places, else 0, else 0
Low Side Outlier Payment When Payment is Much Greater than Cost		
54 Estimated gain on this case	\$31,811.56	IF E41="Gain", then (E44-E49), else "N/A"
55 Is gain > outlier threshold	No	IF E41="Gain", then IF (E54<E27), then "Yes", else "No", else "N/A"
56 DRG cost outlier payment decrease	\$0.00	IF E47="Gain", then IF (E55="Yes"), then ((E4-E47)/E28) 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-E56)
CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT		
60 Add-on amount	\$0.00	Hospital-specific payments separate from DRG payment (not used at this time)
61 Allowed amount	\$68,411.56	Allowed amount = E58+E60
62 Other health coverage	\$300.00	E13
63 Patient share of cost	\$300.00	E13
64 "Lesser of" calculation	\$68,411.56	Smaller pricing values that the payment amount cannot exceed total charges. IF E61+E7, then E7, else E61
65 Payment amount	\$34,806.90	If interim claim (E30="Yes"), then interim claim (E37) amount as payment amount. Otherwise, subtract other health coverage (E62) and patient share of cost (E63) from "Lesser of" (E64) to obtain payment amount.



Claims Pricing under DRG

1. Straight DRG

- 314 base APR-DRGs, each with four levels of severity
- DRG base price = statewide base price adjusted for wage area
 - L.A. area: $(\$6,223 \times 68.8\% \times 1.2282) + (\$6,223 \times 31.2\%) = \$7,200$
- Individual hospitals will have different base prices due to the transition

DRG	Description	Rel Wt	DRG Base Price	DRG Base Payment
139-1	Oth Pneumonia	0.3886	\$7,643	\$2,970
139-2	Oth Pneumonia	0.5773	\$7,643	\$4,412
139-3	Oth Pneumonia	0.8937	\$7,643	\$6,831
139-4	Oth Pneumonia	1.7342	\$7,643	\$13,254
166-1	Coronary Bypass w/o Cath	2.5684	\$7,643	\$19,630
166-2	Coronary Bypass w/o Cath	2.8429	\$7,643	\$21,728
166-3	Coronary Bypass w/o Cath	3.6188	\$7,643	\$27,658
166-4	Coronary Bypass w/o Cath	6.1761	\$7,643	\$47,204

2. Pediatric Adjustor

- Illustrates the Straight DRG modified for a pediatric patient
- Pediatric adjustor of 1.25 is applied

Straight DRG					Pediatric Adjustor Applied		
DRG	Description	Casemix Rel. Wt.	DRG Base Price	DRG Base Payment	Pediatric Adjustor	Payment Rel. Wt.	DRG Base Payment
139-1	Oth Pneumonia	0.3886	\$7,643	\$2,970	1.25	0.48575	\$3,713
139-2	Oth Pneumonia	0.5773	\$7,643	\$4,412	1.25	0.721625	\$5,515
139-3	Oth Pneumonia	0.8937	\$7,643	\$6,831	1.25	1.117125	\$8,538
139-4	Oth Pneumonia	1.7342	\$7,643	\$13,254	1.25	2.16775	\$16,568

3. Transfer Cases

- Payment adjustment follows Medicare model
- Applies to short-stay patients transferred for acute care; (“Transfer” statuses 02-general hospital, 05-children’s or cancer, 65-psych, 66-critical access)
- Transfer adjustment made only if LOS less than national ALOS - 1 day
- No post-acute transfer policy

Example: DRG 190-3, Heart-attack		
LOS= 3 days; Transferred to another general hospital		
Step	Explanation	Amount
DRG base payment	$\$7,643 \times 1.0665$	\$8,151
Transfer case	Discharge status = 02	Yes
National ALOS	Look up from DRG table	4.87
Tsf adjustment	$(\$8,151/4.87) * (3+1)$	\$6,695
DRG payment	$\$6,695 < \$8,151$	\$6,695

4. Cost Outlier Case: Tier 1

- Cost outlier payments supplement base payments in exceptional cases
- Cost is calculated using charges and CCR
- Same calculation model as Medicare 5% of payments as outliers; CA 17%

Example: DRG 720-4 Septicemia with charges of \$180,000		
Step	Explanation	Amount
DRG base payment	$\$7,643 \times 2.7338$	\$20,894
Estimated cost	$\$180,000 \times 39\%$	\$70,200
Estimated loss	$\$70,200 - \$20,894$	\$49,306
Cost outlier case	$\$49,306 > \$40,000$	Yes
Est. loss - cost outlier	$\$49,306 - \$40,000$	\$9,306
Cost outlier payment	$\$9,306 \times 60\%$	\$5,584
DRG payment	$\$20,894 + \$5,584$	\$26,478

5. Cost Outlier Case: Tier 1 & 2

Example: DRG 720-4 Septicemia with charges of \$600,000		
Step	Explanation	Amount
DRG base payment	$\$7,643 \times 2.7338$	\$20,894
Estimated cost	$\$600,000 \times 39\%$	\$234,000
Estimated loss	$\$234,000 - \$20,894$	\$213,106
Cost outlier case	$\$213,106 > \$40,000$	Yes
Est. loss - cost outlier	$\$213,106 - \$40,000$	\$173,106
Cost Outlier Payment tier 1 for loss between \$40,000 & \$125,000	$\$85,000 \times 60\%$	\$51,000
Tier 2 loss over \$125,000	$\$173,106 - \$125,000$	\$48,106
Cost outlier payment tier 2	$\$48,106 \times 80\%$	\$38,485
DRG payment	$\$20,894 + \$51,000 + \$38,485$	\$110,379

Example of two-tier cost outlier threshold:

\$40,000 and \$125,000

- Tier 1 paid at 60% for losses between \$40,000 and \$125,000
- Tier 2 paid at 80% for losses greater than \$125,000

6. Interim Claims

- Hospitals can choose to submit interim claims if a stay exceeds 29 days.
- Hospitals are not required to submit interim claims under any circumstances
- Interim per diem intended to provide cash flow (\$600)

Example: Neonate 1200 g with respiratory distress syndrome (APR-DRG 602-4)

Claim	Type of Bill	Days	Interim Per Diem	Payment
1st Interim claim	112	30	\$600	\$18,000
2nd interim claim	113	30	\$600	\$18,000
Calculate DRG Payment		80		\$139,497
System pays DRG payment minus interim paid amounts	111			\$103,497

Note:

1. APR-DRG 602-4 base rate is $\$7,643 \times 18.2517 = \$139,497$.
2. \$600 is the per diem rate for interim claims.

Topics

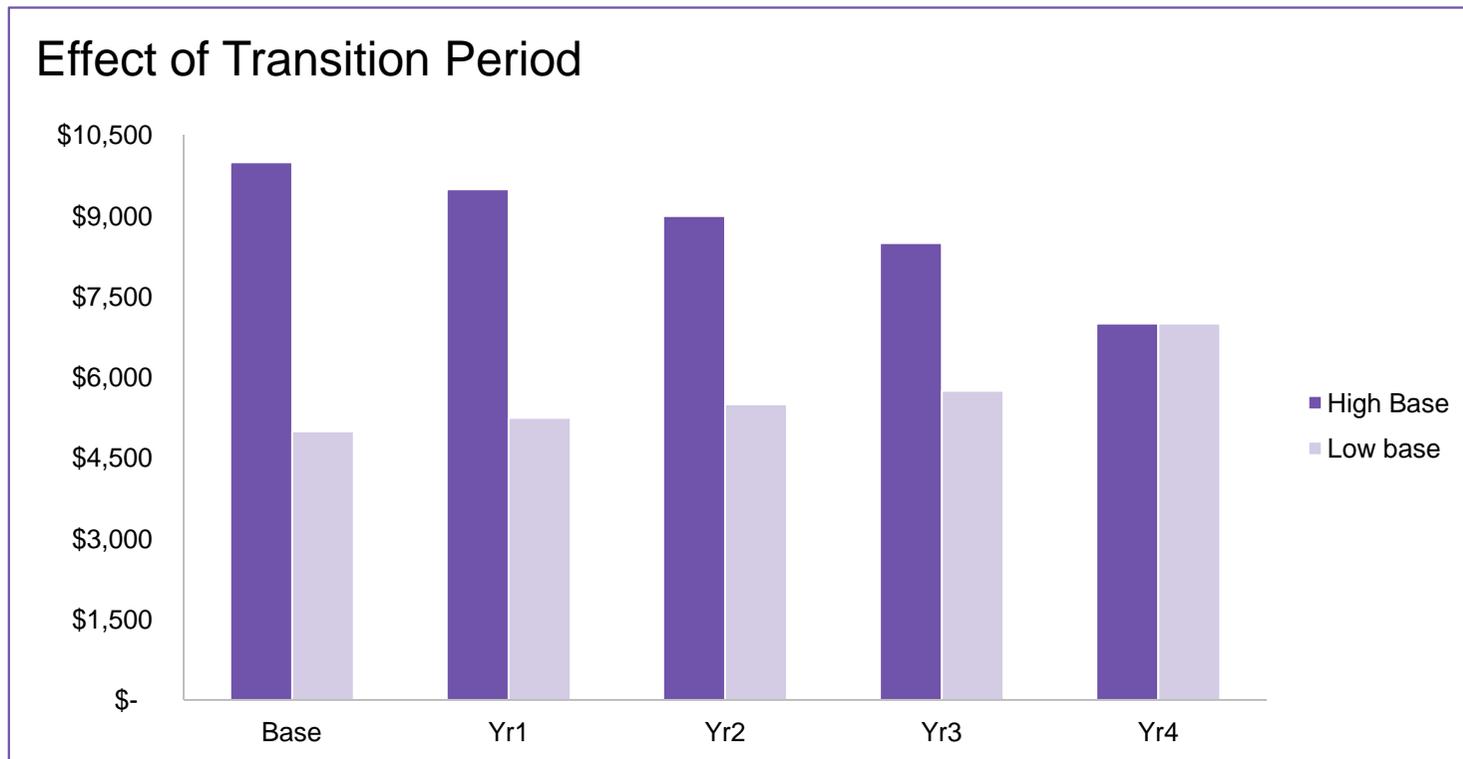
1. Introduction
2. Background: Why and How
3. APR-DRG Grouping Logic
4. Claims Pricing under APR-DRGs
- 5. Hospital Impacts**
6. Provider Education

Hospital Impacts

Likely Impacts on Hospitals

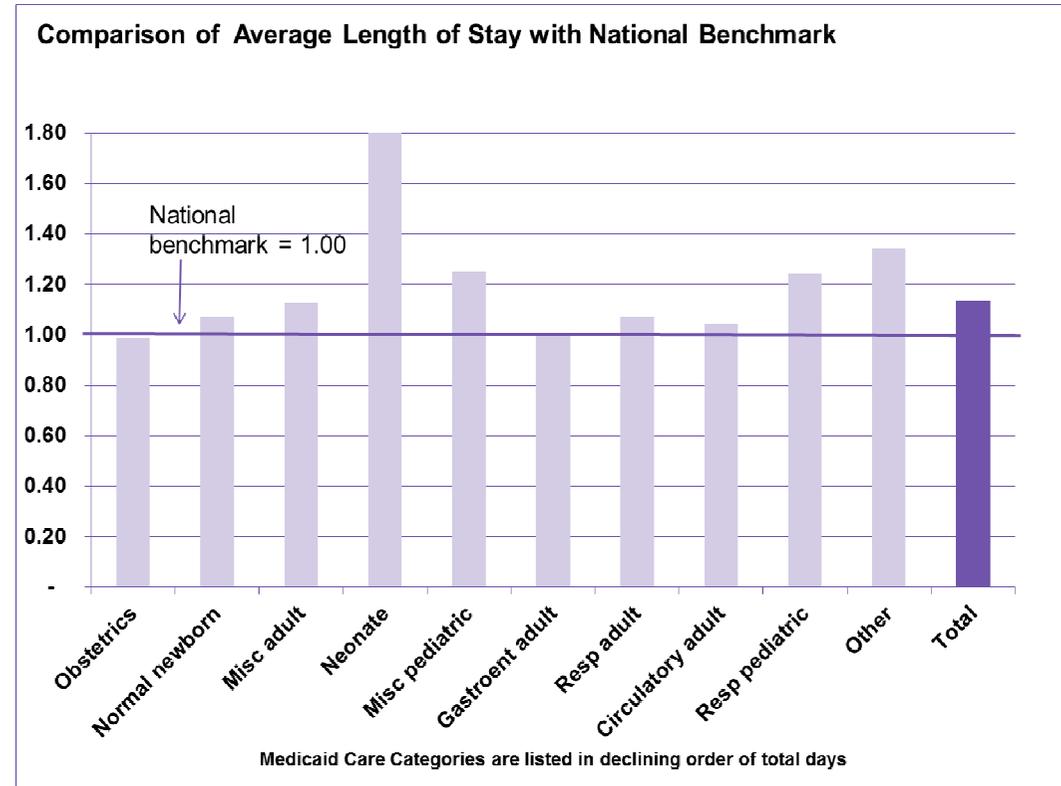
The following are in approximate declining order of importance:

1. Change in payment per hospital – up or down



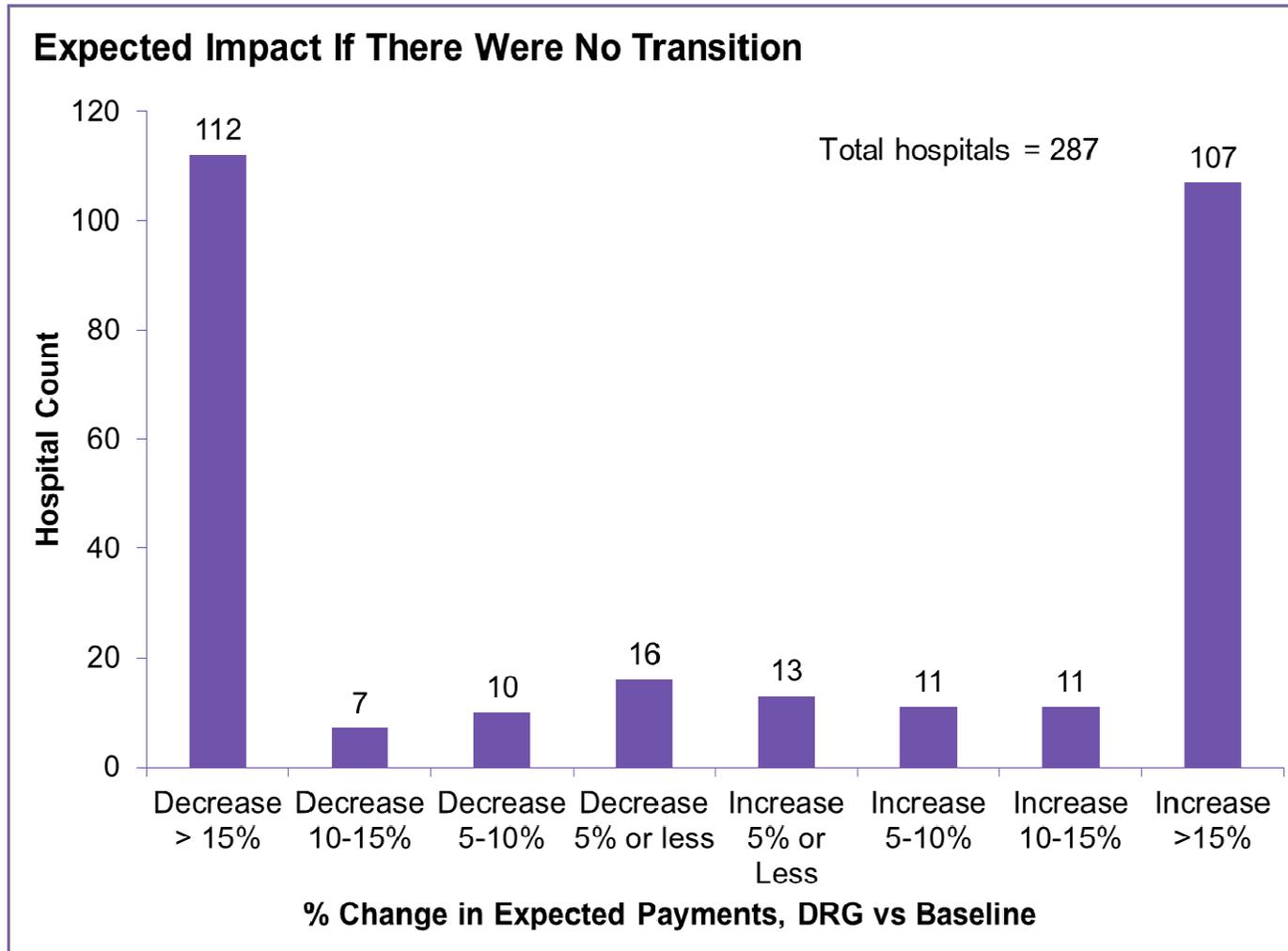
Financial Management

1. Change in payment per hospital – up or down
 - Managing LOS and cost per day are rewarded
 - Increase revenue by increasing casemix and volume
 - Increase margins by increasing efficiency
 - In general, no cost settlement process under DRGs



Hospital Impacts

Statewide Impact – No Transition



Hospital Impacts

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

TAR Summary

2. Decrease in daily TAR for stays paid by DRG
 - Discontinue daily TAR on general acute care admissions
 - Continue TAR on the medical necessity of the admission (admit TAR)
 - No TAR for deliveries and well babies
 - Discontinue TAR on days related to induction of labor
 - Sick babies do require a TAR
 - Continue TAR for procedures
 - Interim claims require a TAR for the claim to be paid
 - Continue daily TAR for administrative days and rehabilitation
 - DPH & NDPH – similar to current process

TAR- General Acute Care

Full Scope, CCS & GHPP

- Admit TAR/SAR (prev. daily TAR/SAR)
 - General acute care inpatient stay
 - Interim claims for general acute care inpatient stay

Restricted Scope

- Daily TAR continues
 - General acute care inpatient stay
 - Interim claims for general acute care inpatient stay

TAR- Obstetrics (OB)

Obstetrics with Delivery- Full or Restricted Scope

- No TAR/SAR (either admit or daily)
 - OB Admission with Delivery (previously no TAR)
 - OB with induction day before delivery (prev. daily TAR)
 - OB prolonged stays (Vag >2 d; C-sect>4d) (prev. daily TAR)

Obstetrics Non-Delivery

- Full Scope – Admit TAR (previously daily TAR)
- Restricted Scope – Daily TAR (previously daily TAR)

TAR- Newborns, Admin, Rehab

Babies

- Well baby stays (only rev code 171 on claim) – full & restricted aid codes
 - No TAR (prev. billed on mom's claim)
- Neonate (sick baby rev codes 172, 173, 174) – full & restricted aid codes (use maternal aid code)
 - Admit TAR only (previously, daily TARs required)
- Well baby becomes sick baby – TAR is required

Per Diem Stays

- Administrative levels 1 & 2 – daily TAR (Pediatric – rev code 190; Adult – rev code 199)
- Rehabilitation stays – daily TAR (Rev codes – 118, 128, 138, 148, 158)
- Hospice – daily TAR

TAR Process

- Refer to “DRG Hospital Inpatient TAR Requirements” on webpage
 - Use the TAR, 50-1 for elective non-emergency admission
 - Use the 18-1 TAR for emergency admissions
 - For a list of CPT-4 procedures requiring TAR, refer to the TAR and non-Benefit List section in the appropriate Part 2 manual
 - TAR field Office Addresses of same manual
- Required documentation – necessary documentation to establish the medical necessity of the
 - Admission – admit TAR
 - Each day – daily TAR

Diagnosis and Procedure Coding

3. Increased importance of diagnosis/procedure coding
 - APR-DRG severity assignment:
 - No single complications/comorbidities list
 - Depends on interaction of primary diagnosis with multiple secondary diagnoses and procedures
 - List principal diagnosis in the principal diagnosis field (unlabeled box 67)
 - Other applicable diagnoses (boxes 67A-67Q)
 - APR-DRG granularity => opportunities to increase severity of illness
 - Logic and experience (e.g., Medicare, MD, PA) => measured casemix will increase
 - Newborn casemix expected to increase in particular (due to birth weight coding, inferred newborn claims)
 - Overall, documentation and coding adjustment built into DRG base price
 - Hospitals must ensure that coding is complete, accurate and defensible

Hospital Impacts

Billing

4. Mother and newborn to be billed on separate claims
5. Sick newborns should be billed with single client ID
 - Either mother's Beneficiary Identification Card (BIC) or newborn's
 - Critical for interim claims when hospital stays > 29 days
 - Revenue codes 172, 173, or 174
 - TAR is required
 - If a well baby (rev code 171) becomes sick, admit TAR is required
6. Newborn weight coded using diagnosis codes
 - ICD-9-CM uses 5th digit to indicate bwt for diagnoses 764 & 765.0-765.1
 - ICD-9-CM codes exist for gestational age

All HFPAs Are Open Areas

7. Transfer from non-contract hospitals

Hospitals will no longer be required to transfer patients based on their previous non-contract designation in closed Health Facility Planning Areas (HFPAs)

- Contract or non-contract facility designations will not apply under the DRG payment method
- All HFPAs will be considered open areas allowing for all hospitals to serve Medi-Cal beneficiaries for both emergency and elective services (subject to approved TAR)

Interim Claims

8. Interim claims for > 29 days
 - Voluntary, never mandatory
 - System will adjust payment on final claim (subtract interim payments)
 - Hospitals should not:
 - adjust their final claim based on interim payments,
 - void the interim payments, or
 - try to return interim payments
 - TAR/SAR is required before payment
 - Bill types 111 & 112 are accepted with discharge status 30
 - Bill type 114 is NOT accepted

Billing

9. Administrative days (level 1) continue to be billed separately
 - TAR required for every day
 - New administrative day level 2 – subacute level – intensity less than acute, but greater than administrative level 1 days
 - Indicate pediatric admin level 2 with rev code 190
 - Indicate adult admin level 2 with rev code 199
10. Rehabilitation days to be billed separately
 - New statewide per diem
 - Revenue codes 118, 128, 138, 148, or 158 as the only accommodation revenue code on the claim
11. Physician services should be billed as separate claims (under SPCP a few hospitals had lab & pathology bundled in)

Hospital Impacts

Billing

12. Blood factor and BMT search and acquisition billed separately

Specialized Services That Can Be Billed on an Outpatient Claim	
Bone Marrow Search and Acquisition Costs	
Management of recipient hematopoietic progenitor cell donor search and cell acquisition	38204
Unrelated bone marrow donor	38204
Blood Factors	
Blood Factor XIII	J7180
Blood Factor Von Willebrand - Injection	J7183 / J7184 / Q2041
Blood Factor VIII	J7185 / J7190 / J7192
Blood Factor VIII / Von Willebrand	J7186
Blood Factor Von Willebrand	J7187
Blood Factor VIIa	J7189
Blood Factor IX	J7193 / J7194 / J7195
Blood Factor Antithrombin III	J7197
Blood Factor Antiinhibitor	J7198

Billing

13. Present-on-admission indicators required except for exempt diagnosis codes
 - CA-MMIS will use V.30 of the Healthcare Acquired Conditions (HAC) utility
 - Payment will be reduced if a HAC is present and the HAC affects DRG assignment
 - Low incidence expected (<1%); fiscal impact expected to be negligible
14. Split paper bills: all diagnosis and procedure codes should be completely recorded on each page. The first page will be used to pay the claim.
15. Late charges (bill type 115) not accepted – submit a claim adjustment instead
16. Erroneous surgeries – bill with an appropriate E code in the first secondary diagnosis field.

Other Impacts

17. Emergency out-of-network MCO admissions

- Rogers rates will be based on DRGs instead of CMAC averages beginning 7/1/13

18. Four-byte DRG code (e.g., 123-4) for hospital IT systems

Topics

1. Introduction
2. Background: Why and How
3. APR-DRG Grouping Logic
4. Claims Pricing under APR-DRGs
5. Hospital Impacts
- 6. Provider Education**

Provider Education

Training

Provider Training to watch for:

- Provider Bulletins: files.medical.ca.gov/pubsdoco/newsroom/newsroom_20872_1.asp
- Provider Training Sessions via WebEx & provided throughout the state in early 2013
 - Claim submission
 - TAR procedures

CA.GOV CALIFORNIA DEPARTMENT OF Health Care Services

HOME SERVICES INDIVIDUALS PROVIDERS & PARTNERS FORMS, I

Home > Providers & Partners > **Diagnosis Related Group Hospital Inpatient Payment Methodology**

Diagnosis Related Group Hospital Inpatient Payment Methodology

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>
- Presentations at www.dhcs.ca.gov/provgovpart/pages/DRG.aspxinfo
- Additional trainings to be scheduled – check webpages above

For More Information

- 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
- Questions to 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.

