

The DRG Base Price for Your Hospital

Hospital Name	Example Hospital
NPI	0123456789

Your hospital's DRG base price for the state fiscal year starting July 1, 2013, will be:	\$8,500
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Your hospital's DRG base price for the state fiscal year starting July 1, 2013, if there had been no transition period: \$7,200

If the two base price values are the same, then a transition base price was not applicable for your hospital. See below.

- Rates are subject to change based on legislative appropriations or other factors. DHCS will notify you if there is a change in your base price. The base price shown above is for Medi-Cal fee-for-service inpatient services.
- The table below shows the estimated impact of the DRG payment method on your hospital. Based on 2009 Medi-Cal utilization, supplemented by OSHPD data, we estimated payment in FY 2013-14 under the current payment method compared with payment under DRGs. The simulation took into account the transition since 2009 of many fee-for-service patients to managed care.
- For many hospitals, DRG base prices will be phased in over four years. The intent is to limit the FY 2013-14 aggregate impact to a hospital's overall payments to no more than 5% (positive or negative) compared to estimated payments in 2013-14 under the previous method. In FY 2014-15, the intention is that the impact relative to the baseline would not exceed 10%. In FY 2015-16, the intention is that the impact relative to the baseline would not exceed 15%. FY 2016-17, the DRG base price will be fully implemented.
- The actual impact in FY 2013-14 and subsequent years will depend on your hospital's volume and mix of stays, outlier stays, and other factors. Actual DRG base price levels in future years would depend on legislative appropriations, annual changes in your hospital's Medicare wage area index value, updates to the APR-DRG grouper version, and other factors.
- The transition will be put into operation through the DRG base price. Medi-Cal will not price each claim first under the old method and then under the new method and blend the two results (as Medicare sometimes does).
- A transition base price will not apply to a hospital if the estimated change in payment is 5% or less; if the estimated impact of DRG payment is under \$50,000; if the hospital had fewer than 100 Medi-Cal stays and Medi-Cal represented less than 2% of the hospital's volume; or if the hospital had no stays in the simulation dataset. These hospitals will receive the statewide base price (adjusted by the wage area index) beginning in 2013-14.
- Under California law, hospital-specific payment rates under the Selective Provider Contracting Program are confidential. Because the transitional DRG base prices are based in part on baseline payments that reflected SPCP rates, the confidentiality requirements of the contracting program apply to DRG base prices.
- The Medi-Cal DRG base price and the APR-DRG relative weights used to calculate payment for Medi-Cal patients are separate from, and cannot be compared to, the Medicare DRG standard amount and the MS-DRG relative weights used to calculate payment for Medicare patients.
- The Department strongly encourages hospitals to visit its DRG web page at www.dhcs.ca.gov/provgovpart/pages/DRG.aspx. This web page contains useful information for providers including monthly bulletins, FAQ documents, DRG calculator for claims pricing, as well as the Policy Design Document (PDD). **Check the webpage for dates and times for webinars specifically related to rate setting and the information in this document.**

Hospital-Specific Information on DRG Payment			
Line	Item	Value	Comment
1	Hospital	Community 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
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
15	Baseline payment under previous method -- CY 2009	\$6,000,000	Note 5
16	Baseline payment under previous method -- trended forward to FY 2013-14	\$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
19	Will this hospital receive a transition base price?	Yes--go to Line 21	
20	<i>Reason why not (if applicable)</i>		Note 7
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
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
Notes			
1	The payment simulation was based on CY 2009 Medi-Cal fee-for-service stays, with two adjustments. a--Because mothers and normal newborns will be billed and paid on separate claims under DRG payment, the estimated number of additional stays for normal newborns was added to each hospital's stay count.		

b--Because of the transition to managed care that has occurred since CY 2009, an estimate was made for each hospital of the number of stays that would have transitioned to managed care by July 1, 2013. This estimate took into account differences in casemix between the fee-for-service population and the managed care population.

For additional information regarding the number of stays, please go to www.dhcs.ca.gov/provgovpart/pages/DRG.aspx, *Medi-Cal DRG Project: Summary of Analytical Dataset*, Sections 2.1.1, 2.5 and 2.12.

- 2 Casemix was measured using All Patient Refined Diagnosis Related Groups, V.29. The average casemix for all Medi-Cal fee-for-service stays in CY 2009 was 0.62. If, for example, your hospital had a casemix value of 0.75, then the interpretation would be that the acuity of the typical patient in your hospital was 21% higher than the acuity of the average Medi-Cal fee-for-service patient.
- 3 The casemix for each hospital was trended forward by a factor of 1.0585, reflecting estimates of both real casemix growth and growth in measured casemix due to improved documentation, coding and capture of the diagnosis and procedure codes used to calculate casemix.
- 4 Billed charges for each hospital were trended forward by a factor of 1.2898, which reflects the compound annual growth rate in Medi-Cal charges per discharge calculated from OSHPD data and applied to the interval between CY 2009 and FY 2013-14. As under Medicare, billed charges affect the determination and calculation of outlier payments.
- 5 For contract hospitals, baseline payment refers to the payment allowed under the Selective Provider Contracting Program. For non-contract hospitals, baseline payment reflects an estimate of 100% of audited allowed costs in 2009. The estimate of audited allowed costs takes into account differences between the cost-to-charge ratio (CCR) used to pay claims in 2009 vs. the CCR reported by the hospital vs. the CCR as finalized by audit. Baseline payments also reflect other adjustments, as shown in *Medi-Cal DRG Project: Summary of Analytical Dataset*, Section 2.4, available at www.dhcs.ca.gov/provgovpart/pages/DRG.aspx. Please note that 2009 baseline payments for some hospitals have been updated since the publication of the document, typically reflecting finalization of audited cost reports since 2011.
- 6 For contract hospitals, the increase in payments reflects actual rate changes since CY 2009 for the specific hospital. For non-contract hospitals, the increase in payments reflects an estimated average increase since CY 2009 of 17.49%, consistent with the growth in the upper payment limit since 2009 for non-contract hospitals. For hospitals with a change in contract status since 2009, a combination of the two methods was used.
- 7 A transition price was not calculated for a hospital if it met any of the following criteria: 1) Estimated impact (up or down) of DRG payment of less than 5%; 2) Estimated impact (up or down) of DRG payment less than \$50,000; 3) Fewer than 100 Medi-Cal FFS stays (line 9) and these stays were estimated to represent less than 2% of the hospital's inpatient volume; 4) No stays in the simulation dataset.
- 8 The first step in calculating the transition base price was to calculate the no-transition base price (Note 11). If a hospital did not meet any of the criteria shown in Note 7, then a transition base price was calculated. For these hospitals, the transition base price was set so that:
 - No hospital would see a decrease in estimated payments (relative to baseline) of more than 5%. For these transition hospitals, the transition base price is higher than if there were no transition period.
 - To ensure budget neutrality, other transition hospitals have a 2013-14 base price that is lower than it would have been if there were no transition period. (A floor was set so that no hospital would have a transition base price less than 50% of what it otherwise would have been.) Most of these hospitals have an expected increase in payments (relative to baseline) of about 2% and will see further increases in future years. Because of the 50% floor, a few of these hospitals have expected increases exceeding 5% in 2013-14.
- 9 For most stays, DRG payment equals the DRG relative weight x the DRG base price. Other factors can also influence payment and are reflected in this simulation. These include policy adjustors for sick newborns and pediatric patients, transfer adjustments, outlier payments and a limitation that payment cannot exceed the billed charge.
- 10 Outlier payments are expected to equal about 17% of all DRG payments across the state. In analyzing payment under DRGs, hospitals should take into account both DRG base payments and DRG outlier payments.
- 11 The no-transition DRG base price for each hospital equals the statewide DRG price of \$6,223 (\$10,218 for remote rural hospitals) adjusted by the wage area index shown in Line 8. As with Medicare, the wage area index adjustment applies to 68.8% of the DRG base price.

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