Medi-Cal SFY 2019-20 DRG Payment

Provider Training

May 21 & May 23, 2019

Contents

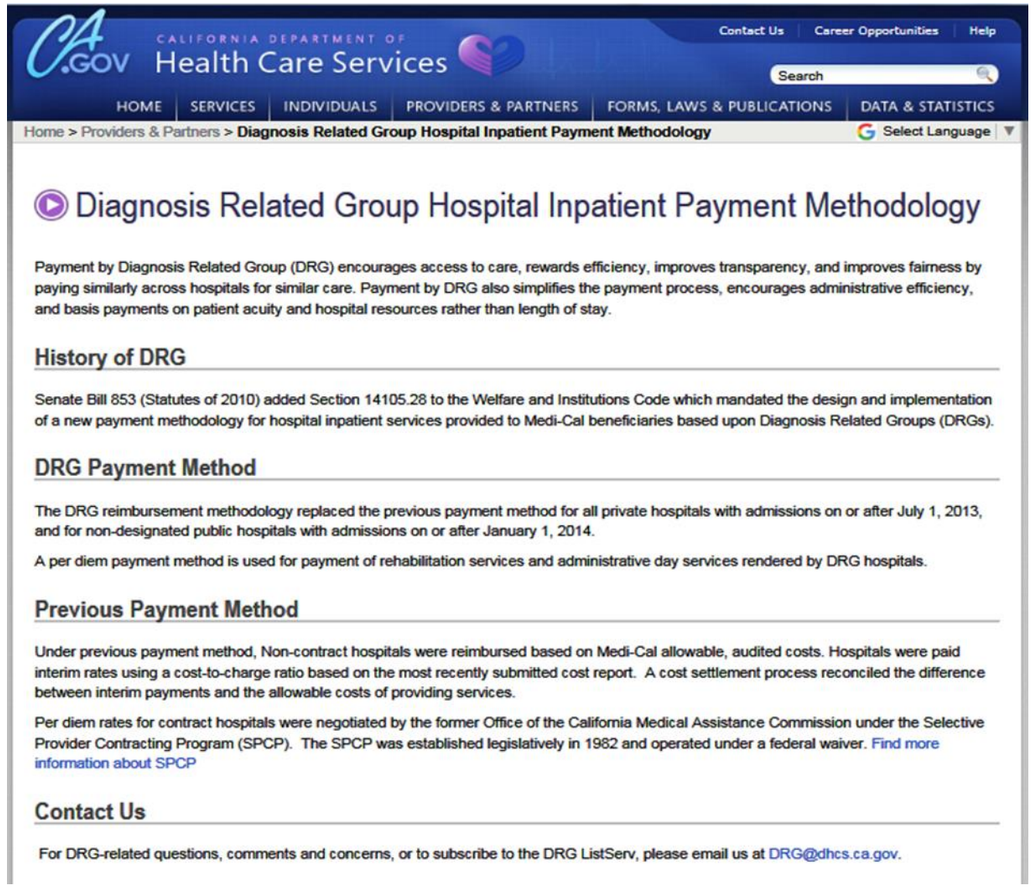
- All Patient Refined Diagnosis Related Groups (APR-DRG) Background
- State Fiscal Year (SFY) 2018-19 Experience
- SFY 2019-20 Updates
- Cost Reporting
- Further Information

APR-DRG Background

APR-DRG Background

DRG Refresher Training

- **Medi-Cal Learning Portal**
  https://learn.medi-cal.ca.gov/Home.aspx
  - Recorded provider training webinars for each SFY since implementation in 2013-14
- **Provider Education and Bulletins**
  https://www.dhcs.ca.gov/provgovpart/Pages/DRG-Provider-Edu.aspx
  - PDF versions of provider training presentations, as well as other trainings from early in the DRG program
  - Various bulletins notifying providers of changes to policies and procedures
- **DHCS DRG Webpage**
  https://www.dhcs.ca.gov/provgovpart/pages/drg.aspx
  - Links to information about the DRG program and its history
  - Pricing resources for each SFY, including DRG calculators, FAQs, and grouper settings



APR-DRG Background

Policy History

Policy for SFYs 2013-14 to 2016-17:

- Implementation on 7/1/13
- Three-year base rate transition, with all hospitals at statewide or remote rural base rate starting July 1, 2016
- Non-Designated Public Hospitals (NDPHs) and Medicaid expansion on 1/1/14
- ICD-10 implementation 10/1/15
- OB policy adjustor added 7/1/15

Policy changes for SFY 2017-18:

- Shift payment from outliers to base rates to align payment incentives with DRG goals
  - Increase outlier threshold, lower marginal rate, eliminate tier 2 of outlier payment
  - Increase statewide base rate and pediatric policy adjustor

Policy changes for SFY 2018-19:

- Increase payment levels for higher acuity stays
  - Add high-acuity policy adjustors for Severity of Illness (SOI) 4, lower pediatric policy adjustor for SOI 1-3
  - Adjust outlier threshold and marginal rate, lower statewide base rate

APR-DRG Background

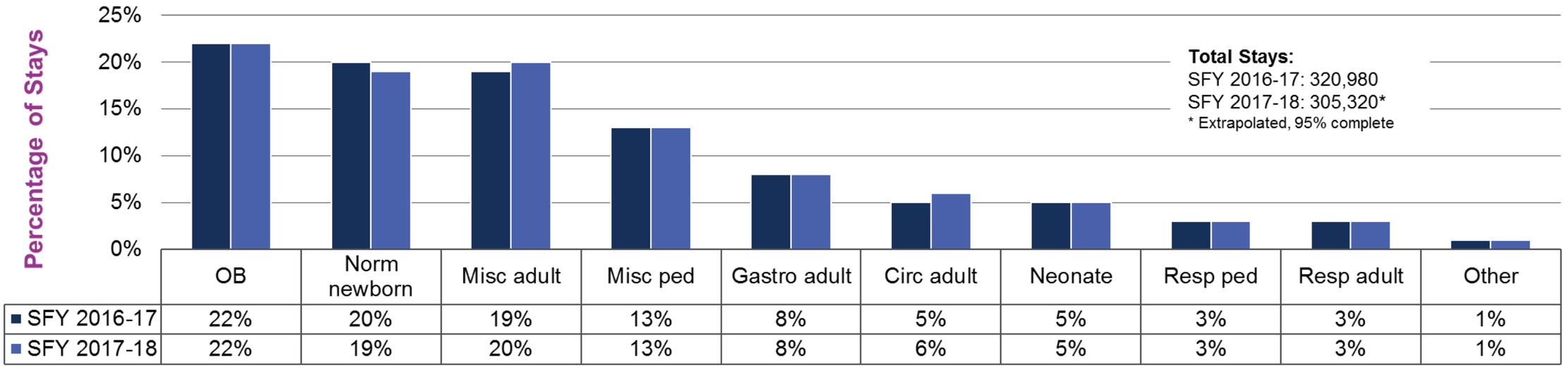
Trends

- Stability as a guiding principle for policy decision-making
- Total payments have been decreasing due to reductions in stays and an increase in beneficiary enrollment transitioning from fee-for-service (FFS) into managed care organization (MCO) plans
- Overall increase in expensive stays
- Observed steady increases in the percentage of payments allocated for outlier stays between SFY 2013-14 and SFY 2016-17; policy change is keeping outlier pool at target levels
- Distribution of stays and payments over time is generally similar among Medicaid Care Categories (MCCs)
- Effect on FFS volumes and payments going forward depends on interaction of three trends
  - Pace of new Medi-Cal enrollees
  - Pace of transition from FFS to managed care
  - Actual casemix and utilization

Stays by Medicaid Care Category

- Proportions of stays by MCC are stable from SFY 2016-17 to 2017-18

Stays by Medicaid Care Category
SFY 2016-17 Compared to SFY 2017-18



	OB	Norm newborn	Misc adult	Misc ped	Gastro adult	Circ adult	Neonate	Resp ped	Resp adult	Other
SFY 2016-17	22%	20%	19%	13%	8%	5%	5%	3%	3%	1%
SFY 2017-18	22%	19%	20%	13%	8%	6%	5%	3%	3%	1%

Medicaid Care Categories

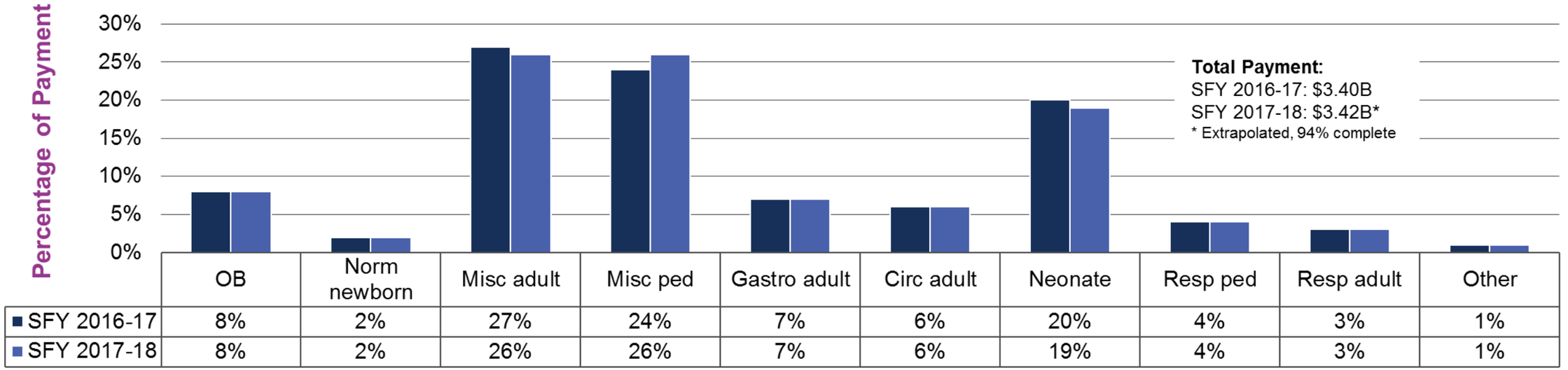
Data Source: MIS/DSS | Dates Represented: 7/1/2016 - 6/30/2018 paid through 12/24/2018 | Date Downloaded: 1/7/2019

Prepared by the California Department of Health Care Services.

Payment by Medicaid Care Category

- Payment distribution by MCC is also similar from SFY 2016-17 to 2017-18

Payment by Medicaid Care Category
SFY 2016-17 Compared to SFY 2017-18



	OB	Norm newborn	Misc adult	Misc ped	Gastro adult	Circ adult	Neonate	Resp ped	Resp adult	Other
SFY 2016-17	8%	2%	27%	24%	7%	6%	20%	4%	3%	1%
SFY 2017-18	8%	2%	26%	26%	7%	6%	19%	4%	3%	1%

Medicaid Care Categories

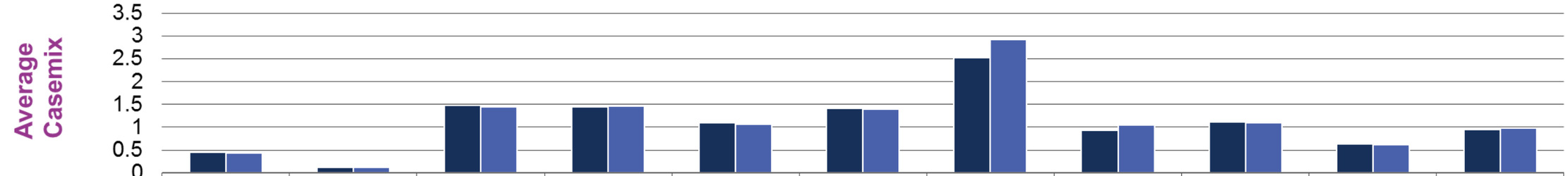
Data Source: MIS/DSS | Dates Represented: 7/1/2016 - 6/30/2018 paid through 12/24/2018 | Date Downloaded: 1/7/2019

Prepared by the California Department of Health Care Services.

Casemix by Medicaid Care Category

- Casemix has been increasing over time despite stability in underlying weights
- Average casemix increased 4% in SFY 2017-18, from 0.95 to 0.99
  - Increases are primarily in Neonate (up 16%) and Respiratory Pediatric (up 13%)

Average Casemix by Medicaid Care Category
SFY 2016-17 Compared to SFY 2017-18



	OB	Norm newborn	Misc adult	Misc ped	Gastro adult	Circ adult	Neonate	Resp ped	Resp adult	Other	Total
SFY 2016-17	0.45	0.12	1.48	1.45	1.09	1.41	2.52	0.93	1.11	0.63	0.95
SFY 2017-18	0.44	0.12	1.44	1.47	1.06	1.4	2.92	1.05	1.09	0.62	0.99

Medicaid Care Categories

Data Source: MIS/DSS | Dates Represented: 7/1/2016 - 6/30/2018 paid through 12/24/2018 | Date Downloaded: 1/7/2019

Prepared by the California Department of Health Care Services.

SFY 2018-19 Experience

SFY 2018-19 Experience

Policy Change Summary

- Implement high-acuity policy adjustor, pay more for most expensive stays
- Outlier payment pool target was kept at 13-14% to maintain DRG payment incentives

Regular annual updates:

- Budget neutral overall
- Updates to DRG software
- Updates to national wage areas
- Wage area neutrality factor
- Hospital-Specific Relative Value (HSRV) relative weights
- Cost-to-charge ratios (CCRs)

Changes for SFY 2018-19

- Implement high-acuity (SOI 4) policy adjustor
- Lower pediatric policy adjustor to 1.25 for lower-acuity (SOI 1-3) stays
- Lower statewide base rate to $6,507
- Lower outlier threshold to $57,000
- Increase marginal rate to 60%

SFY 2018-19 Experience

Policy Change Summary – Policy Adjustors

- Implement high-acuity policy adjustor, pay more for most expensive stays
- There are several factors that determine if a policy adjustor is applicable to a stay:
  - Patient age
  - Medicaid Care Category
  - Hospital Designated NICU status
  - Severity of Illness (SOI)

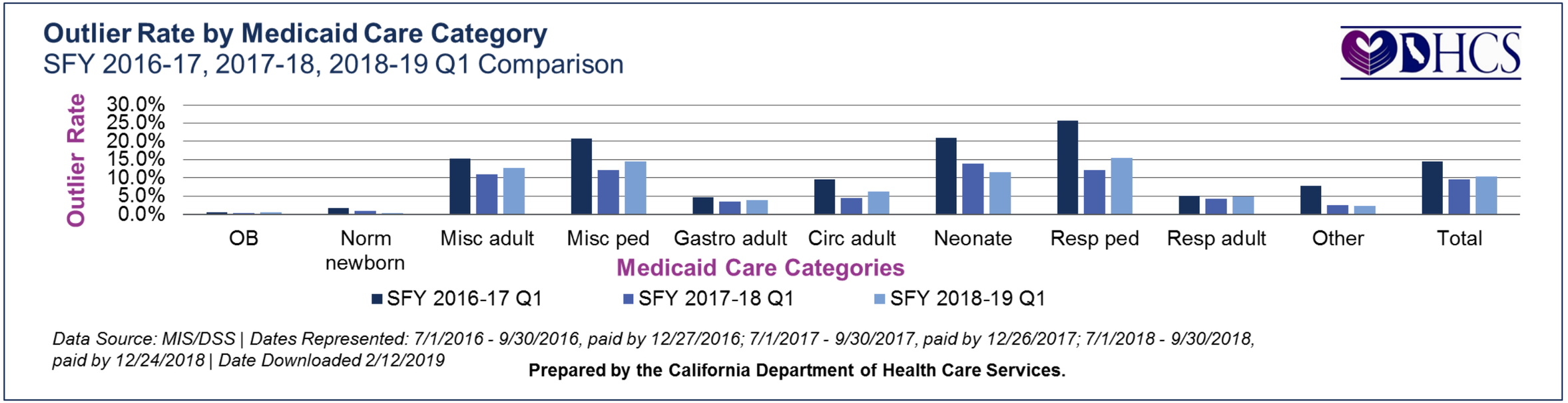
Category	SOI 1-3 Policy Adjustor	SOI 4 Policy Adjustor
Obstetrics	1.06	1.17
Pediatrics	1.25	1.75
Adult	1.00	1.10
Neonate	1.25	1.75
Neonate (Designated NICU)	1.75	2.45

Data Source: CA DRG SFY 2019-20 Simulation 4 | Date Downloaded 2/19/2019

SFY 2018-19 Experience

Outlier Payments Policy Impact

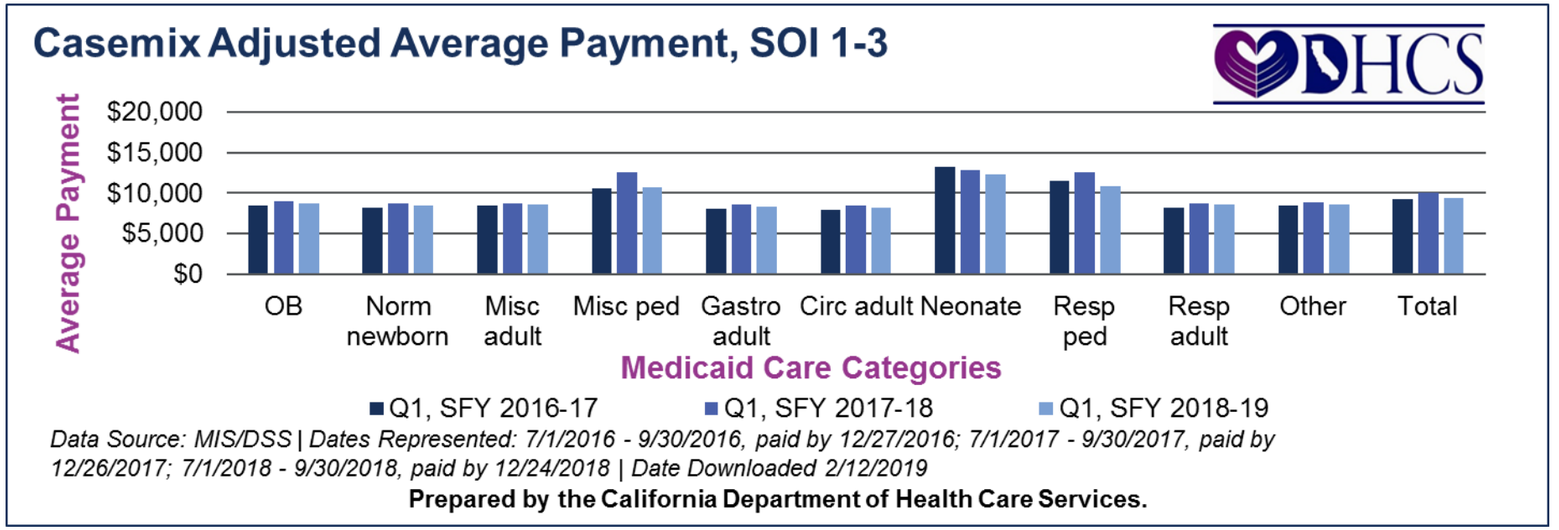
- The outlier rate decreased substantially in Q1 of SFY 2017-18 due to changes in the outlier policy
- Simulations suggest the decrease was more than expected, so the outlier threshold was lowered and marginal rate increased in SFY 2018-19
- Most categories show outlier rate increases in Q1 of SFY 2018-19 as compared to Q1 of SFY 2017-18

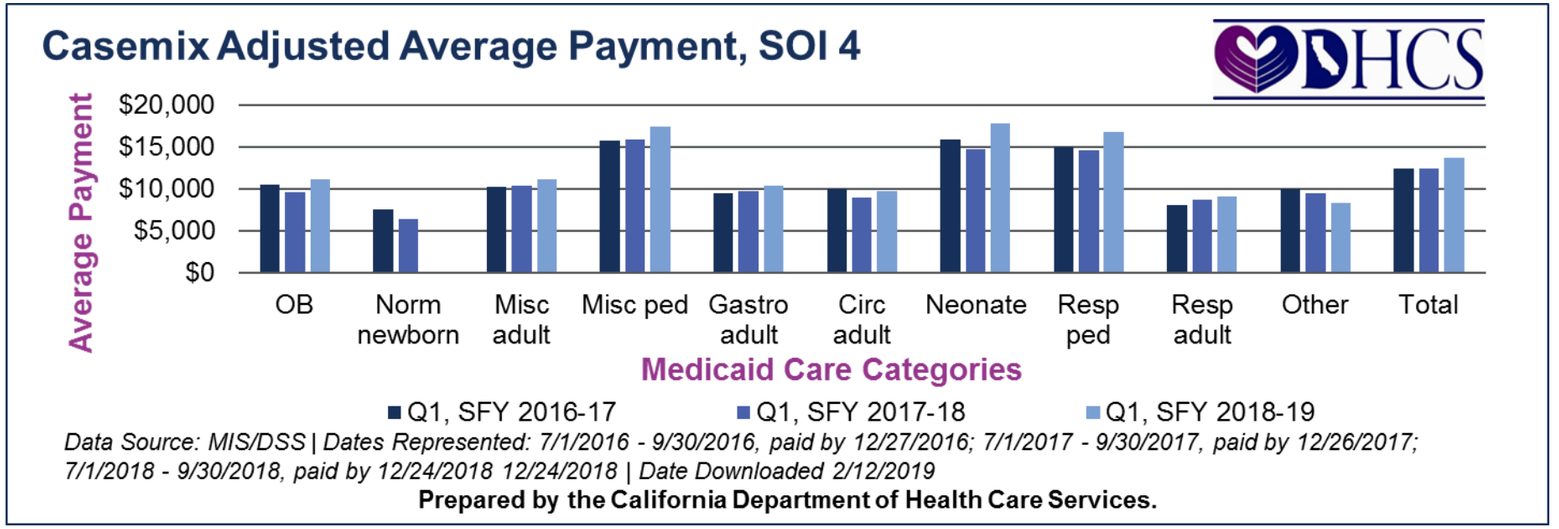


SFY 2018-19 Experience

High Acuity Policy Adjustor Impact

- The change in outlier policy in SFY 2017-18 led to reduced payment for some high severity cases
- In SFY 2018-19, Medi-Cal introduced a high severity policy adjustor to increase payments for these expensive stays
- Payments for high severity cases have increased in Q1 of SFY 2018-19





SFY 2019-20 Updates

SFY 2019-20 Updates

SFY 2019-20 Overview

- Budget neutrality remains the overall requirement, while maintaining stability and integrity of the payment method
- Minimal payment changes across hospitals remain a priority
- Regular annual updates include CCRs, wage index values, and the California wage area neutrality factor
- Medi-Cal will not move to APR-DRG V.36 or V.36 HSRV weights in SFY 2019-20 and will instead continue to use V.35

SFY 2019-20 Policy Decisions

- APR-DRG V.35 grouper and HSRV weights will remain in use for SFY 2019-20

Regular annual updates:

- Budget neutral overall
- Wage area index values
- Wage area neutrality factor
- CCRs

Policy changes from SFY 2018-19 to 2019-20*

- Statewide base rate: $6,584
  - ❑ $77 increase
- Remote rural base rate: $14,615
  - ❑ $1,783 increase
- Marginal cost percentage used in outlier payment calculation will decrease from 60% to 55%
- Outlier threshold will increase from $57,000 to $61,000

Impacts on individual hospitals will depend on actual utilization and casemix

*Subject to federal approval

SFY 2019-20 Updates

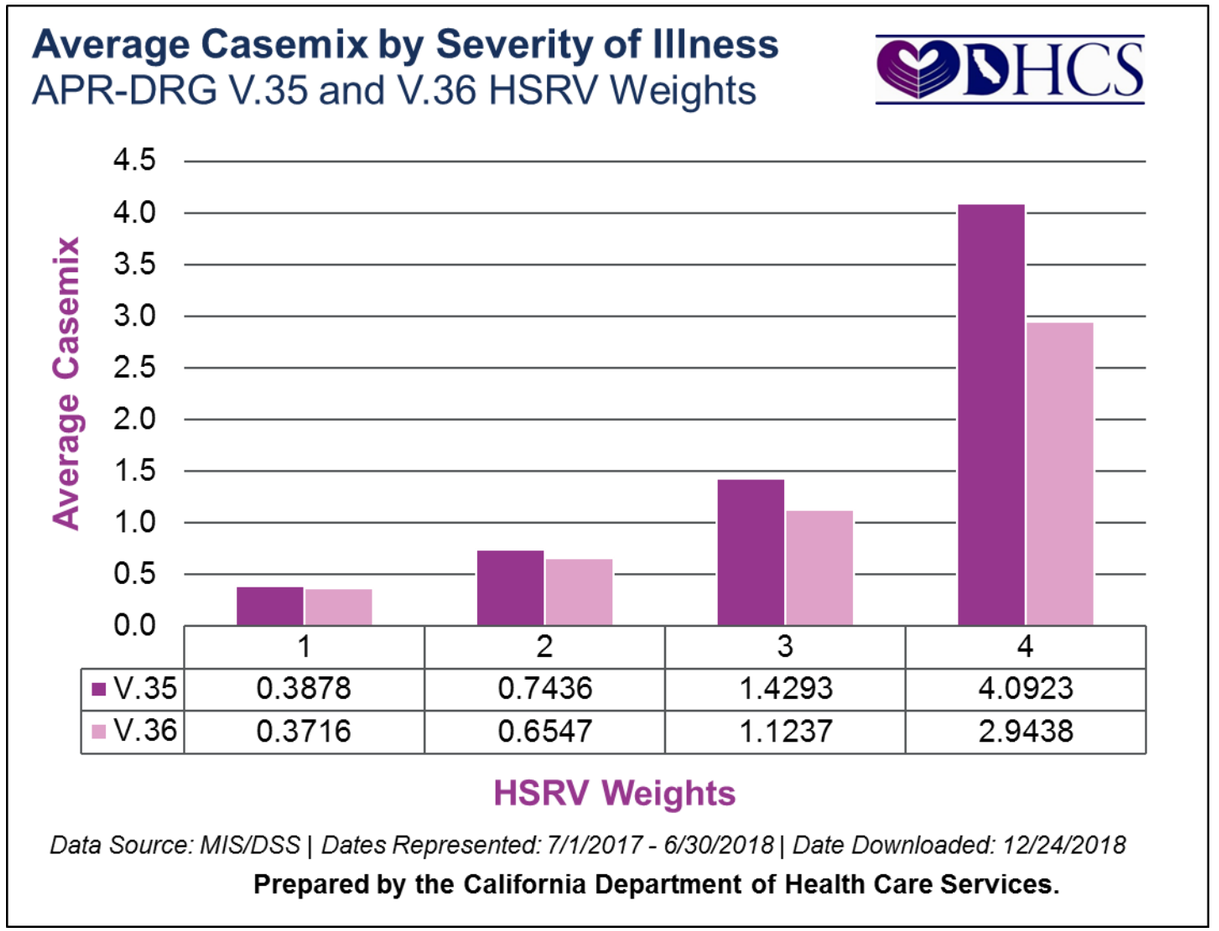
3M Changes to APR-DRG V.36

- A new data source was used to update the APR-DRG grouper and weights
  - 16 million claims based on Medicare, Medicaid, and private insurance across a range of states
- V.36 is the first time that two years of ICD-10 data (CYs 2016 and 2017) were available to calculate weights
- 90% of HSRV weights decreased
  - Increases were primarily in obstetrics, normal newborns, and neonates
- The APR-DRG grouping algorithm was modified in order to make better use of ICD-10 specificity
  - More stays group to SOI 4

Changes in APR-DRG V.36

Moving to V.36 HSRV grouper and weights would result in major changes:

- In the Medi-Cal SFY 2017-18 dataset, decreases in casemix are largest for high-severity DRGs, although more stays will group to higher severity DRGs under V.36
- Overall measured casemix in the Medi-Cal population decreased from 0.98 to 0.82 (-16%)



SFY 2019-20 Updates

Decision to Use APR-DRG V.35

- Remaining on V.35 for the next year will have multiple benefits:
  - Keep payment stable while we assess the impact of recent payment policy changes
  - Allow us to more fully understand the impact of the new weight distribution and consider how to respond to those changes
  - Provide the opportunity to analyze total changes to payment distribution across MCCs, DRGs, and hospitals
  - Provide the opportunity to assess the stability of 3M’s new weight distribution going forward

Technical Updates

- Updated Medicare wage area index values
  - The California neutrality factor was calculated to be 0.9731, similar to last year, so that the wage area values would continue to be neutral across California regardless of changes elsewhere
  - Overall, the average wage index value (weighted by stays) does not change after the neutrality factor is applied
- Updated cost-to-charge ratios: 2017 reported CCRs

SFY 2019-20 Updates

Grouper Software Settings

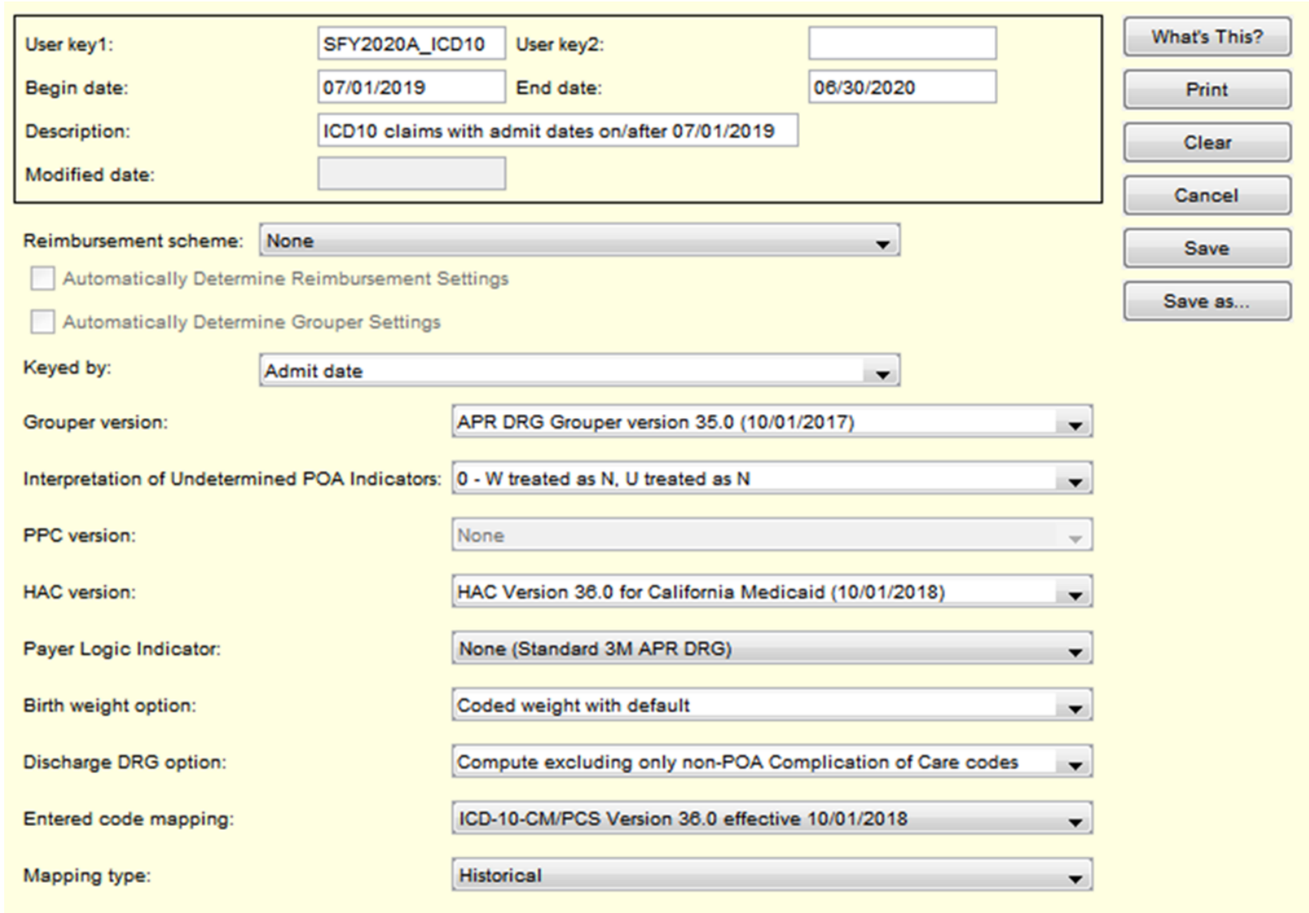
- For claims with admission dates on or after July 1, 2019, continue to use:
  - Grouper V.35
  - HAC V.36 for California Medicaid until HAC V.37 is implemented in October 2019
  - Entered Code Mapping: Remain on V.36 Mapper until V.37 Mapper is implemented in October 2019
  - Mapping Type: Historical for all SFY 2019-20 claims
  - Grouper ICD Version Qualifier: The ICD Version Qualifier should be set to “0 ICD-10” in the grouper

SFY 2019-20 Medi-Cal DRG Claims Grouper Setting Scenarios							
Scenario	Admit Date	Discharge Date	Grouper Version	Mapping	Mapper Version	ICD Version	HAC Version
A	7/1/19 to 9/30/19	Before 10/1/19	35.0	Historical	36.0	ICD-10 (0)	V.36 for California Medicaid
B	7/1/19 to 6/30/20	On or after 10/1/19	35.0	Historical	37.0	ICD-10 (0)	V.37 for California Medicaid

Grouper Software Settings (continued)

SFY 2019-20 DRGs admit date on or after 7/1/19

- Historical mapping will be required throughout SFY 2019-20
- The mapper for V.37 will be effective for discharges on or after 10/1/19
- The complete SFY 2019-20 Grouper Software Settings document will be available on the DRG webpage
  - A CSV file to expedite installation of the new settings, instead of adding them manually, will be available as well



Cost Reporting

Cost Report Submission

Cost report submission requirements:

- Cover letter (Includes the detail of special circumstances, contact personnel, etc.)
- Signed copy of CMS 2552-10
- Signed copy of DHCS 3092
- CPA audited financial statements
- Working trial balance (in Excel format) and grouping schedules
- Working papers used to prepare the CMS 2552-10 and DHCS 3092 (all working papers, files named for the W/S or Schedule they relate to)
- Email cost report submissions to Acute.Submissions@dhcs.ca.gov (Cost report tracking section (CRTS) (formerly ARAS))

Common Causes for Cost Report Rejection

- Not reporting on the correct CMS 2552-10 Title schedules
  - DRG hospitals must be reported on Title V
  - DPH hospitals must be reported on Title XIX
  - Administrative day data must be reported under Title XIX
- Not completing some or all of the DHCS 3029 Medi-Cal Supplemental Schedules
- Reporting freestanding Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on the CMS 2552-10
  - Only Medicare Certified Provider-Based FQHCs and RHCs can be reported on the CMS 2552-10
- Not all of the schedules on the CMS 2552-10 have the same run date and time
  - The schedules on the CMS 2552-10 must be from the same cost report run
  - Schedules on the CMS 2552-10 are not complete, mathematically accurate and/or flow from schedule to schedule
- The Quality Assurance Fees (QAF) have not been completely eliminated from the CMS 2552-10
- Not submitting a copy of the Certified Public Accountant (CPA) audited financial statements with the CMS 2552-10 and DHCS 3029

Common Reasons for Cost Report Adjustments

1. Overstating costs or including non-reimbursable costs in reimbursable cost centers on Schedule A
2. Miscellaneous revenue being offset against non-reimbursable cost centers on Schedule A-8
3. Excluding statistics for non-reimbursable cost centers on Schedule B-1
4. Not including observation bed days or misreporting the census for total patient days on Schedule D-1
5. Misreporting Medi-Cal Days and Ancillary Charges on Schedules D-1 and D-3
6. Not including all Medi-Cal Charges on Schedule E-3
7. Not eliminating all (including FQHCs and RHCs) provider based physicians' professional component costs from Schedule A-8 (via Schedule A-8-2) and Schedule C
8. Not applying RCE limits to provider based physicians' provider component costs on Schedule A-8-2

CCR Review and Correction

- CCR (cost-to-charge ratio) calculation
  - Total Medi-Cal Costs (W/S E-3, Part VII, Column 1, Line 7) / Total Medi-Cal Charges (W/S E-3, Part VII, Column 1, Line 12)
- CCRs for FYE 2017 were provided to SNFD in October 2018 and used for rate setting for SFY 2019-20
- Review of CCR changes from the prior year
  - Less than 5% difference – No further review
  - Greater than 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), CRTS 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, CRTS will forward revised CCR to SNFD for inclusion in the rate setting for the next fiscal year

Further Information

Further Information

Reminders for Accurate Billing and Pricing

- Diagnosis and procedure coding must be accurate, complete and defensible; continue to include Present on Admission (POA) codes as appropriate
- Reference the Hospital Characteristics File on the DRG website for your hospital-specific base rate and CCR
- Use the year-specific pricing resources such as the DRG Pricing Calculators and FAQs on the DRG website to understand pricing and predict payment
  - The calculator is intended to be helpful to users to estimate pricing, but it cannot capture all the editing and pricing complexity of the Medicaid claims processing system
  - In cases of difference, the claims processing system is correct
- Meet treatment authorization requirements
- Reference the Medi-Cal Provider Manual
- Reference provider bulletins regarding claims processing often
- Reference Medi-Cal Inpatient Claims Processing Update at or DRG billing updates http://www.dhcs.ca.gov/provgovpart/Pages/DRG-Provider-Edu.aspx

Further Information

Looking Ahead

1. Monitor 3M’s changes to APR-DRG grouper and weights when V.37 is released
2. Continue to review Medi-Cal policy and payment levels
   - Monitor impact of payment policy changes
   - Re-evaluate policy for SFY 2020-21 if necessary
3. Monitor legislation
4. DRG payment integrity
   - DRG validation
   - DRG outlier recalculation
   - High-dollar claim review

Further Information

Keep in Touch

James Mason

Safety Net Financing Division

Department of Health Care Services

(916) 345-7897

James.Mason@dhcs.ca.gov

DRG Mailbox

DRG@dhcs.ca.gov

With thanks to

DHCS: Loni Anderson, Serene Erby, Karen del Gallego, Nzinga Griffin, Julie Hoang, Jillian Mongetta, Edwin Narayan

Conduent: Kristi Sheakley, Christine Bredfeldt, Bud Davies, Angela Sims, Andrew Townsend