MEDI-CAL SSW RENEWAL (ATTACHMENT 2)

SSW Historical Timeline: Utilization Review (UR) Approach & Payment Method

Program/Authority/Timeline[i]	Payment Method	Designated Public Hospitals (DPHs) UR Approach	Payment Method	Non-Designated Public Hospitals (NDPHs) & Private Hospitals UR Approach
Medi-Cal's 2005 Hospital/Uninsured Care Demonstration Waiver [ii]	CPE	**TARs:** Review 100 percent of TARs for all hospital days.	Per Diem Rate	**TARs:** Review 100 percent of TARs for all hospital days.
SSW (June 2008-June 2010 & Extensions): • **DPHs** (several pilot hospitals)[iii] begin to perform own acute inpatient UR using evidence-based standardized medical review criteria, e.g., InterQual®. • **NDPHs and Private Hospitals** continued with TAR process.	CPE	**TARs:** Review 100 percent of TARs for all hospital days (non-pilot DPHs). **TAR-Free:** Review statistically valid samples of paid claims. Each acute day within the sample is reviewed to ensure medical necessity is met.	Per Diem Rate	**TARs:** Review 100 percent of TARs for all hospital days.
SSW (October 2013 - September 2015): • **DPHs** (all) perform own acute inpatient UR using evidence-based standardized medical review criteria. • **NDPHs and Private Hospitals** adopt DRGs[iv], 2014 and 2013.	CPE	**TAR-Free:** Review statistically valid samples of paid claims. Each acute day within the sample is reviewed to ensure medical necessity is met.	DRG	**TARs:** Review TARs for admissions only to ensure medical necessity is met.
SSW (October 2015 - September 2017): • **DPHs** perform own acute inpatient UR using evidence-based standardized medical review criteria. • **NDPHs and Private Hospitals** *begin* transition to TAR-Free process[v].	CPE	**TAR-Free:** Review statistically valid samples of paid claims. Each acute day within the sample is reviewed to ensure medical necessity is met.	DRG	**TARs:** Review TARs for admissions only to ensure medical necessity is met. **TAR-Free:** Review statistically valid samples of paid claims ensure admissions were medically necessary.
SSW (October 2017 - September 2019): • **DPHs** perform own acute inpatient UR using evidence-based standardized medical review criteria. • **NDPHs and Private Hospitals** continue transition to TAR-Free process.	CPE	**TAR-Free:** Review statistically valid samples of paid claims. Each acute day within the sample is reviewed to ensure medical necessity is met.	DRG	**TARs:** Review TARs for admissions only to ensure medical necessity is met. **TAR-Free:** Review statistically valid samples of paid claims ensure admissions were medically necessary.
SSW (October 2019 - September 2024): • **DPHs** perform own acute inpatient UR using evidence-based standardized medical review criteria. • **NDPHs and Private** Hospitals continue transition to TAR-Free process.	CPE	**TAR-Free:** Review statistically valid samples of paid claims. Each acute day within the sample is reviewed to ensure medical necessity is met.	DRG	**TARs:** Review TARs for admissions only to ensure medical necessity is met. **TAR-Free:** Review statistically valid samples of paid claims to ensure admissions were medically necessary.
SSW (October 2024 – September 2029 Pending): • **DPHs** perform own acute inpatient UR using evidence-based standardized medical review criteria; *Note, future administrative proposals may transition reimbursement for DPHs from CPE methodology to a DRG-type methodology.*[vi] • **NDPHs and Private** Hospitals continue transition to TAR-Free process.	CPE *(May transition to DRGs in the future.)*	**TAR-Free:** Review statistically valid samples of paid claims. *If transitioned to DRGs, the UR Approach will change from reviewing each acute day within the sample to reviewing for admission only to ensure medical necessity is met.*	DRG	**TARs:** Review TARs for admissions only to ensure medical necessity is met. **TAR-Free:** Review statistically valid samples of paid claims to ensure admissions were medically necessary.

[i] Beginning in 1982, DHCS (formerly the Department of Health Services) operated the Selective Provider Contracting Program (SPCP) via a federal Section 1915(b) waiver that allowed Medi-Cal to selectively contract with hospitals to provide general acute care inpatient services to fee-for-service (FFS) beneficiaries at negotiated per diem rates. SPCP contract hospitals were paid via these negotiated rates (eligible hospitals also received supplemental reimbursements via inter-governmental transfers) in lieu of the Certified Public Expenditures (CPEs) and All Patient Refined-Diagnosis Related Groups (APR-DRGs) used today. UR management of SPCP contracted services required state-employed Skilled Professional Medical Personnel, physicians and nurses as Medi-Cal Consultants, to review 100 percent of all hospital days via the TAR process to determine if services provided were medically necessary and covered by the Medi-Cal program. The chart on the preceding page does not reflect this time; instead, the chart begins with Medi-Cal's initial Section 1115 Demonstration waiver discussed below.

[ii] In 2005, CMS approved Medi-Cal's initial Section 1115 demonstration waiver, i.e., the *Medi-Cal Hospital/Uninsured Care Demonstration Waiver*, which allowed DHCS to begin to phase out the SPCP. This waiver established three distinct hospital types in California, i.e., Designated Public Hospitals (DPHs), Non-Designated Public Hospitals (NDPHs), and Private Hospitals and significantly changed the way in which Medi-Cal paid hospitals for FFS acute inpatient services by phasing out the use of inter-governmental transfers and allowing DHCS to use CPEs as the non-federal share of Medi-Cal expenditures for DPHs. California's 21 DPHs are the state's safety-net hospitals and include county-owned or affiliated systems and University of California academic medical centers.

[iii] In 2008, DHCS piloted a TAR-Free process wherein DPHs began performing their own acute inpatient UR using evidence-based standardized medical review criteria, such as InterQual® or MCG® to establish medical necessity and claim for services. Simultaneously, DHCS began to transition its UR management approach from Medi-Cal Consultants reviewing 100 percent of all hospitals days to conducting post-payment clinical and administrative compliance reviews using statistically valid samples of paid inpatient claims to ensure federal funds were claimed appropriately. **By 2013-14, all 21 DPHs successfully transitioned to the TAR-Free process and continue to operate TAR-Free today.**

[iv] On July 1, 2013, and January 1, 2014, respectively, all Private Hospitals and NDPHs transitioned from billing each day of an approved acute inpatient stay to a payment methodology based on APR-DRGs, as mandated by Welfare and Institutions Code Section 14105.28. As a result, Medi-Cal's SPCP was fully eliminated, and NDPHs and Private Hospitals transitioned from submitting a TAR to the field office for each day of a hospital stay to submitting a TAR for an admission only to ensure the admission was medically necessary. Some exceptions exist for reviewing TARs for admissions only, i.e., additional reviews are required for restricted aid codes, Acute Administrative Days, and Acute Inpatient Intensive Rehabilitation services for NDPHs and Private Hospitals. Also, Hospice General Inpatient Care continues to require daily TARs for all hospitals (DPHs, NDPHs and Private Hospitals).

[v] In April 2016, DHCS began further transitioning NDPHs and Private Hospitals to the TAR-Free process using evidence-based standardized review criteria, such as InterQual® or MCG®. As part of this effort, DHCS began reviewing paid claim samples to ensure hospitals were appropriately using standardized medical review criteria and to ensure acute inpatient services provided were medically necessary. Approximately 100 NDPHs and Private Hospitals have transitioned to the TAR-Free process to date, and the transition of additional hospitals continues today.

[vi] As part of the 2024-25 Governor's Budget Proposed Plan, California initiated several Medi-Cal targeted rate increases, including the transition of DPH reimbursement for inpatient services from the existing CPE methodology to an APR-DRG methodology, effective January 1, 2025. Although not enacted this budget year, if enacted in future budget years, DHCS will change its UR approach from reviewing each acute day within the sample to reviewing for admission only to ensure medical necessity is met. This would align the TAR-Free UR approach for DPHs, NDPHs, and Private Hospitals.