Medi-Cal SFY 2024-25 DRG Payment Policies

Provider Training

June 11 and 13, 2024

Agenda topics

- All Patient Refined Diagnosis Related Groups (APR-DRG) Background
- SFY 2024-25 Updates
- Cost Reporting
- Outlier Audits and Recalculation
- Further Information

Presentation available at: https://learn.medi-cal.ca.gov/

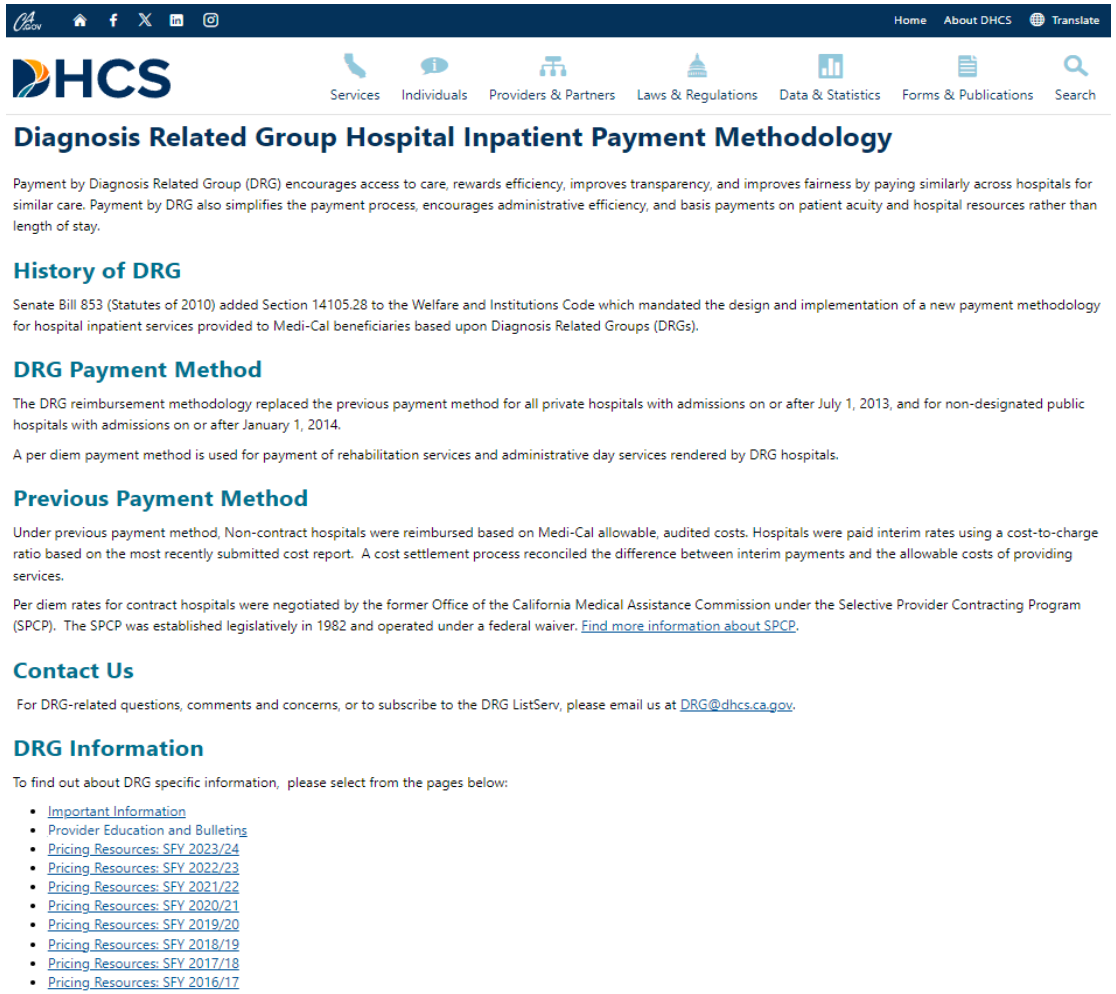
Submit questions at: DRG@dhcs.ca.gov

APR-DRG background

APR-DRG background

DRG refresher training

- **Medi-Cal Learning Portal**
  https://learn.medi-cal.ca.gov/
  - Provider training webinars for previous SFYs
- **Provider Education and Bulletins**
  https://www.dhcs.ca.gov/provgovpart/Pages/DRG-Provider-Edu.aspx
  - PDF versions of provider training presentations
  - 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



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Diagnosis Related Group Hospital Inpatient Payment Methodology

Payment by Diagnosis Related Group (DRG) encourages access to care, rewards efficiency, improves transparency, and improves fairness by paying similarly across hospitals for similar care. Payment by DRG also simplifies the payment process, encourages administrative efficiency, and basis payments on patient acuity and hospital resources rather than length of stay.

History of DRG

Senate Bill 853 (Statutes of 2010) added Section 14105.28 to the Welfare and Institutions Code which mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon Diagnosis Related Groups (DRGs).

DRG Payment Method

The DRG reimbursement methodology replaced the previous payment method for all private hospitals with admissions on or after July 1, 2013, and for non-designated public hospitals with admissions on or after January 1, 2014.

A per diem payment method is used for payment of rehabilitation services and administrative day services rendered by DRG hospitals.

Previous Payment Method

Under previous payment method, Non-contract hospitals were reimbursed based on Medi-Cal allowable, audited costs. Hospitals were paid interim rates using a cost-to-charge ratio based on the most recently submitted cost report. A cost settlement process reconciled the difference between interim payments and the allowable costs of providing services.

Per diem rates for contract hospitals were negotiated by the former Office of the California Medical Assistance Commission under the Selective Provider Contracting Program (SPCP). The SPCP was established legislatively in 1982 and operated under a federal waiver. Find more information about SPCP.

Contact Us

For DRG-related questions, comments and concerns, or to subscribe to the DRG ListServ, please email us at DRG@dhcs.ca.gov.

DRG Information

To find out about DRG specific information, please select from the pages below:

- Important Information
- Provider Education and Bulletins
- Pricing Resources: SFY 2023/24
- Pricing Resources: SFY 2022/23
- Pricing Resources: SFY 2021/22
- Pricing Resources: SFY 2020/21
- Pricing Resources: SFY 2019/20
- Pricing Resources: SFY 2018/19
- Pricing Resources: SFY 2017/18
- Pricing Resources: SFY 2016/17

CONDUENT

APR-DRG background

Policy history past SFYs

Policy changes for SFY 2020-21:

- Increased statewide base rate
- Increased remote rural base rate
- Policies remained the same as in SFY 2019-20

Policy changes for SFY 2021-22:

- Increased statewide base rate
- Increased remote rural base rate
- Modified payment by severity of illness (SOI)
  - Increased higher-acuity policy adjustors for SOI 4
- Adjusted outlier threshold

Policy changes for SFY 2022-23:

- Increased statewide base rate
- Increased remote rural base rate
- Increased outlier threshold
- Reduced outlier percent to payment ratio
- Modified payment by severity of illness (SOI)
  - Increased Misc. and Resp Pediatric higher-acuity policy adjustors for SOI 4

Policy changes for SFY 2023-24:

- Increased statewide base rate
- Increased remote rural base rate
- No change in policy adjustors
- No change in outlier threshold or marginal cost percentage

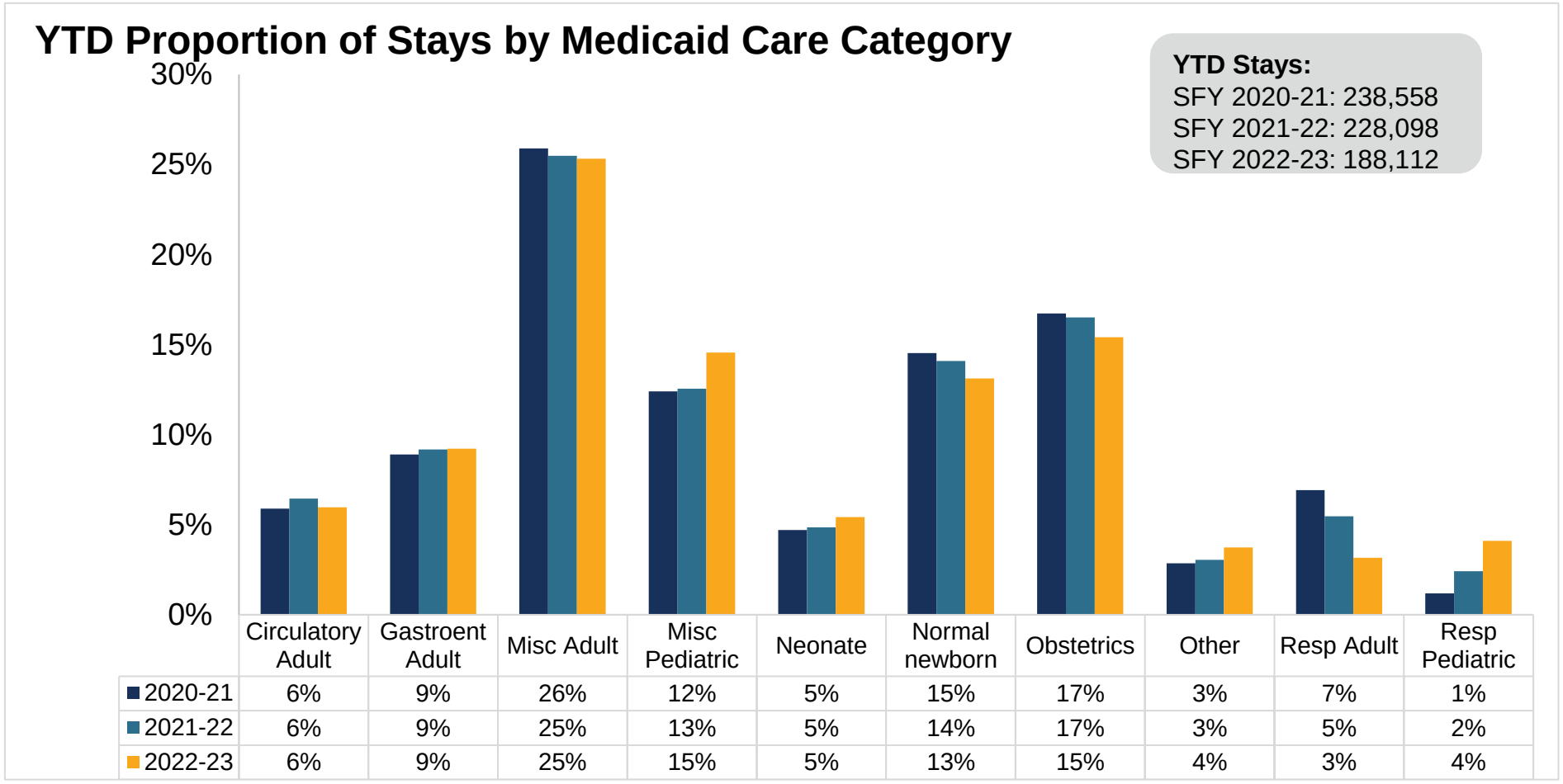
APR-DRG background

Trends past SFYs

- Stability, budget neutrality, access-to-care, transparency, and fairness are the guiding principles for policy decision making
- Total hospital stays have been decreasing
- Overall increase in payment for most children's hospital stays
- Actual outlier percent to payment ratios are greater than policy simulated results
- Effect on fee-for-service (FFS) stays and payments depend on the following three trends:
  - New Medi-Cal FFS enrollment
  - Beneficiary transitions from FFS to managed care plans
  - Actual DRG casemix and utilization

APR-DRG background

Stays by Medicaid Care Category



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2020-21	6%	9%	26%	12%	5%	15%	17%	3%	7%	1%
2021-22	6%	9%	25%	13%	5%	14%	17%	3%	5%	2%
2022-23	6%	9%	25%	15%	5%	13%	15%	4%	3%	4%

Data Source: CAMMIS Production Data | Dates Represented 7/1/2020 - 3/25/2024 paid through 3/25/2024 | Date Download 5/28/2024

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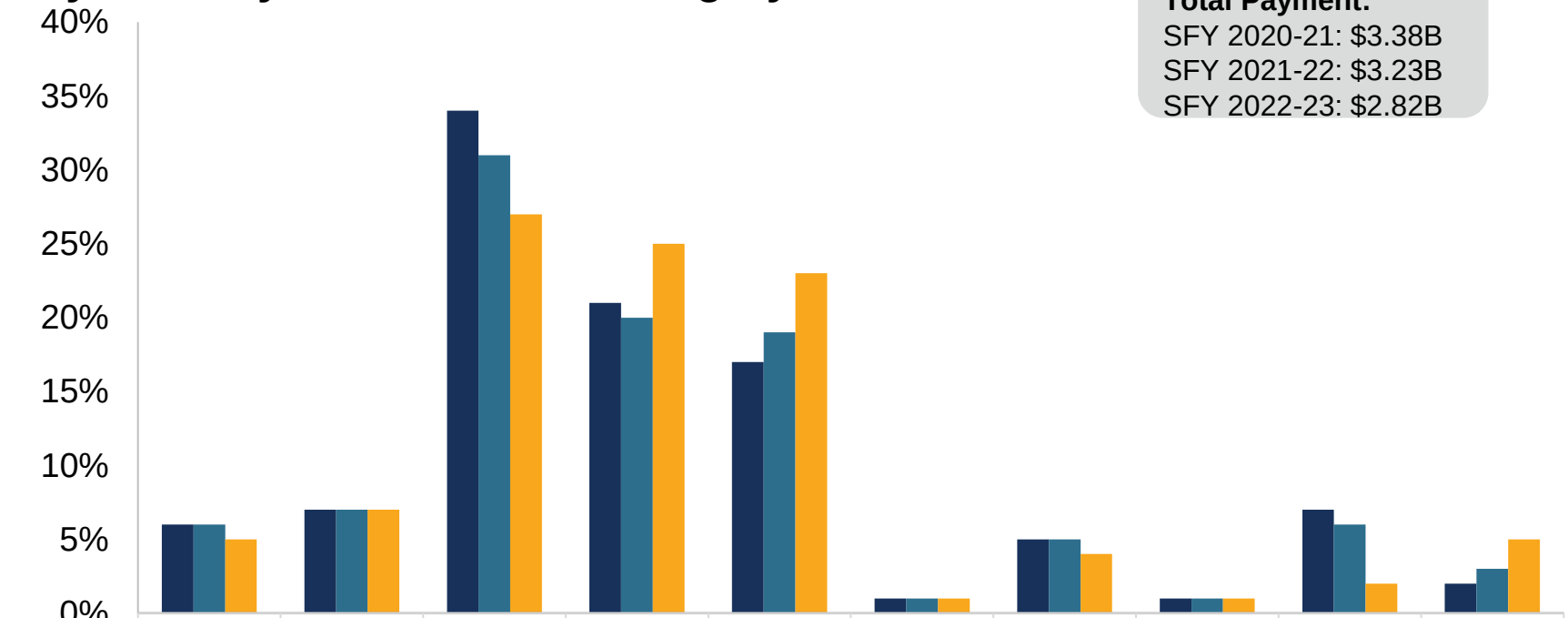
Payment by Medicaid Care Category

YTD Payments by Medicaid Care Category

Total Payment:
SFY 2020-21: $3.38B
SFY 2021-22: $3.23B
SFY 2022-23: $2.82B



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2020-21	6%	7%	34%	21%	17%	1%	5%	1%	7%	2%
2021-22	6%	7%	31%	20%	19%	1%	5%	1%	6%	3%
2022-23	5%	7%	27%	25%	23%	1%	4%	1%	2%	5%

Data Source: CAMMIS Production Data | Dates Represented 7/1/2020 - 3/25/2024 paid through 3/25/2024 | Date Download 5/28/2024

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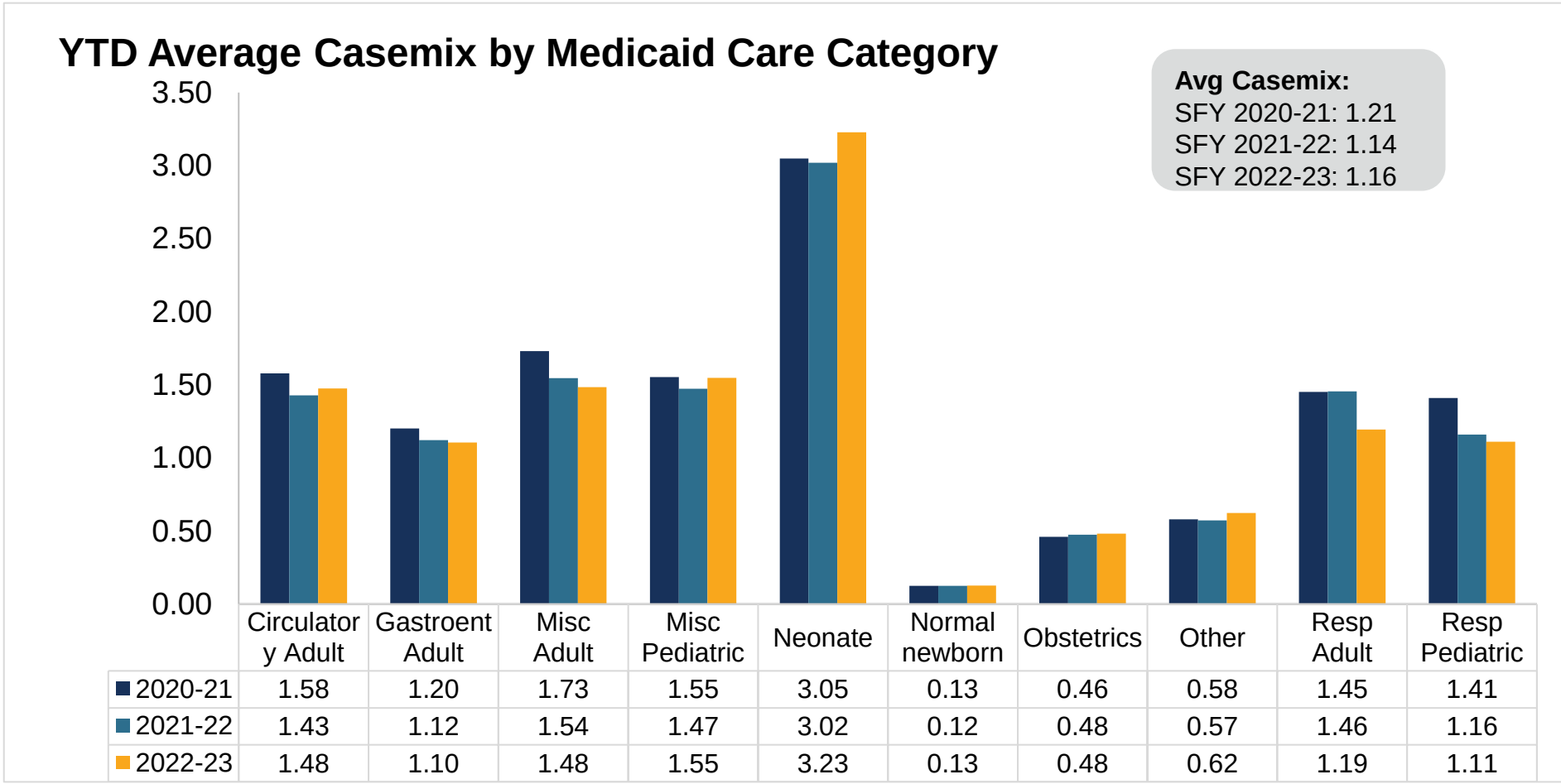
APR-DRG Background

Casemix by Medicaid Care Category



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2020-21	1.58	1.20	1.73	1.55	3.05	0.13	0.46	0.58	1.45	1.41
2021-22	1.43	1.12	1.54	1.47	3.02	0.12	0.48	0.57	1.46	1.16
2022-23	1.48	1.10	1.48	1.55	3.23	0.13	0.48	0.62	1.19	1.11

Data Source: CAMMIS Production Data | Dates Represented 7/1/2020 - 3/25/2024 paid through 3/25/2024 | Date Download 5/28/2024

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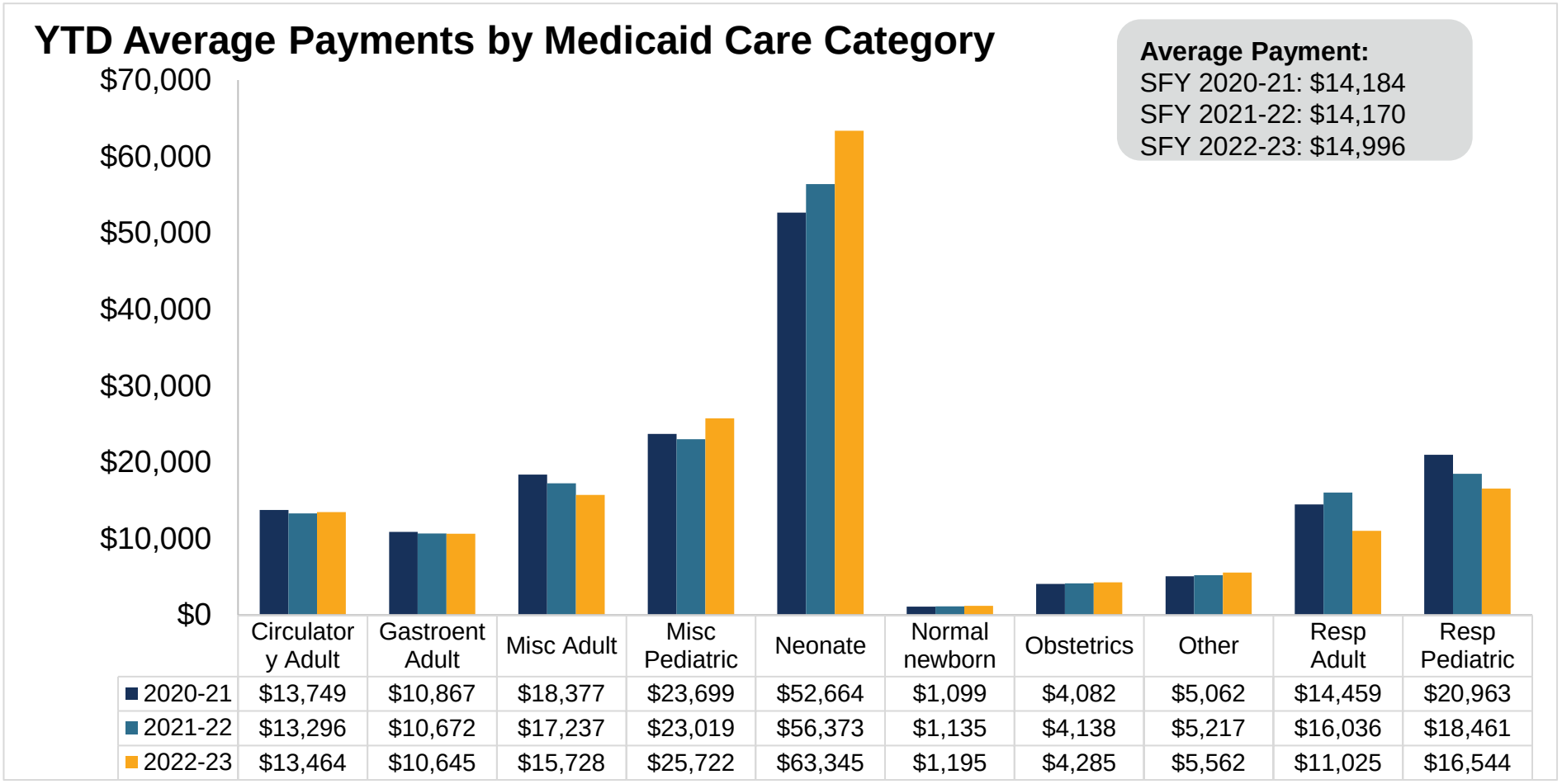
Pay per Stay by Medicaid Care Category



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2020-21	$13,749	$10,867	$18,377	$23,699	$52,664	$1,099	$4,082	$5,062	$14,459	$20,963
2021-22	$13,296	$10,672	$17,237	$23,019	$56,373	$1,135	$4,138	$5,217	$16,036	$18,461
2022-23	$13,464	$10,645	$15,728	$25,722	$63,345	$1,195	$4,285	$5,562	$11,025	$16,544

Data Source: CAMMIS Production Data | Dates Represented 7/1/2020 - 3/25/2024 paid through 3/25/2024 | Date Download 5/28/2024

SFY 2024-25 updates

SFY 2024-25 updates

SFY 2024-25 overview

- Minimal payment changes across hospitals remain a priority
- Regular technical updates include CCRs, wage index values, and the California wage area neutrality
- Move to 3M APR-DRG software version 41 (V41)
- Base rates increase for statewide and decrease for remote rural hospitals
- Target outlier total percentage at 16.5%
- Increased OB SOI 1-3 policy adjustor to 1.06; all other policy adjustors remain unchanged
- Outlier threshold increased to $99,000; marginal percentage remains unchanged

SFY 2024-25 updates

SFY 2024-25 policy decisions

Technical annual updates:

- Wage area index values
- Wage area neutrality factor 0.8477
- CCRs
- Hospital specific relative weights (HSRV) V41
- Re-centered HSRV weights to align with CA population 0.8913

Policy changes from SFY 2024-25*

- Statewide base rate: $8,380
  - $226 increase
- Remote rural base rate: $21,340
  - $295 decrease
- OB SOI 1-3 policy adjustor 1.06
- Outlier threshold increase to $99,000
- Marginal cost percentage remains at 53%

Impacts on individual hospitals will depend on actual utilization and casemix

*Subject to federal approval

SFY 2024-25 updates

Grouper software settings

For claims with admission dates on or after July 1, 2024

- Grouper Version 41
- HAC Version 41.1 for California Medicaid
- Entered Code Mapping: Remain on Version 41.1 Mapper
- Mapping Type: Historical for all SFY 2024-25 claims
- Grouper ICD Version Qualifier: The ICD Version Qualifier should be set to “0 ICD-10” in the grouper

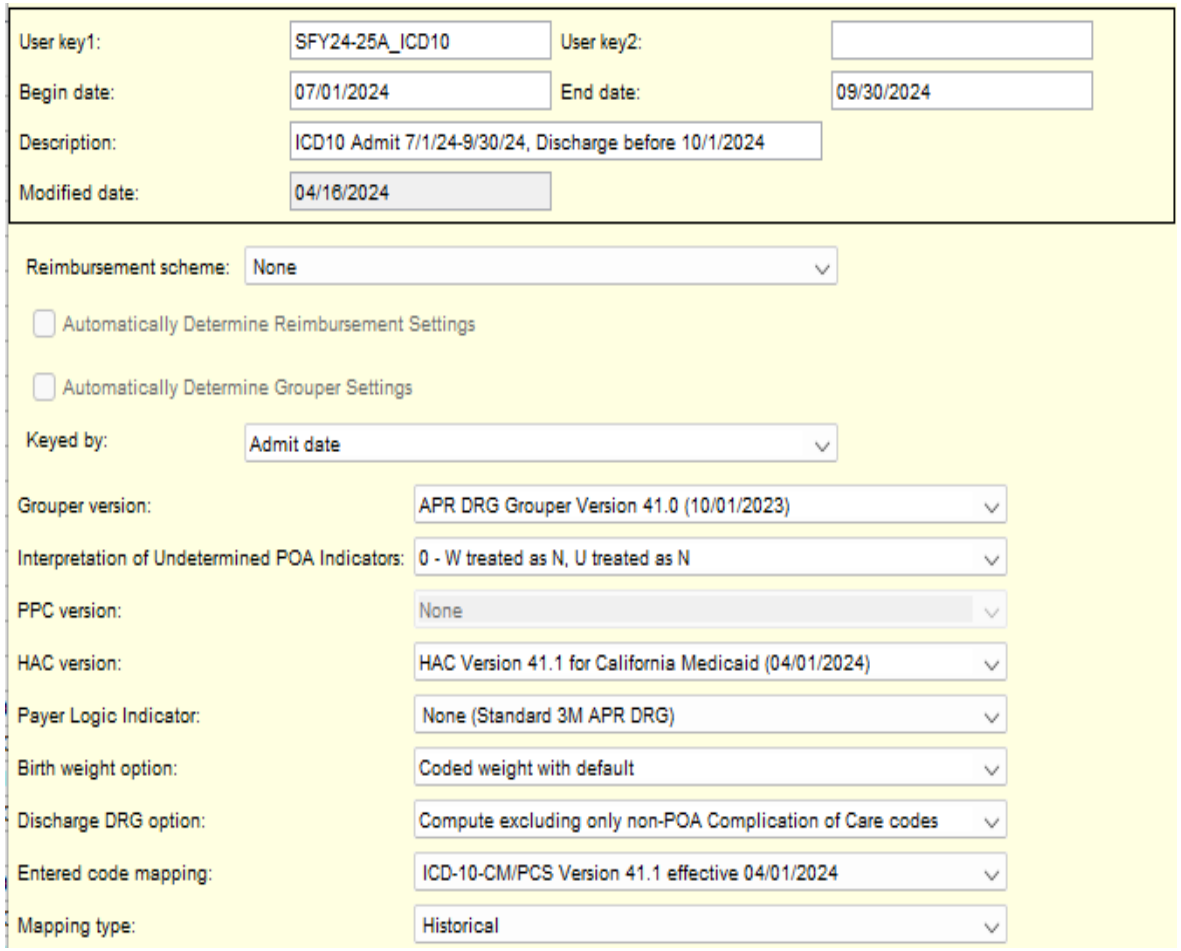
SFY 2024/25 Medi-Cal DRG Claims Grouper Setting Scenarios						
Scenario	**Admit Date**	**Discharge Date**	**Grouper Version**	**Mapping**	**Mapper Version**	**HAC Version**
A	7/1/24 to 9/30/24	Before 10/1/2024	41	Historical	41.1	41.1 for California Medicaid

SFY 2024-25 updates

Grouper software settings

SFY 2024-25 DRG admit date on or after 7/1/24

- The Mapper and HAC will subsequently be updated for discharges on or after 10/1/24
- The complete SFY 2024-25 grouper software settings document will be available on the DRG web page
  - A CSV file to expedite installation of the new settings, instead of adding them manually, will be available as well.



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Cost reporting

Cost report submission

Cost report submission requirements:

- Cost Reporting and Tracking Section (CRTS) reviews cost reports and determines acceptance or rejection
- Cover letter (Includes the detail of special circumstances, contact personnel, etc.)
- Signed copy of CMS 2552-10
- CPA audited financial statements (covering the entire financial period reported)
- Working trial balance (in Excel format) and grouping schedules
- Working papers used to prepare the CMS 2552-10 (specifically A-6 and A-8)
- Email cost report submissions to Acute.Submissions@dhcs.ca.gov
- Email cost report submission questions to Acute.Questions@dhcs.ca.gov

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
- 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, including certification page
  - 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

Cost reporting

Common causes for cost report rejection (con't)

- 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
  - If the cost report is due and audited financials are still in preparation, submit a filing extension request to Acute.Questions@dhcs.ca.gov and include the extension reason and additional time needed to file the cost report with audited financial statements
- DRG hospitals answered "Y" to WS S-2, line 70 and/or line 75 regarding Inpatient Psychiatric/Rehabilitation Facility PPS, but did not report amounts on WS A, line 40 and/or line 41

Cost reporting

Common reasons for cost report adjustments

1. Reported cost and statistics do not agree with source documents
2. Overstating costs or including non-reimbursable costs in reimbursable cost centers on Schedule A
3. Miscellaneous revenue being offset against non-reimbursable cost centers on Schedule A-8
4. Excluding statistics for non-reimbursable cost centers on Schedule B-1
5. Revert simplified method statistics to standardized statistics per CMS Pub. 15-2
6. Not including observation bed days or misreporting the census for total patient days on Schedule D-1
7. Reconciling Medi-Cal Days and Ancillary Charges to the Fiscal Intermediary payment summary on Schedules D-1 and D-3
8. Not including all Medi-Cal Charges on Schedule E-3
9. 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
10. Not applying RCE limits to provider based physicians' provider component costs on Schedule A-8-2

Cost reporting

CCR review and correction

- CCR (cost-to-charge ratio) calculation
  - Total Medi-Cal Costs (W/S E-3, Part VII, Column 1, Line 4) / Total Medi-Cal Charges (W/S E-3, Part VII, Column 1, Line 12)
- CCRs for FYE 2022 were provided to the Safety Net Financing Division (SNFD) in 2023-24 and used for rate setting for SFY 2024-25
  - CCRs pending for some hospitals
- Review of CCR changes from the prior year
  - Less than 5% difference – No further review
  - Greater than 5% difference – CCR narrative must be completed to identify causes such as:
    - Reporting error in prior or current year, changes in services provided, or changes in utilization
- If amended cost report is accepted by CRTS by December 31, CRTS will forward revised CCR to SNFD for inclusion in the rate setting for the next fiscal year

Outlier audits and recalculation

Outlier audits and recalculation

Overview

- DHCS – DRG Outlier Recalculation Policy:
  - Material change between reported/paid CCR (interim) and contemporaneous audited CCR, outlier payments may be subjected to recalculation
  - Current policy defines a material change as a $10,000 aggregate claims change and total outlier payments of at least $500,000 and above in aggregate annually
  - The Department has discretion to review hospitals with material misstatements even if the outlier payments for the period do not meet the $500,000 threshold
  - Usually part of the Cost Report Audit, but may be a separate audit report if necessary

Outlier audits and recalculation

Overview (con't)

DHCS – DRG Outlier Recalculation Policy:

- Will result in either over-or-under payment
- Paid CCRs – The cost to charge ratio used to pay outlier claims (interim CCR)
- Audited CCRs – The cost to charge ratio based on the contemporaneous audited cost report

A&I Timeline – 36-Month Statue of Limitations:

- All audits of hospital cost reports have a 36-month statute of limitation from the date of cost report submission
- Hospitals with separate rate setting components (i.e. Distinct Part Nursing Facility) may have the outlier recalculation issued separately from the cost report but within the 36-month statute of limitation

Outlier audits and recalculation

What cost report periods are used

Cost Reports Used to Determine the Paid CCR:

- DRG SFY 2022-23 – Cost Report FYE 2020
- DRG SFY 2023-24 – Cost Report FYE 2021
- DRG SFY 2024-25 – Cost Report FYE 2022

(Interim CCR FYE exceptions may apply)

Further information

Further information

Reminders for accurate billing and pricing

- Present on Admission (POA) indicators should be reported on UB04 when submitting claims
- Include infant birth weights and gestational age codes on the UB04
- Vaginal Deliveries (obstetric stays) must include current procedure codes as well as diagnosis codes or the claim will deny
- Separate mom and baby claims when billing
- Reference the DRG Hospital Characteristics File on the DRG website for your hospital-specific base rate and interim CCR
- Use the year-specific pricing resources such as the DRG Pricing Calculators 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 Medicaid claims processing system is correct

Further information

Reminders for accurate billing and pricing (con't)

- Meet treatment and service authorization requirements (TAR/SAR)
- Reference the Medi-Cal Provider Manual
- Reference Provider Bulletins, News Articles and ListSERV notifications often
- Reference Medi-Cal Inpatient Claims Processing Updates or DRG billing updates at https://www.dhcs.ca.gov/provgovpart/Pages/DRG-Provider-Edu.aspx
- Medi-Cal Billing Phone Support Services 1-800-541-5555
  - Additional Medi-Cal Provider telephone and correspondence support options: https://files.medi-cal.ca.gov/pubsdoco/contact.aspx
  - For all billing inquiries, contact the Correspondence Specialist Unit (CSU) at:

    California MMIS Fiscal Intermediary, Attn: CSU, P.O. Box 13029, Sacramento, CA 95813-4029

Further information

Reminders for accurate billing and pricing (con't)

- Reference DRG Provider Manual for specific billing instructions
  - High dollar claims, over 22 lines, split billing, and separately payable/carve-out services
  - https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx
- Always bill other healthcare coverage prior to Medi-Cal
- Ensure bill types and discharge status codes are consistent with type of claim
- Interim claims must be voided prior to submitting final claim

Further information

Looking ahead

- DRG is updating policy resource documents
  - Medi-Cal Provider Manual and Medi-Cal Inpatient Claims Processing Updates
- Monitor 3M’s changes to APR-DRG grouper weights when released
- Continue to review Medi-Cal policy and payment levels
  - Monitor impact of payment policy changes
- Monitor legislation
- DRG payment system integrity
  - DRG validations
  - Update procedure and diagnosis codes when appropriate
  - High-dollar claim review

Further information

Keep in touch

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With Thanks To

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