Continuation of DRG Outlier Recalculation Policy

In November 2017, the Department of Health Care Services (DHCS) published an article titled "State Fiscal Year 2016 – 2017 DRG Outlier Recalculation Policy" which detailed policy relating to the All Patient Refined Diagnosis-Related Group (APR-DRG). The policy will continue as outlined in accordance with the California's Medicaid State Plan, Title 19 of the *Social Security Act*, California State Plan, Attachment 4.19-A, paragraph E.2, page 17.54, under Pre-and Post-Payment review, and will continue through upcoming years at DHCS' discretion.

- This policy affects only APR-DRG outlier payments.
- The policy applies to hospitals receiving APR-DRG outlier payments of at least $500,000 and above, in aggregate annually. The $500,000 is prorated based on the hospital's fiscal year end cost report submission. For example, hospitals with a fiscal year end of December 31, 2017, will be included in the outlier recalculation if they receive APR-DRG outlier payments of at least $250,000, based on six months of prorating.

DHCS will continue cost report audits in the manner and form prescribed in *Welfare and Institutions Code* (W&I Code), Section 14170(a)(1), and determine the audited cost-to-charge ratios (CCRs). Additional hospitals may be included in the outlier recalculation policy when DHCS audits cost reports due to issues such as incorrect reporting.

The outlier recalculation may occur through the recoupment of funds or through an additional payment made to the hospital.

For further information or questions regarding Outlier Recalculation policy, providers may contact DHCS at drg@dhcs.ca.gov.

This provider bulletin is published under the authority specified in paragraph (2) of subdivision (f) of Section 14105.28 of the W&I Code, which provides in part:

"Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of the Part 1 of Division 3 of Title 2 of the Government Code, *or any other provision of law, the department may implement and administer this section by means of provider bulletins, all-county letters, manuals, or other similar instructions, without taking regulatory action."*

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