Medi-Cal SFY 2020-21 DRG Payment

Provider Training

June 23 and 25, 2020

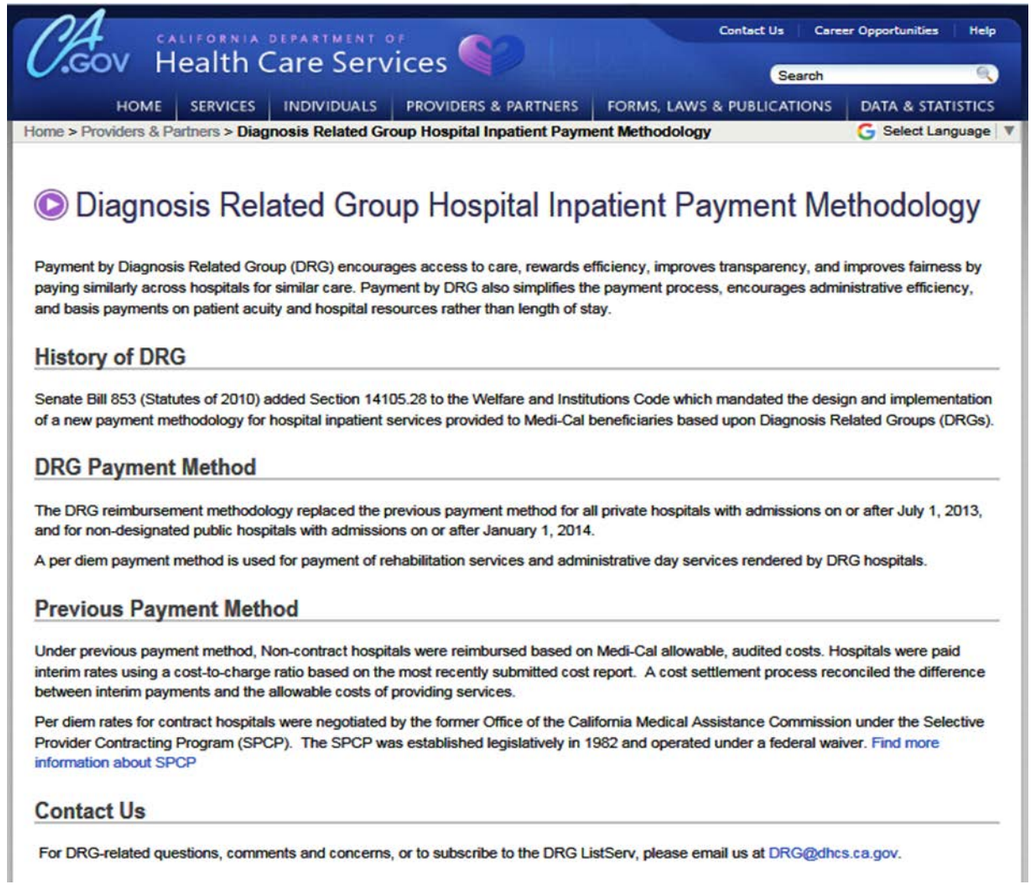
Contents

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 Previous State Fiscal Years
- **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



Policy History

Policy changes for SFY 2017-18:

- Increase statewide base rate
- Increase outlier threshold
- Eliminate tier 2 of outlier payments
- Increase policy adjustors for pediatric stays

Policy changes for SFY 2018-19:

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

Policy changes for SFY 2019-20:

- Increase statewide base rate
- Increase remote rural base rate
- Increase outlier threshold
- Reduce outlier marginal rate

APR-DRG Background

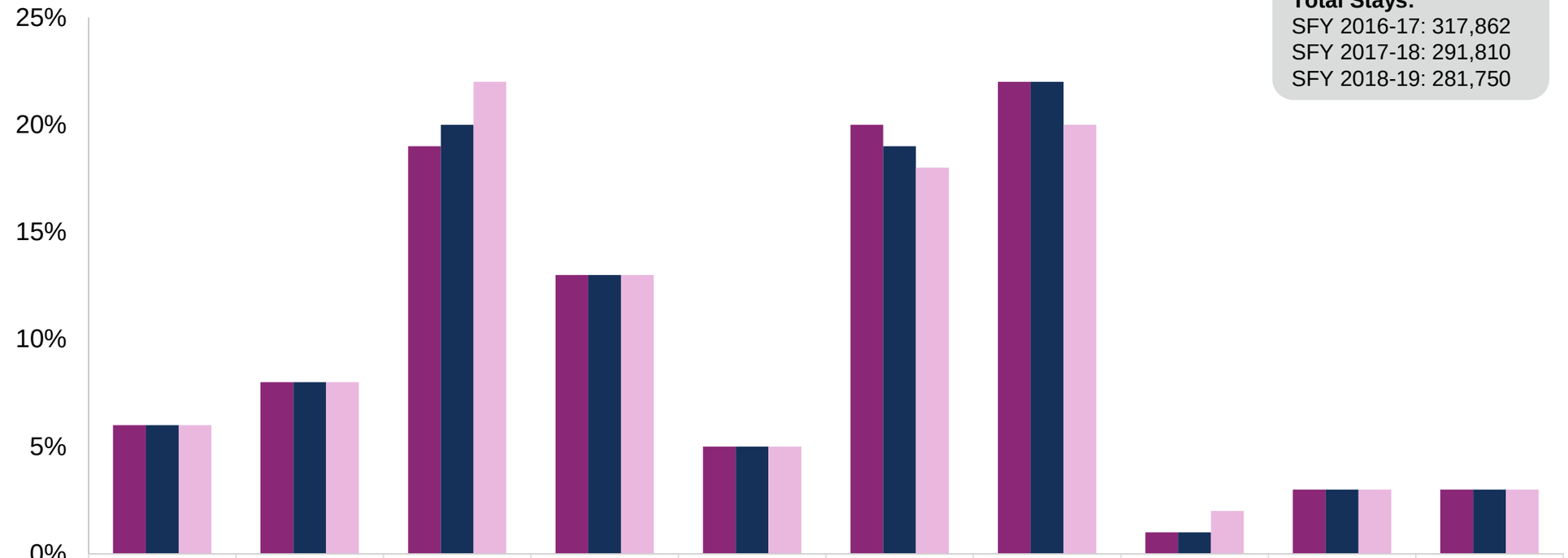
Trends

- Stability as a guiding principle for policy decision-making
- Total hospital stays have been decreasing while payments per stay continue to increase due to more costly services
- Overall increase in more expensive, specialty service 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 2018-19

Stays by Medicaid Care Category



Total Stays:
SFY 2016-17: 317,862
SFY 2017-18: 291,810
SFY 2018-19: 281,750

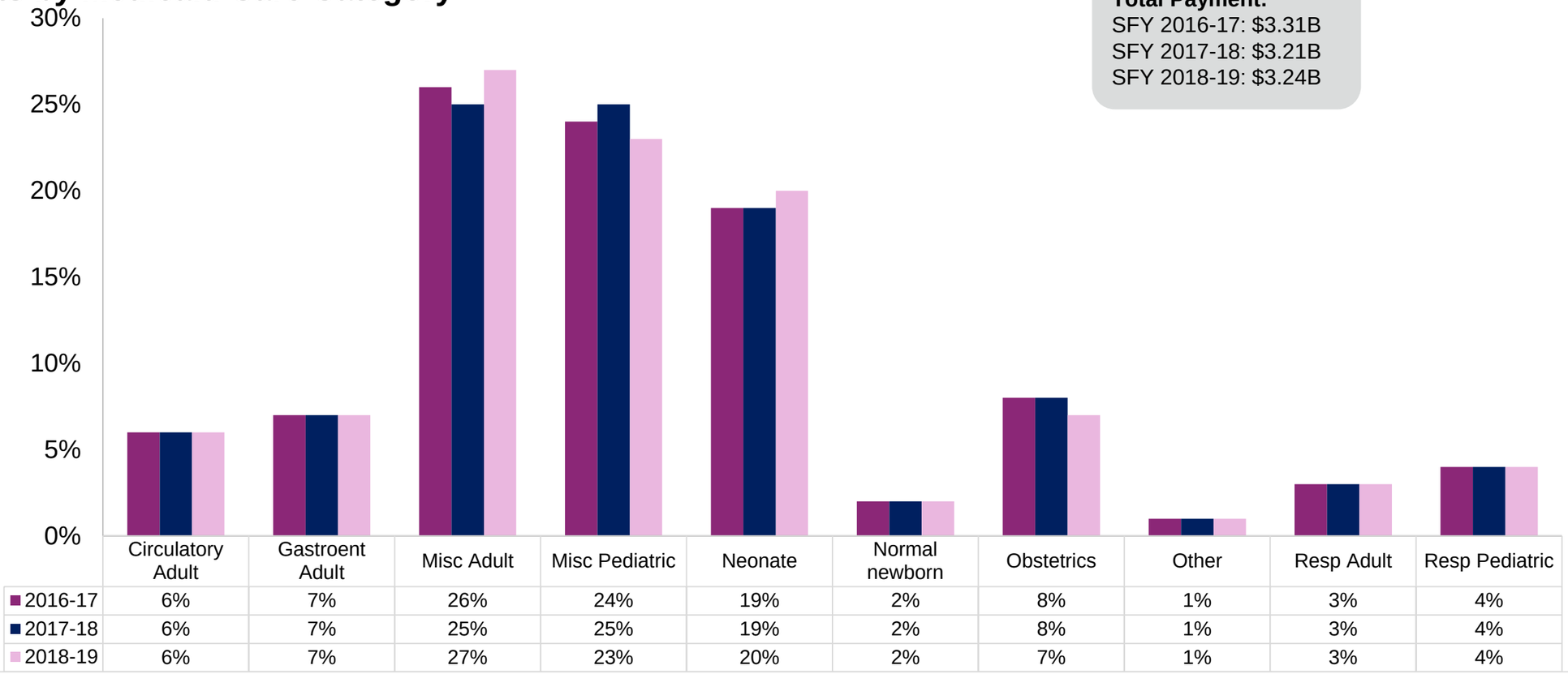
	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2016-17	6%	8%	19%	13%	5%	20%	22%	1%	3%	3%
2017-18	6%	8%	20%	13%	5%	19%	22%	1%	3%	3%
2018-19	6%	8%	22%	13%	5%	18%	20%	2%	3%	3%

Data Source: CAMMIS | Dates Represented: 7/1/2017 – 6/30/2019 paid through 3/23/2019 | Date Download 3/23/2020

Payment by Medicaid Care Category

- Payment distribution by MCC is stable from SFY 2016-17 to 2018-19

Payments by Medicaid Care Category



Total Payment:
SFY 2016-17: $3.31B
SFY 2017-18: $3.21B
SFY 2018-19: $3.24B

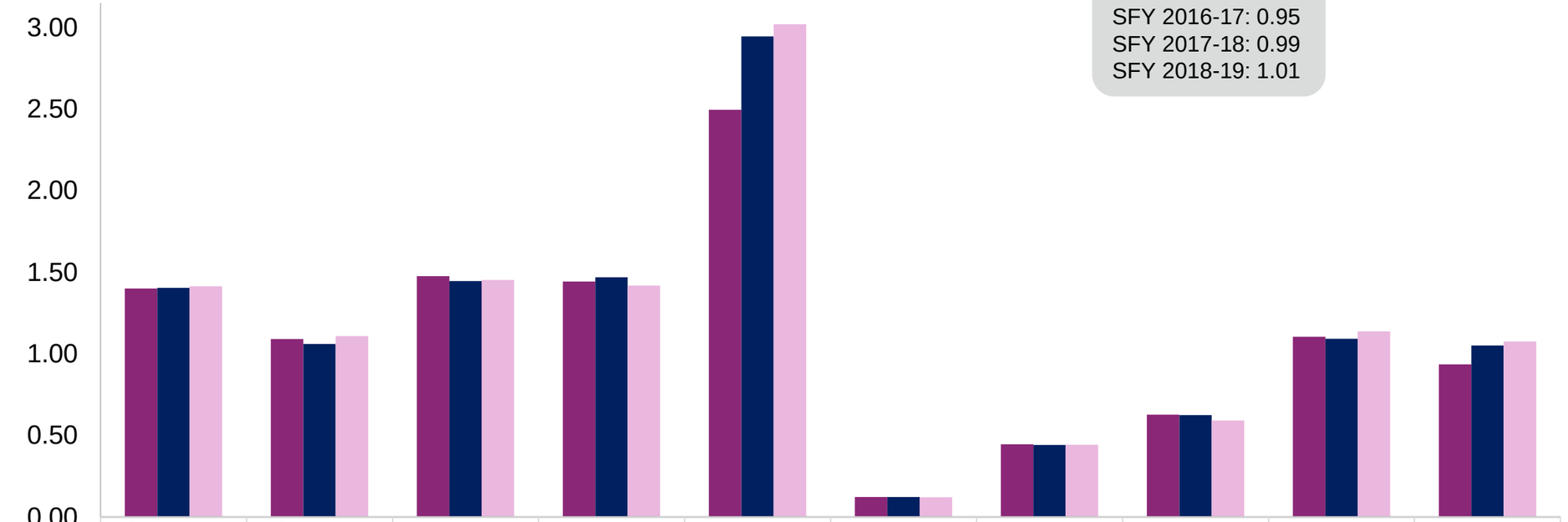
	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2016-17	6%	7%	26%	24%	19%	2%	8%	1%	3%	4%
2017-18	6%	7%	25%	25%	19%	2%	8%	1%	3%	4%
2018-19	6%	7%	27%	23%	20%	2%	7%	1%	3%	4%

Data Source: CAMMIS | Dates Represented: 7/1/2017 – 6/30/2019 paid through 3/23/2019 | Date Download 3/23/2020

Casemix by Medicaid Care Category

- Casemix has been increasing over time despite stability in underlying weights
- Average casemix increased 2% in SFY 2018-19 from SFY 2017-18, from 0.99 to 1.01
  - Increases are primarily in Neonate (up 7%) and Respiratory Pediatric (up 3%)

Casemix by Medicaid Care Category



Total Casemix:
SFY 2016-17: 0.95
SFY 2017-18: 0.99
SFY 2018-19: 1.01

	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2016-17	1.40	1.09	1.48	1.44	2.50	0.12	0.45	0.63	1.10	0.94
2017-18	1.41	1.06	1.45	1.47	2.95	0.12	0.44	0.63	1.09	1.05
2018-19	1.41	1.11	1.45	1.42	3.02	0.12	0.44	0.59	1.14	1.08

Data Source: CAMMIS | Dates Represented: 7/1/2017 – 6/30/2019 paid through 3/23/2019 | Date Download 3/23/2020

SFY 2019-20 Experience

SFY 2019-20 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 2019-20

- Increase statewide base rate to $6,584
- Increase Remote Rural base rate to $ 14,615
- Increase outlier threshold to $61,000
- Decrease marginal rate to 55%

SFY 2019-20 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 2020-21, Simulation 12 | Date Downloaded 5/29/2020

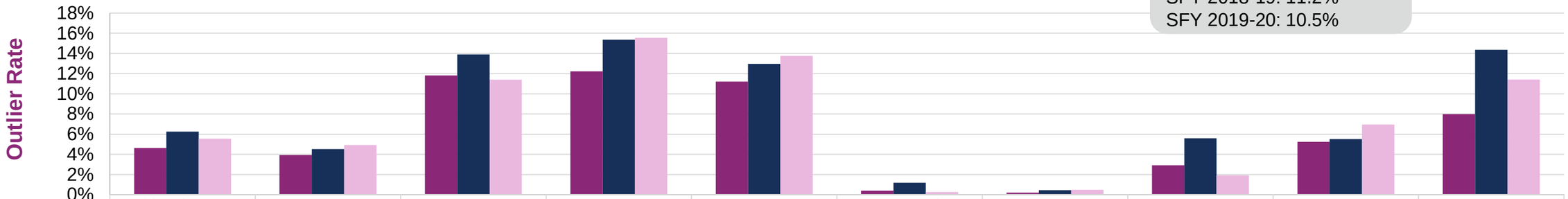
SFY 2019-20 Experience

Outlier Payments Policy Impact

- The outlier rate decreased substantially in SFY 2018-19 due to changes in the outlier policy
- Outlier threshold was increased and marginal rate decreased in SFY 2019-20
- Most categories show outlier rate increases in SFY 2019-20 as compared to SFY 2018-19

Outlier Rate by Medicaid Care Category
SFY 2017-18, 2018-19, 2019-20

Total Payment:
SFY 2017-18: 9.1%
SFY 2018-19: 11.2%
SFY 2019-20: 10.5%



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2017-18	4.6%	3.9%	11.8%	12.2%	11.2%	0.4%	0.2%	2.9%	5.2%	8.0%
2018-19	6.2%	4.5%	13.9%	15.4%	13.0%	1.2%	0.4%	5.6%	5.5%	14.4%
2019-20	5.6%	4.9%	11.4%	15.5%	13.8%	0.3%	0.5%	1.9%	7.0%	11.4%

Medicaid Care Categories

Data Source: MIS/DSS | Dates Represented: 7/1/2017 – 6/30/2018, paid by 3/25/2018; 7/1/2018 – 6/30/2019, paid by 3/23/2019; 7/1/2019 – 5/6/2020, paid by 3/30/2020

Prepared by the California Department of Health Care Services

SFY 2020-21 Updates

SFY 2020-21 Updates

SFY 2020-21 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 Version 37 or Version 37 HSRV weights in SFY 2020-21 and will instead continue to use Version 35
- A specified alternative method for a provider to utilize the statewide average CCR is added

SFY 2020-21 Policy Decisions

- APR-DRG V.35 grouper and HSRV weights will remain in use for SFY 2020-21

Regular annual updates:

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

Policy changes from SFY 2019-20 to 2020-21*

- Statewide base rate: $6,596
  - ❑ $12 increase
- Remote rural base rate: $15,036
  - ❑ $421 increase
- Marginal cost percentage used in outlier payment calculation will remain 55%
- Outlier threshold will remain $61,000

Impacts on individual hospitals will depend on actual utilization and casemix

*Subject to federal approval

Decision to Use APR-DRG Version 35

- Remaining on Version 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 0.9584, 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: 2018 reported CCRs

SFY 2020-21 Updates

Grouper Software Settings

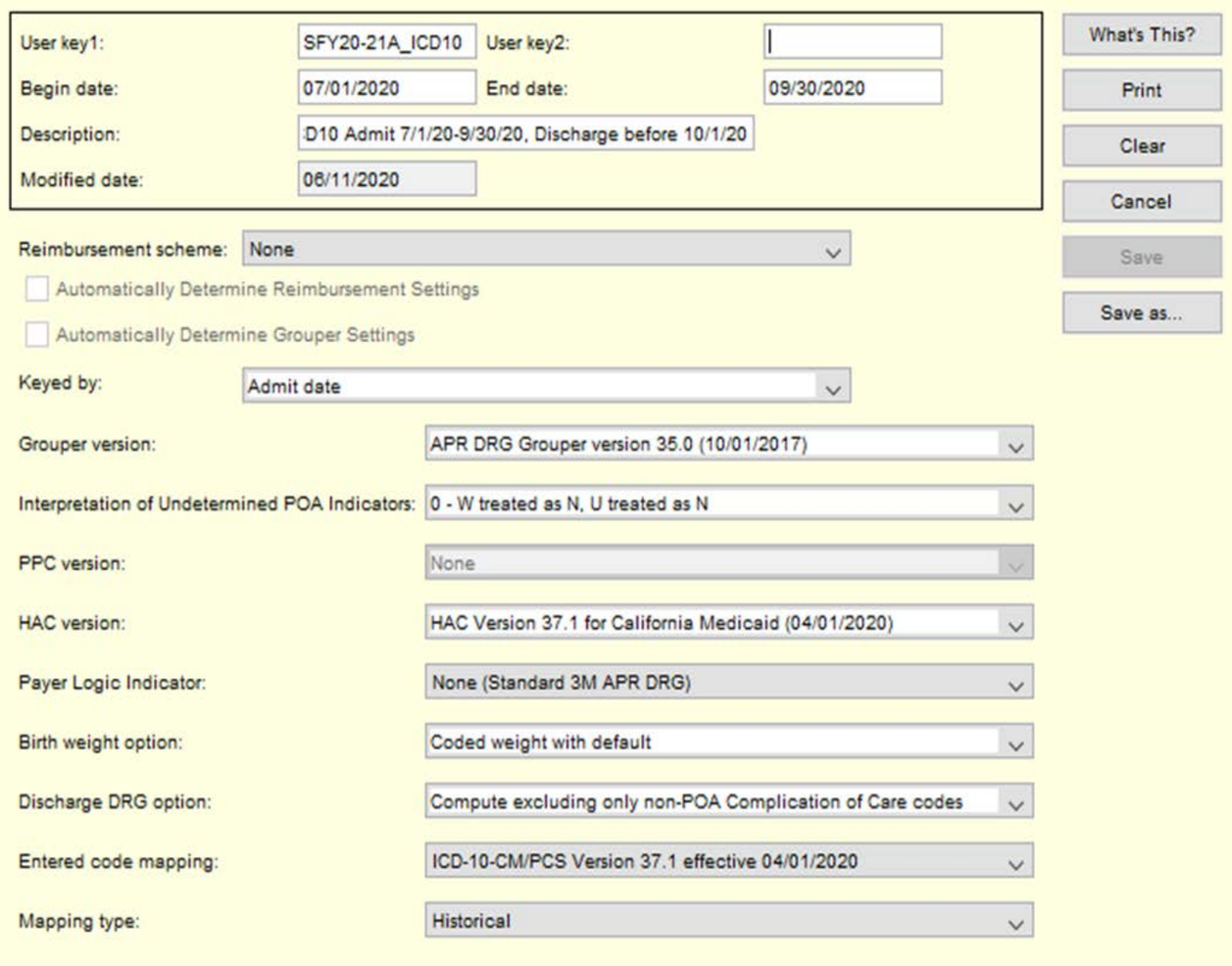
- For claims with admission dates on or after July 1, 2020, continue to use:
  - Grouper Version 35
  - HAC Version 37.1 for California Medicaid until new HAC version is released in October 2020
  - Entered Code Mapping: Remain on Version 37.1 Mapper until new Mapper is released in October 2020
  - Mapping Type: Historical for all SFY 2020-21 claims
  - Grouper ICD Version Qualifier: The ICD Version Qualifier should be set to “0 ICD-10” in the grouper

SFY 2020-21 Medi-Cal DRG Claims Grouper Setting Scenarios							
Scenario	**Admit Date**	**Discharge Date**	**Grouper Version**	**Mapping**	**Mapper Version**	**ICD Version**	**HAC Version**
A	7/1/20 to 9/30/20	Before 10/1/20	35.0	Historical	37.1	ICD-10 (0)	V.37.1 for California Medicaid
B	7/1/20 to 6/30/21	On or after 10/1/20	35.0	Historical	TBD	ICD-10 (0)	TBD

Grouper Software Settings (continued)

SFY 2020-21 DRG admit date on or after 7/1/20

- Historical mapping will be required throughout SFY 2020-21
- The Mapper and HAC will be updated for discharges on or after 10/1/20
- The complete SFY 2020-21 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:

(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
- Signed copy of DHCS 3092
- 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 and DHCS 3092 (all working papers and files named for the W/S or Schedule they relate to)
- 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
- Not completing some or all of the DHCS 3092 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, 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
- 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 3092.
  - 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.

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. Misreporting Medi-Cal Days and Ancillary Charges 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

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 2018 were provided to SNFD in November 2019 and used for rate setting for SFY 2020-21
- 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
    - 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

Overview

DHCS – DRG Outlier Recalculation Policy:

- DRG Post Payment Review
  - Material change between reported/paid CCR 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.

Overview (Cont.)

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.
  - Taken from most current accepted filed cost report schedule E-3 line 4 divided by line 12.
- Audited CCRs – The cost to charge ratio based on the contemporaneous audited cost report.
  - On audit report DRG schedule 1

Timelines

36-Month Statute of Limitation:

- 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.

What Cost Report Periods are Used

Cost Reports Used to Determine the Paid CCR:

(Most Current 2 Years Prior)

- DRG Policy Year 1 (SFY 2013-14) – Cost Report FYE 2011
- DRG Policy Year 2 (SFY 2014-15) – Cost Report FYE 2012
- DRG Policy Year 3 (SFY 2015-16) – Cost Report FYE 2013
- DRG Policy Year 4 (SFY 2016-17) – Cost Report FYE 2014
- DRG Policy Year 5 (SFY 2017-18) – Cost Report FYE 2015
- DRG Policy Year 6 (SFY 2018-19) – Cost Report FYE 2016
- DRG Policy Year 7 (SFY 2019-20) – Cost Report FYE 2017

How the Recalculations are Calculated

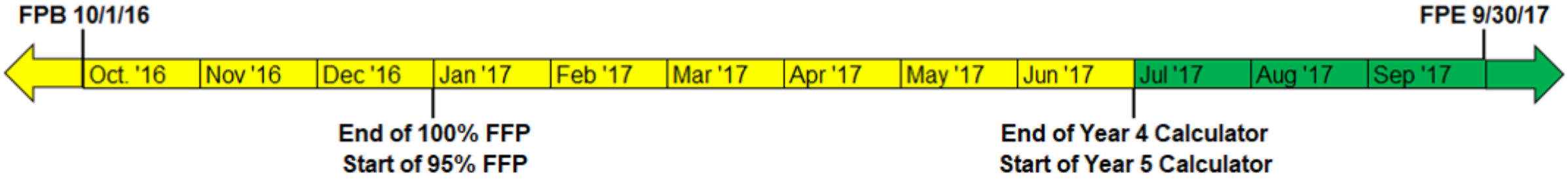
- Outlier claims are recalculated using the audited CCR from audit report of the contemporaneous cost report.
- The recalculated claims are compared with the paid claims.
- The difference in payment in aggregate for all outlier claims results in either an overpayment or underpayment.
- Outliers recalculations follow each individual DRG policy year’s criteria and are based on the admission date.
- Outliers recalculations will be broken out by aide code and applicable federal participation percentages for processing by the fiscal intermediary on the audit report.

How the Recalculations are Calculated (Cont.)

- If the hospital cost report fiscal year matches the state DRG policy year end, the audited CCR will be used to recalculate all claims with admissions overlapping the hospital cost report year.
- If the hospital cost report fiscal year does not match the state DRG policy year end, the audited CCR will be used to recalculate all claims with admissions overlapping the hospital cost report year. In this instance, the original claim set will have 2 paid CCR's but only one final audited CCR. This will match the charges on the billing with the charges and claims reported in the hospital's audited cost report.

How Recalculations are Calculated (Cont.)

VISUAL EXAMPLE



	Year 4 Calculator
	Year 5 Calculator

1 Year 4 Calculator Exclude Expanded Eligible
2 Year 4 Calculator Expanded Eligible (100% FFP)
3 Year 4 Calculator Expanded Eligible (95% FFP)
4 Year 5 Calculator Exclude Expanded Eligible
5 Year 5 Calculator Expanded Eligible (95% FFP)

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
- Birth weight must be included as a diagnosis code or the system will select default normal birth weight.
- 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 Version 38 is released
2. Continue to review Medi-Cal policy and payment levels
   - Monitor impact of payment policy changes
   - Re-evaluate policy for SFY 2021-22 if necessary
3. Monitor legislation
4. DRG payment integrity
   - DRG validation
   - DRG outlier recalculation
   - High-dollar claim review

Further Information

Keep in Touch

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