Medi-Cal SFY 2021-22 DRG Payment Policies

Provider Training

June 22 and 24, 2021

Agenda Topics

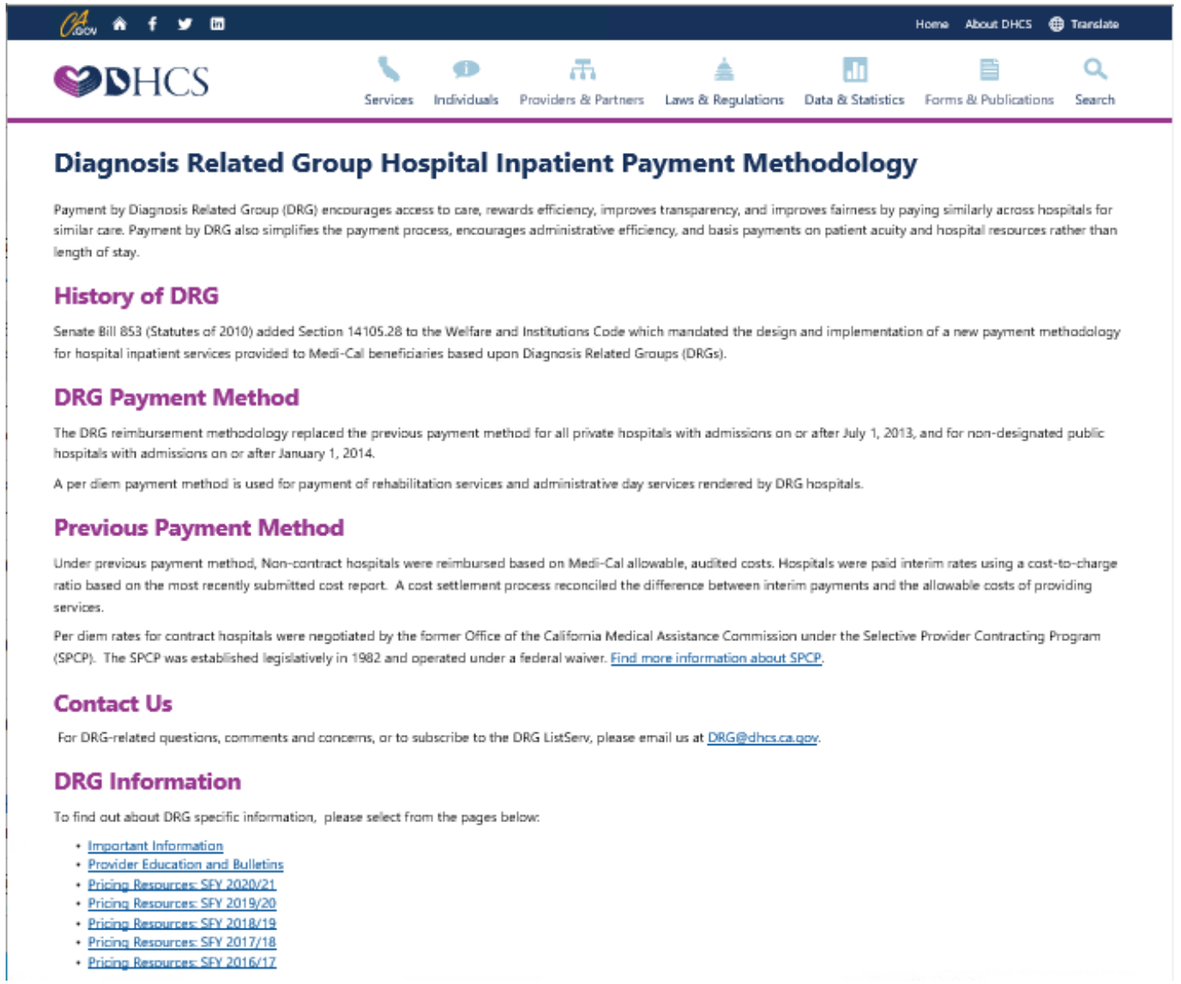
- All Patient Refined Diagnosis Related Groups (APR-DRG) Background
- State Fiscal Year (SFY) 2020-21 Experience
- SFY 2021-22 Updates
- Cost Reporting
- Outlier Audits and Recalculation
- Further Information

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



Policy History Past SFYs

Policy changes for SFY 2017-18:

- Increased statewide base rate
- Increased outlier threshold
- Eliminated tier 2 of outlier payments
- Increased policy adjustors for pediatric stays

Policy changes for SFY 2018-19:

- Modified payment by severity of illness (SOI)
  - Increased higher-acuity policy adjustors for SOI 4
  - Reduced pediatric policy adjustor for SOI 1-3
- Adjusted outlier threshold and percent to payment ratio
- Decreased statewide base rate

Policy changes for SFY 2019-20:

- Increased statewide base rate
- Increased remote rural base rate
- Increased outlier threshold
- Reduced outlier percent to payment ratio

Policy changes for SFY 2020-21

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

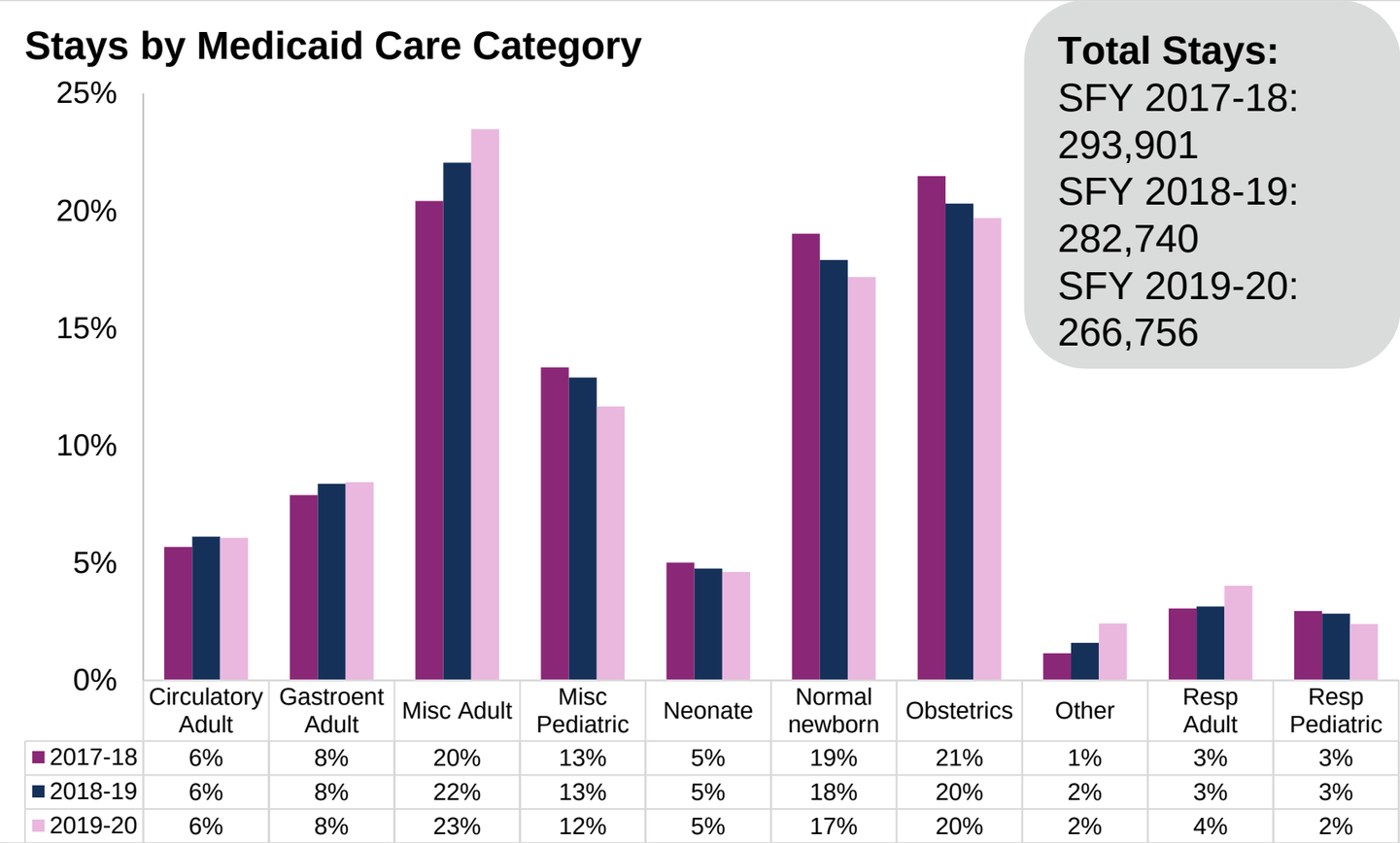
Trends Past SFYs

- Stability, budget neutrality, access-to-care, transparency, and fairness are the guiding principles for policy decision making
- Total hospital stays have been decreasing while payments per stay continue to steadily increase
- Overall increase in more expensive, specialty service stays
- Actual outlier percent to payment ratios are greater than policy simulated results
- Distribution of stays and payments over time is generally similar among Medicaid Care Categories (MCCs)
- 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

- Proportions of stays by MCC from SFY 2017-18 to 2019-20

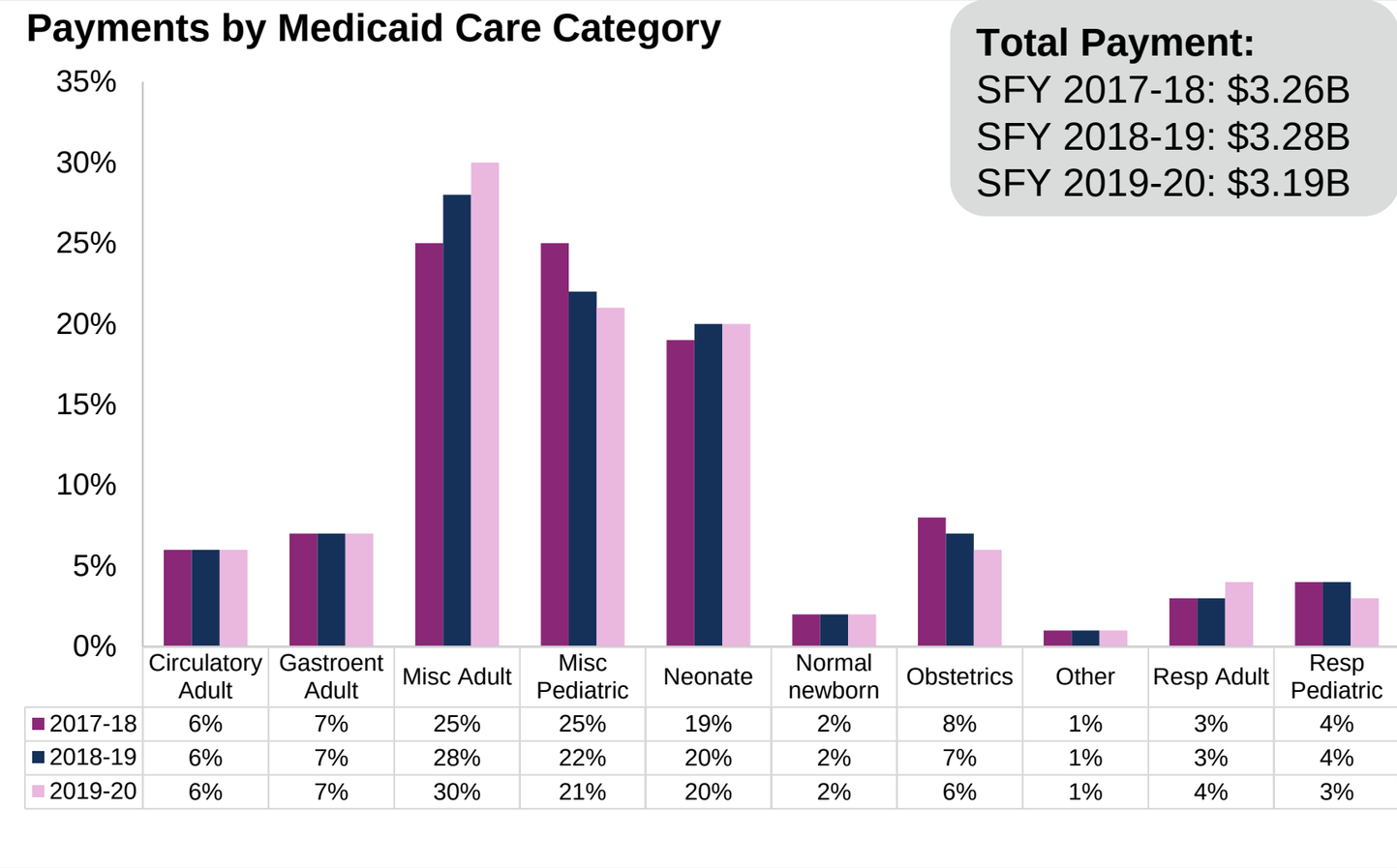


	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2017-18	6%	8%	20%	13%	5%	19%	21%	1%	3%	3%
2018-19	6%	8%	22%	13%	5%	18%	20%	2%	3%	3%
2019-20	6%	8%	23%	12%	5%	17%	20%	2%	4%	2%

Data Source: CAMMIS Production Data | Dates Represented: 7/1/2017 – 6/30/2020 paid through 6/7/2021 | Date Download 6/11/2021

Payment by Medicaid Care Category

- Payment distribution by MCC from SFY 2017-18 to 2019-20

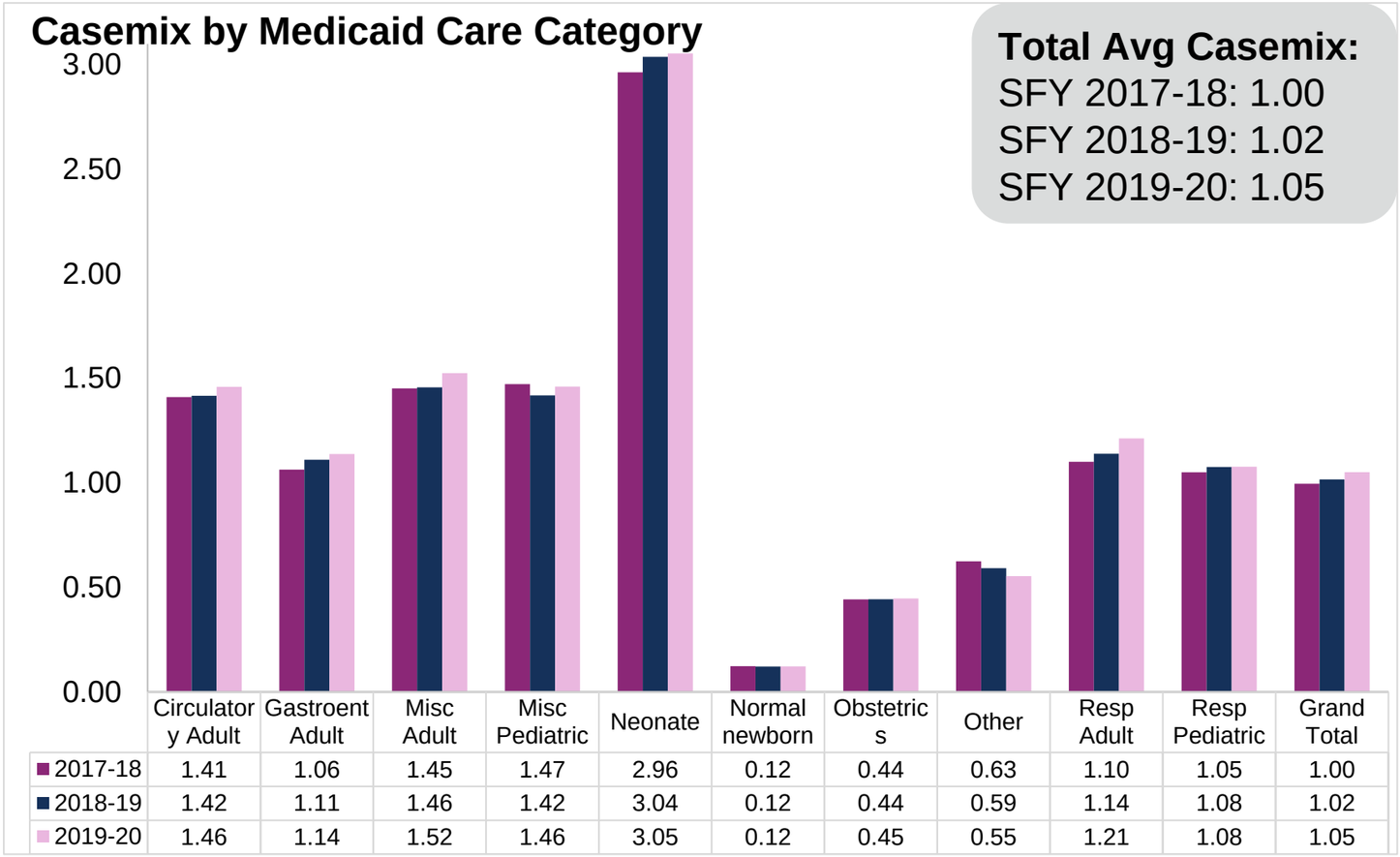


	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
2017-18	6%	7%	25%	25%	19%	2%	8%	1%	3%	4%
2018-19	6%	7%	28%	22%	20%	2%	7%	1%	3%	4%
2019-20	6%	7%	30%	21%	20%	2%	6%	1%	4%	3%

Data Source: CAMMIS Production Data | Dates Represented: 7/1/2017 –6/30/2020 paid through 6/7/2021 | Date Download 6/11/2021

Casemix by Medicaid Care Category

- Actual average hospital casemix from SFY 2017-18 to 2019-20



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric	Grand Total
2017-18	1.41	1.06	1.45	1.47	2.96	0.12	0.44	0.63	1.10	1.05	1.00
2018-19	1.42	1.11	1.46	1.42	3.04	0.12	0.44	0.59	1.14	1.08	1.02
2019-20	1.46	1.14	1.52	1.46	3.05	0.12	0.45	0.55	1.21	1.08	1.05

Data Source: CAMMIS Production Data | Dates Represented: 7/1/2017 – 6/30/2020 paid through 6/7/2021 | Date Download 6/11/2021

SFY 2020-21 Current Experience

SFY 2020-21 Policy Change Summary

No policy changes compared to SFY 2019-20

Technical updates:

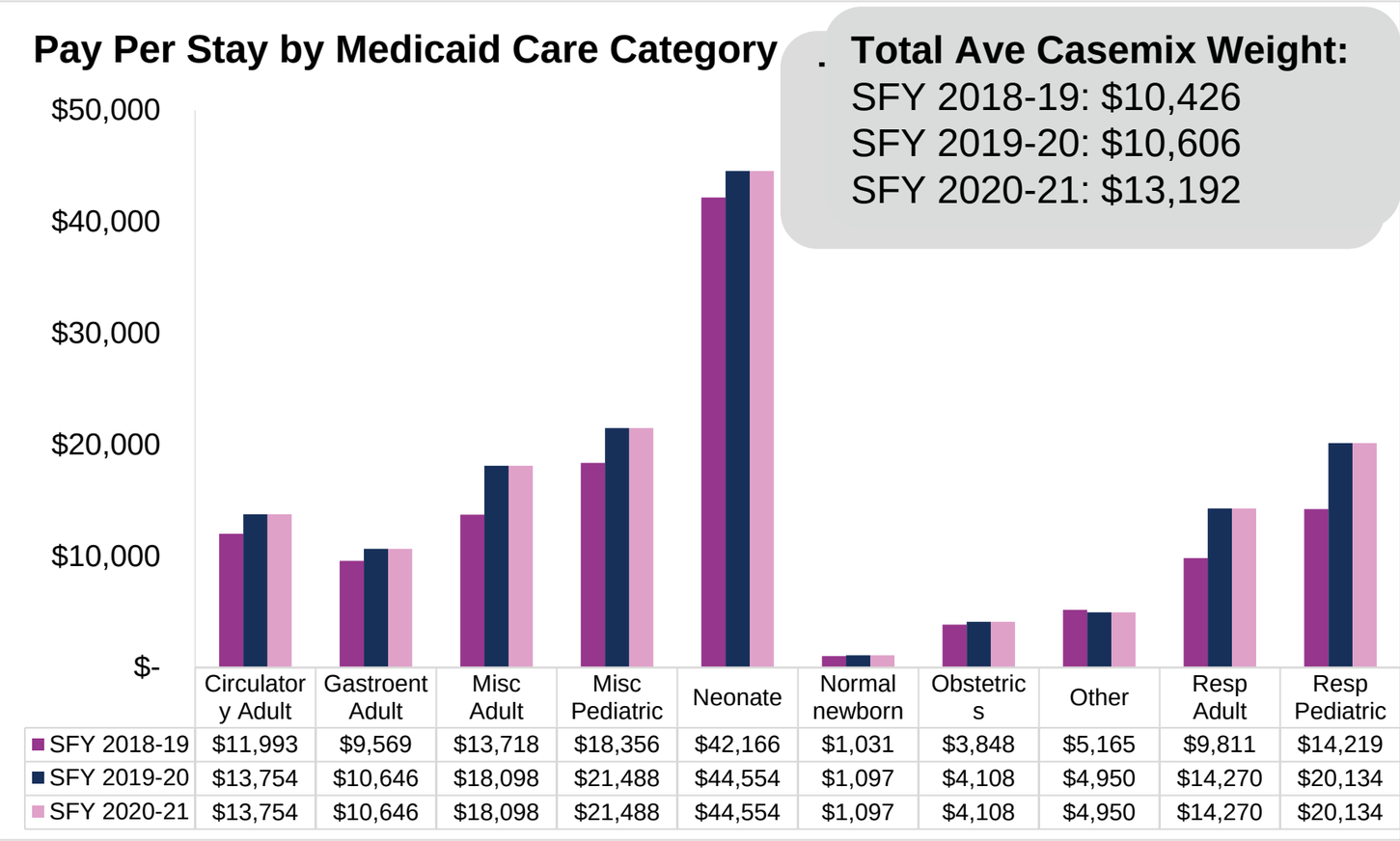
- Updated wage area assignments
- Applied wage area neutrality factor
- Updated cost-to-charge ratios (CCRs)

Changes for SFY 2020-21:

- Increased statewide base rate to $6,596
- Increased Remote Rural base rate to $15,036

SFY 2020-21 Current Payments

- Actual Pay per Stay by Medicaid Care Category from SFY 2018-19 to SFY 2020-21



	Circulatory Adult	Gastroent Adult	Misc Adult	Misc Pediatric	Neonate	Normal newborn	Obstetrics	Other	Resp Adult	Resp Pediatric
SFY 2018-19	$11,993	$9,569	$13,718	$18,356	$42,166	$1,031	$3,848	$5,165	$9,811	$14,219
SFY 2019-20	$13,754	$10,646	$18,098	$21,488	$44,554	$1,097	$4,108	$4,950	$14,270	$20,134
SFY 2020-21	$13,754	$10,646	$18,098	$21,488	$44,554	$1,097	$4,108	$4,950	$14,270	$20,134

Total Ave Casemix Weight:
SFY 2018-19: $10,426
SFY 2019-20: $10,606
SFY 2020-21: $13,192

Data Source: CAMMIS Production Data | DRG Claims Paid SFY 18-19 paid through 6/3/2019 | DRG Claims Paid SFY 19-20 paid through 6/1/2020 | DRG Claims Paid SFY 20-21 paid through 6/7/2021 | Date Download 6/11/2021

SFY 2021-22 Updates

SFY 2021-22 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 38 (V38)
- Base rates increase for statewide and remote rural hospitals
- Slight updates to policy adjustors
- Maintain outlier percent of payment between 13-15%

SFY 2021-22 Policy Decisions

Technical annual updates:

- Wage area index values
- Wage area neutrality factor 0.9588
- CCRs
- Hospital specific relative weights (HSRV) V38
- Re-centered HSRV weights to align with CA population 1.0419

Policy changes from SFY 2020-21 to 2021-22*

- Statewide base rate: $6,941
  - ❑ $345 increase
- Remote rural base rate: $15,091
  - ❑ $55 increase
- Marginal cost percentage used in outlier payment calculation will remain 55%
- Outlier threshold: $67,000
  - ❑ $6,000 increase

Impacts on individual hospitals will depend on actual utilization and casemix

*Subject to federal approval

SFY 2021-22 Overview

- Policy adjustors based on MCC and SOI
- Maintain a higher Designated Neonate payment policy

SOI 1		
MCC	Baseline Adjustor	14 SIM Adjustor
Circulatory Adult	1.00	1.00
Gastroent Adult	1.00	1.00
Misc Adult	1.00	1.00
Misc Pediatric	1.25	1.25
Neonate Des	1.75	1.75
Neonate Std	1.25	1.25
Normal newborn	1.00	1.00
Obstetrics	1.06	1.00
Other	1.00	1.00
Resp Adult	1.00	1.00
Resp Pediatric	1.25	1.25

SOI 2		
MCC	Baseline Adjustor	14 SIM Adjustor
Circulatory Adult	1.00	1.00
Gastroent Adult	1.00	1.00
Misc Adult	1.00	1.00
Misc Pediatric	1.25	1.25
Neonate Des	1.75	1.75
Neonate Std	1.25	1.25
Normal newborn	1.00	1.00
Obstetrics	1.06	1.00
Other	1.00	1.00
Resp Adult	1.00	1.00
Resp Pediatric	1.25	1.25

SOI 3		
MCC	Baseline Adjustor	14 SIM Adjustor
Circulatory Adult	1.00	1.00
Gastroent Adult	1.00	1.00
Misc Adult	1.00	1.00
Misc Pediatric	1.25	1.25
Neonate Des	1.75	1.75
Neonate Std	1.25	1.25
Normal newborn	1.00	1.00
Obstetrics	1.06	1.00
Other	1.00	1.00
Resp Adult	1.00	1.00
Resp Pediatric	1.25	1.25

SOI 4		
MCC	Baseline Adjustor	14 SIM Adjustor
Circulatory Adult	1.10	1.20
Gastroent Adult	1.10	1.15
Misc Adult	1.10	1.20
Misc Pediatric	1.75	1.65
Neonate Des	2.45	2.45
Neonate Std	1.75	1.95
Normal newborn	1.00	1.00
Obstetrics	1.17	1.30
Other	1.00	1.25
Resp Adult	1.10	1.25
Resp Pediatric	1.75	1.75

DRG Carve-Out Updates

Additional carve-out services available in SFY 2021-22

Specialty services or medications available during an inpatient hospital stays but billed as an outpatient service

- Additional blood factors added, including Sevenfact
- The high-cost drug Zolgensma

SFY 2021-22 Updates

Grouper Software Settings

For claims with admission dates on or after July 1, 2021

- Grouper Version 38
- HAC Version 38.1 for California Medicaid
- Entered Code Mapping: Remain on Version 38.1 Mapper
- Mapping Type: Historical for all SFY 2021-22 claims
- Grouper ICD Version Qualifier: The ICD Version Qualifier should be set to “0 ICD-10” in the grouper

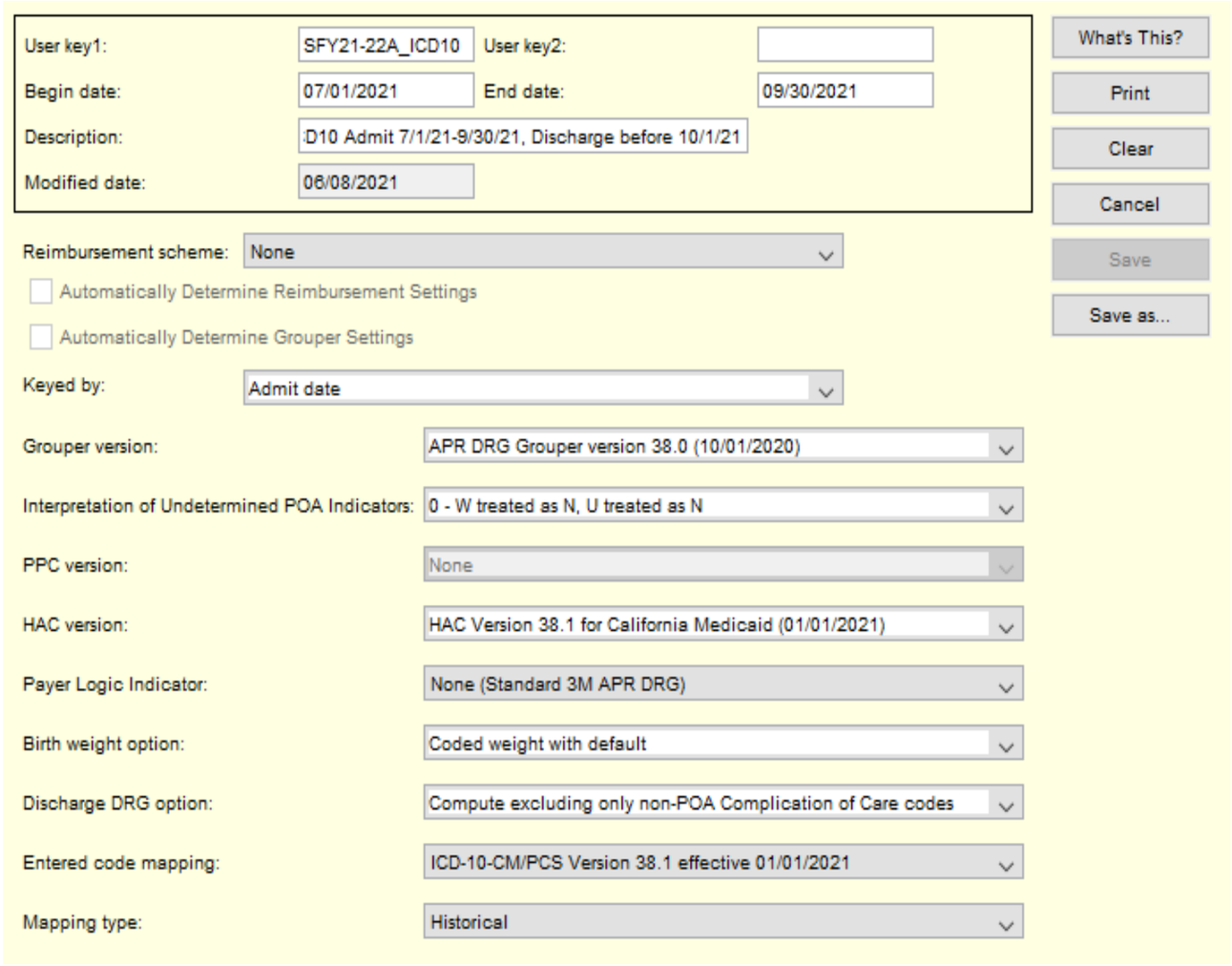
SFY 2021/22 Medi-Cal DRG Claims Grouper Setting Scenarios							
Scenario	Admit Date	Discharge Date	Grouper Version	Mapping	Mapper Version	ICD Version	HAC Version
A	7/1/21 to 9/30/21	Before 10/1/21	38	Historical	38.1	ICD-10 (0)	38.1 for California Medicaid
B	7/1/21 to 6/30/22	On or after 10/1/21	38	Historical	TBD	ICD-10 (0)	TBD

Grouper Software Settings

SFY 2021-22 DRG admit date on or after 7/1/21

- The Mapper and HAC will subsequently be updated for discharges on or after 10/1/21

- The complete SFY 2021-22 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.



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 2019 were provided to SNFD in November 2020 and used for rate setting for SFY 2021-22
- 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

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

Timeline – 36 months 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.

What Cost Report Periods are Used

Cost Reports Used to Determine the Paid CCR:

- DRG SFY 2016-17 – Cost Report FYE 2014
- DRG SFY 2017-18 – Cost Report FYE 2015
- DRG SFY 2018-19 – Cost Report FYE 2016
- DRG SFY 2019-20 – Cost Report FYE 2017
- DRG SFY 2020-21 – Cost Report FYE 2018
- DRG SFY 2021-22 – Cost Report FYE 2019

Further Information

Further Information

Reminders for Accurate Billing and Pricing

- Include infant birth weights and gestational age procedure codes on the UB04.
- Vaginal Deliveries (obstetric stays) must include procedure codes (V.38) as well as diagnosis codes or the claim will deny.
- Reference the DRG 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 Medicaid claims processing system is correct.
- Meet treatment and service authorization requirements (TAR/SAR).
- Reference the Medi-Cal Provider Manual.
- Reference Provider Bulletins regarding claims processing 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.

Further Information

Looking Ahead

- 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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