Florida Agency for Health Care Administration

DRG Payment Implementation

Fifth DRG Public Meeting

January 8, 2013

Presentation by MGT of America, Inc. and Navigant Consulting, Inc.

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Meeting Agenda

Agenda	Time
Project Guiding Principles	9:00 – 9:10
Payment Design Decisions	9:10 – 10:00
Pay-to-Cost Changes	10:00 – 10:10
Adjustments from 2010/2011 to 2013/2014	10:10 – 10:20
Changes in Simulations Since Last Public Meeting	10:20 – 10:30
Detailed Results of Simulation 17	10:30 – 11:00
Billing and Authorization Changes	11:00 – 11:05
Health Care Acquired Condition Payment Adjustments	11:05 – 11:10
Interpretation of Individual Hospital Simulation Results	11:10 – 11:20
Public Comment	11:20 – 12:00

Project Guiding Principles

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Project Guiding Principles

Guiding Principles for Evaluating Options	
Efficiency	Is the option aligned with incentives for providing efficient care?
Access	Does the option promote access to quality care, consistent with federal requirements?
Equity	Does the option promote equity of payment through appropriate recognition of resourse intensity and other factors?
Predictability	Does the option provide predictable and transparent payment for providers and the State?
Transparency and Simplicity	Does the option enhance transparency, and contribute to an overall methodology that is easy to understand and replicate?
Quality	Does the option promote and reward high value, quality-driven healthcare services?

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Project Guiding Principles

Other Design Considerations	
Budget Neutrality	Funding is not unlimited – goal for design is to be budget neutral.
Adaptability	Does the option promote adaptability for future changes in utilization and the need for regular updates?
Forward Compatibility	Is the option flexible enough to support payment structures in anticipated future service models?
Policy	Is the option consistent with State and Federal policy priorities?

Payment Design Decisions

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Affected Providers and Services

Design Consideration	Decision
Affected providers	• All inpatient acute care providers except the four state-owned psychiatric facilities
Affected services	• All services at these providers (including psychiatric and rehabilitation), excluding only: ○ Transplants currently paid via global fee – will continue reimbursement via global fee ○ Technical component of newborn hearing test will be paid in addition to DRG payment

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DRGs

Design Consideration	Decision
DRG Grouper	• APR-DRGs - version 30, released 10/1/2012
DRG Relative Weights	• National weights re-centered to 1.0 for Florida Medicaid • Re-centering factor is 0.7614 which is the casemix of the 2010/2011 simulation dataset • For each DRG, the Florida Medicaid relative weight equals [national relative weight / 0.7614] • Florida relative weights for each APR-DRG for 2013/2014 are provided in Appendix G of the DRG Conversion and Implementation Plan available on the AHCA website

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Standard Payment

Design Consideration	Decision
Hospital Base Rates	• One standardized amount • No wage area adjustment • Base rates used to distribute funds from general revenue and Public Medical Assistance Trust Fund
Per-Claim Add-On Payments	• Used to distribute the IGT funds paid on a per-claim basis today • Two add-ons per claim, one for automatic IGTs another for self-funded IGTs • Casemix adjust both supplemental IGT payments on each claim by multiplying the hospital's average per stay IGT payments times (the DRG relative weight / the hospital's casemix) • Example in Appendix A, slide, 52

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Policy Adjustors

Design Consideration	Decision
Targeted Service Adjustors	• Service adjustor for rehabilitation services • Example in Appendix A, slide, 53
Targeted Provider Adjustors	• Rural hospitals • Free-standing long term acute care (LTAC) hospitals • High Medicaid utilization and high outlier hospitals (more than 50% Medicaid utilization – FFS and MC, and more than 30% payments in the form of outliers) • Example in Appendix A, slide, 54
Application of Adjustors	• Select maximum adjustor from all that apply for the hospital stay • Example in Appendix A, slide, 55

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Payment Adjustments

Design Consideration	Decision
Outlier Payment Policy	• Adopt "Medicare-like" stop-loss model • Include a single threshold amount • Apply only to cases where payment is significantly below estimated provider cost (no provider gain outlier adjustment) • Include IGT supplemental payments before determination of outlier payment • Example in Appendix A, slide, 56
Transfer Payment Policy	• Adopt "Medicare-like" model for acute transfers • Discharge statuses applicable to acute transfer policy = 02, 05, 65, 66 • Do not include a post-acute transfer policy • Example in Appendix A, slide, 57

Payment Adjustments, cont'd

Design Consideration	Decision
Non-Covered Days ○ 45-day benefit limit ○ Undocumented non-citizens ○ Medicaid fee-for-service eligibility for part of a stay	• Prorate payment based on number of covered days versus total length of stay • Payment equals [(full DRG payment, including outlier and IGT supplemental payments) * (covered days / length of stay)] • For 45-day benefit limit reduce payment only if none of the days of the stay are covered within the benefit limit. If the limit is not exhausted at time of admission, or additional days are obtained because the stay crosses into a new state fiscal year then full DRG payment applies. • Example in Appendix A, slide, 58

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Payment Adjustments, cont'd

Design Consideration	Decision
Charge Cap	• Include charge cap logic which pays the lessor of Medicaid allowed amount and provider charges (used instead of a hospital gain outlier adjustment) • Apply to DRG payment and IGT supplemental payments • Example in Appendix A, slide, 59

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Policy Decisions

Design Consideration	Decision
Prior Authorizations	• Remove length of stay limitations for admissions that will be reimbursed under the DRG method • Only exception will be recipients who have reached 45 day benefit limit prior to admission and recipients who are undocumented non-citizens
Interim Claims	• Do not allow

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Initial Implementation Decisions

Design Consideration	Decision
Transition Period	• None
Adjustment for Expected Coding and Documentation Improvements	• 6 percent
Adjustment for Real Casemix Increase between 2010/2011 and 2013/2014	• 0.5 percent per year – 1.5 percent for the three years
Total Payment Adjustment for Casemix Difference between Simulation Data and First Year of Implementation	• 7.5 percent

Final Rates*

Parameter	Value*	Goal
Hospital base rate	$ 3,230.64	Budget neutrality for the Medicaid program
Rural provider adjustor	1.733	Pay-to-cost ratio of 100%
LTAC provider adjustor	1.633	Pay-to-cost ratio of 65%
High Medicaid utilization and high outlier provider adjustor	1.762	Pay-to-cost ratio of 95%
Rehabilitation service adjustor	1.30	Free-standing rehab pay-to-cost of 50%
Outlier threshold	$ 31,000	Overall outlier payment percentage between 5 and 10%
Outlier marginal cost factor	80%	Overall outlier payment percentage between 5% and 10%

* All rates subject to change based on updates from the Social Service Estimating Conference and direction from legislature.

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Pay-to-Cost Changes

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Pay-to-Cost Changes

CCRs Calculated for Previous Simulations

FL Hosp Cost Calc Worksheets 2010-07-01.pdf - Adobe Reader

File Edit View Window Help

3 / 320 129% Comment Share

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Office of Medicaid Cost Reimbursement Planning and Analysis

Computation of Hospital Prospective Payment Rates

For Rate Semester July 1,2010 through December 31, 2010

100030 - 2010/07
1,989.44 / 209.62

Shands Teaching Hospital

Type of Control: Non-Profit (Other) (3) — County: Alachua (1)

Fiscal Year : 7/1/2008-6/30/2009 — Type of Action: Unaudited Cost Report [1] — District: 3

Hospital Classification: Specialized: Statutory Teaching

	Total		Medicaid	
Type of Cost/Charges	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)
1. Ancillary	429,957,687.00	201,148,011.00	71,309,770.00	27,793,948
2. Routine	169,713,866.00		31,875,094.00	
3. Special Care	91,886,639.00		8,754,532.00	
4. Newborn Routine	18,170,724.00		13,599,262.00	
5. Intern-Resident	0.00		0.00	
6. Home Health				
7. Malpractice				
8. Adjustments	-8,969,371.24	-2,542,056.76	-1,586,525.23	-351,252.76
9. Total Cost	700,759,544.76	198,605,954.24	123,952,132.77	27,442,695.24
10. Charges	1,694,121,700.00	693,605,151.00	284,012,065.00	84,988,899.00
11. Fixed Costs	58,720,210.00		9,844,185.40	

Statistics (E)	
Total Bed Days	315,795
Total Inpatient Days	248,139
Total Newborn Days	22,763
Medicaid Inpatient Days	42,223
Medicaid Newborn IP Days	12,523
Medicare Inpatient Days	89,980
Prospective Inflation factor	1.0515406162
Medicaid Paid Claims	119,939
Property Rate Allowance	0.80
First Semester in effect:	2010/07
Last Rate Semester in Effect:	2010/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation/FPLI Data (H)	
1. Normalized Rate	2,485.81	272.88	County Ceiling Base	Exempt	Exempt	Semester DRI Index	1.8770
2. Base Rate Semester	2010/01	2010/01	Variable Cost Base	Exempt	Exempt	Cost Report DRI Index	1.785
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,617.92	189.45	FPLI Year Used	2008
4. Rate of Increase (Year/Sem.)	1.011969	1.008253	County Ceiling	1,426.52	167.04	FPLI	0.8817

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Total Medicaid Cost	123,952,132.77	27,442,695.24
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	(-) 9,844,185.40	

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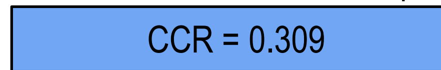
CCRs Calculated for Latest Simulations

7/1/2010 6/30/2011

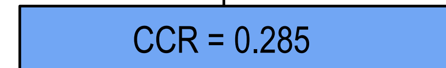
Date Range of DRG Simulation Dataset

10/1/2009 9/30/2010

Example Hospital Cost Reports
(based on hospital fiscal year)



10/1/2010 9/30/2011



Claim 1: admission date 8/15/2010; CCR = 0.309

8/15/2010

Claim 2: admission date 2/10/2011; CCR = 0.285

2/10/2011

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New Pay-to-Cost Figures[1]

Category	2010/2011 Previously Reported	Goal, Previous Simulatns	2010/2011 Newly Calc'd	Goal, Newer Simulatns	2013/2014 Estimate[2]	Goal, Latest Simulatns
Florida Medicaid, overall	83%	83%	91%	91%	88%	88%
Rural hospitals	85%	85%	98%	98%	114%	100%
LTAC hospitals	55%	60%	66%	66%	61%	65%
Rehabilitation hospitals	50%	60%	54%	60%	46%	50%
High Medicaid utilization and high outlier percentage hospitals (free-standing children's hospitals)	86%	86%	97%	95%	99%	95%
Obstetric services	94%	85%	104%	>= 91%	99%	>= 88%

[1] More detail is available in Appendix B – Dataset Summary

[2] Costs inflated; payments calculated using 2012/2013 per diem rates, then increased slightly to align with projections presented at November 2012 SSEC

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Adjustment from 2010/2011 to 2013/2014

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Cost

Cost

- Applied a single multiplier to all claims to increase the estimated cost values from the midpoint of SFY 10/11 to the midpoint of SFY 12/13
- Used Global Insight healthcare market basket indices to determine inflation factor
- Value used was 1.07769

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Payments

Payments

1. Started with 2012/2013 per diem rates
2. Applied 2% inflationary increase to state share
3. Added $50 million to self-funded IGT amounts
4. Multiplied full historical allowed amount by the percentage change in per diem rate applicable to each provider (For example, if a provider's per diem increased by 10% between 10/11 and 12/13, then all the provider's historical allowed amounts were increased by 10%.)
5. Multiplied this new adjusted allowed amount by 2012/2013 percentages for state share, automatic IGTs, and self-funded IGTs
6. Made small additional increase to align with projections made at November 2012 Social Services Estimating Conference

Payments, cont'd

Inpatient Reimbursement Estimates for 2013/2014				
	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Total
Estimating conf nbrs for 2013/2014 *	$ 1,975,206,378	$ 622,159,318	$ 762,775,396	$ 3,360,141,092
Estimate 13/14 minus 10.5% **	$ 1,767,809,708	$ 556,832,590	$ 682,683,980	$ 3,007,326,277
Minus addition 3% to align with simul dataset	$ 1,714,775,417	$ 540,127,612	$ 662,203,460	$ 2,691,557,018
Simul dataset nbrs for 13/14 after steps 1 - 5 ***	$ 1,627,975,470	$ 516,136,317	$ 600,396,850	$ 2,744,508,638
Short fall in simulation dataset	$ 86,799,947	$ 23,991,295	$ 61,806,610	$ 172,597,851
Simul dataset nbrs for 13/14 after step 6 ***	$ 1,714,775,417	$ 540,127,612	$ 662,203,460	$ 2,917,106,489

Notes:

* From November 2012 Social Services Estimating Conference

** 10.5% more Medicaid days estimate in 2013/2014 than in 2010/2011; 1,811,047 ==> 2,001,336

*** Referring to steps on previous slide

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Changes in Simulations Since Last Public Meeting

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Changes in Simulations Since Last Public Meeting

- Updated cost-to-charge ratios, which affected pay-to-cost goals and outlier calculations
- Removed wage index adjustment to base rate
- Regrouped with version 30 APR-DRGs (released 10/1/2012)
- Changed provider adjustor for free-standing rehabilitation hospitals to a service adjustor for rehabilitation services
- Reduced payment for undocumented non-citizens with non-covered days
- Applied a maximum policy adjustor instead of all adjustors
- Removed obstetric service adjustor
- Replaced provider gain outlier logic with charge cap
- Inflated costs from 2010/2011 to 2013/2014
- Applied budget estimates from Nov 2012 SSEC

Affected Providers and Services

Simulation Number	Description	Base Rate	Outlier Percentage
5	Presented at 11/15/2012 DRG Public Meeting	$3131.73	8.5%
14*	Last simulation with 2010/2011 dollars – includes all policy decisions	$3,611.75	7.4%
16**	2013/2014 dollars, 2010/2011 casemix	$3,472.94	7.7%
17	2013/2014 dollars and casemix	$3,230.64	7.7%

* More detail is available in Appendix C – Simulation 14

** More detail is available in Appendix D – Simulation 16

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Detailed Results of Simulation 17

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Detailed Results of Simulation 17

Calculation of Budget Goals by Provider Category

	A	B	C	D	E	F	G	H	I
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Estimated Cost	Percentage of Cost Goal	Total Budget Goal with IGTs	DRG Reimbursement from GR and PMATF
1	Rural	11,140	$ 50,266,032	$ 6,556,021	$ 303,015	$ 50,108,442	100%	$ 50,108,442	**$ 43,249,407**
2	LTAC	86	$ 1,365,292	$ -	$ 283,076	$ 2,688,734	65%	$ 1,747,677	**$ 1,464,601**
3	High Medicaid & High Outlier	9,229	$ 142,780,176	$ 45,760,831	$ 1,864,429	$ 190,763,390	95%	$ 181,225,220	**$ 133,599,960**
4	All Other	397,552	$1,520,363,917	$487,810,761	$ 659,752,940	$3,079,379,988			**$1,536,461,450**
5									
6	**Totals:**	418,007	$1,714,775,417	$540,127,612	$ 662,203,460				
7									
8				Total Budgeted Payment:	$ 2,917,106,490				

Notes:

1) For rural, LTAC, and high-Medicaid-high-outlier hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals a percentage of estimated cost minus any per-claim payments being made via IGTs. For example, I1 = [H1 - (D1 + E1)].

2) For "All Other" hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals the total historical allowed amount from GR and assessment minus the total planned DRG reimbursement from GR and assessment for rural, LTAC, and high-Medicaid-high-outlier hospitals.
I4 = [C6 - (I1 + I2 + I3)].

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Detailed Results of Simulation 17

Simulation 17 Parameters

DRG Payment Simulation 17					
Simulation Parameters	Value - Overall	Value - All Other Hospitals	Value - Rural Hospitals	Value - LTAC Hospitals	Value - High Medicaid High Outlier Hospitals
Baseline payment, total	$2,917,106,490	$2,667,927,618	$57,125,068	$1,648,369	$190,405,436
Baseline payment, general revenue and PMATF	$1,714,775,417	$1,520,363,917	$50,266,032	$1,365,292	$142,780,176
Baseline payment, automatic IGTs	$540,127,612	$487,810,761	$6,556,021	$0	$45,760,831
Baseline payment, self-funded IGTs	$662,203,460	$659,752,940	$303,015	$283,076	$1,864,429
Simulation payment goal	$2,917,106,490	$2,684,025,151	$50,108,442	$1,747,677	$181,225,220
Simulation payment, result	$2,898,138,683	$2,666,405,325	$49,945,678	$1,747,615	$180,040,065
Difference	-$18,967,807	-$17,619,826	-$162,764	-$62	-$1,185,155
Simulation payment, general revenue and PMATF	$1,714,776,958	$1,536,461,792	$43,256,715	$1,464,538	$133,593,912
Simulation payment,automatic IGTs	$531,841,221	$480,812,252	$6,391,896	$0	$44,637,073
Simulation payment, self-funded IGTs	$651,520,504	$649,131,281	$297,066	$283,077	$1,809,080
DRG base price	$3,230.64	$3,230.64	$3,230.64	$3,230.64	$3,230.64
Cost outlier pool (percentage of total payments)	7.7%	7%	1%	7%	20%
Wage index adjustment of base price	None				
Policy adjustor - Provider	n/a	None	1.733	1.633	1.762
Policy adjustor - DRG (service)	Rehabilitation - 1.3				
Policy adjustor - Age	None				
Documentation & coding adjustment	7.5% - 1.5% for real casemix change and 6% for documentation and coding improvement				
Relative weights	APR v.30 national re-centered to 1.0 for FL Medicaid				
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost (MC) percentage	$31,000 80%				
Low side (provider gain) threshold and marginal cost (MC) percentage	None				
Charge Cap	Yes - adjusting state share and IGT payments				
Undocumented non-citizen non-covered day adjustment	Yes - adjusting state share and IGT payments				

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Summary by Service Line - Total

Simulation 17 Summary of Simulation by Service Line												
Service Line	Stays	Casemix Recentered	Casemix DCI	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,745	1.70	1.83	$ 1,049,338,607	$ 758,939,658	$ 860,110,424	$ 101,170,765	13%	72%	82%	$ 73,775,242	9%
Neonate	11,641	4.10	4.41	$ 382,962,880	$ 460,717,205	$ 372,611,823	$ (88,105,382)	-19%	120%	97%	$ 58,184,376	16%
Obstetrics	111,700	0.57	0.62	$ 463,395,877	$ 457,674,917	$ 408,328,621	$ (49,346,296)	-11%	99%	88%	$ 2,624,619	1%
Pediatric	46,320	1.11	1.19	$ 419,469,726	$ 402,818,179	$ 407,201,120	$ 4,382,941	1%	96%	97%	$ 46,299,537	11%
Gastroent Adult	27,910	1.34	1.44	$ 315,005,545	$ 226,189,382	$ 242,541,742	$ 16,352,359	7%	72%	77%	$ 12,795,008	5%
Circulatory Adult	24,525	1.69	1.81	$ 323,051,525	$ 176,606,751	$ 267,428,406	$ 90,821,655	51%	55%	83%	$ 13,902,964	5%
Resp Adult	18,092	1.31	1.40	$ 198,943,694	$ 162,254,933	$ 153,613,165	$ (8,641,768)	-5%	82%	77%	$ 9,628,006	6%
Normal newborn	90,713	0.16	0.18	$ 80,677,975	$ 113,891,255	$ 94,444,109	$ (19,447,146)	-17%	141%	117%	$ 1,180,581	1%
Mental Health	12,442	0.68	0.73	$ 43,551,130	$ 104,004,283	$ 49,897,929	$ (54,106,355)	-52%	239%	115%	$ 255,998	1%
Rehab	1,787	1.92	2.07	$ 27,785,993	$ 42,432,034	$ 24,782,163	$ (17,649,871)	-42%	153%	89%	$ 697,808	3%
Transplant Pediatric	51	14.60	15.69	$ 11,402,025	$ 7,036,233	$ 10,383,257	$ 3,347,024	48%	62%	91%	$ 4,109,176	40%
Transplant Adult	81	10.49	11.27	$ 7,355,577	$ 4,541,658	$ 6,795,925	$ 2,254,268	50%	62%	92%	$ 707,303	10%
Total	**418,007**	**1.00**	**1.075**	**$ 3,322,940,554**	**$ 2,917,106,490**	**$ 2,898,138,683**	**$ (18,967,807)**	**-1%**	**88%**	**87%**	**$ 224,160,618**	**8%**

Notes:
1) "Transplant" includes only those cases paid per diem, not through the global period.
2) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

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Detailed Results of Simulation 17

Pay-to-Cost by Service Line - Total

Simulation 17
Pay-to-Cost Ratio by Service Line

Legend: Baseline Pay-to-Cost; Simulation Pay-to-Cost

Statewide average is 88%.

Y-axis: Pay-to-Cost Ratio (0%, 50%, 100%, 150%, 200%, 250%)
X-axis: Service Line

Service Line	Baseline Pay-to-Cost	Simulation Pay-to-Cost
Misc Adult	72%	82%
Neonate	120%	97%
Obstetrics	99%	88%
Pediatric	96%	97%
Gastroent Adult	72%	77%
Circulatory Adult	55%	83%
Resp Adult	82%	77%
Normal newborn	141%	117%
Mental Health	239%	115%
Rehab	153%	89%
Transplant Pediatric	62%	91%
Transplant Adult	62%	92%

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Detailed Results of Simulation 17

Change in Payment by Service Line

Simulation 17
Percent Change in Reimbursement by Service Line

Service Line	Percent Change in Reimbursement
Misc Adult	13%
Neonate	-19%
Obstetrics	-11%
Pediatric	1%
Gastroent Adult	7%
Circulatory Adult	51%
Resp Adult	-5%
Normal newborn	-17%
Mental Health	-52%
Rehab	-42%
Transplant Pediatric	48%
Transplant Adult	50%

Y-axis: Percent Change in Reimbursement (60%, 40%, 20%, 0%, -20%, -40%, -60%)
X-axis: Service Line

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Detailed Results of Simulation 17

Summary by Provider Category

Simulation 17 Summary of Simulation by Provider Category												
Provider Category	Stays	Casemix Recentered	Casemix DCI	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,620	0.99	1.07	$ 3,211,965,823	$ 2,860,291,083	$ 2,826,600,355	$ (33,690,727)	-1%	89%	88%	$ 217,492,088	8%
Trauma	167,942	1.19	1.28	$ 1,719,730,833	$ 1,730,385,472	$ 1,626,314,308	$ (104,071,163)	-6%	101%	95%	$ 149,525,983	9%
Statutory Teaching	98,530	1.19	1.28	$ 1,089,986,603	$ 1,067,045,755	$ 967,357,200	$ (99,688,555)	-9%	98%	89%	$ 93,386,255	10%
High Charity	112,464	0.91	0.98	$ 788,454,451	$ 657,824,339	$ 678,185,504	$ 20,361,166	3%	83%	86%	$ 44,582,831	7%
Public	76,884	0.96	1.03	$ 555,580,178	$ 587,410,570	$ 577,475,907	$ (9,934,664)	-2%	106%	104%	$ 32,244,987	6%
General Acute	123,619	0.88	0.94	$ 741,748,703	$ 523,577,680	$ 588,367,061	$ 64,789,382	12%	71%	79%	$ 30,268,415	5%
CHEP	75,786	1.01	1.09	$ 573,978,730	$ 475,370,010	$ 494,713,908	$ 19,343,899	4%	83%	86%	$ 33,861,041	7%
Children	9,263	1.79	1.93	$ 191,573,836	$ 190,581,597	$ 180,245,623	$ (10,335,975)	-5%	99%	94%	$ 35,439,967	20%
Rural	11,140	0.66	0.71	$ 50,108,442	$ 57,125,068	$ 49,945,678	$ (7,179,390)	-13%	114%	100%	$ 391,489	1%
Rehabilitation	525	1.85	1.99	$ 8,428,885	$ 3,915,175	$ 4,343,021	$ 427,846	11%	46%	52%	$ 201,899	5%
Long Term Acute Care	86	2.87	3.09	$ 2,688,734	$ 1,648,369	$ 1,747,615	$ 99,246	6%	61%	65%	$ 116,898	7%
Out of state	412	1.22	1.31	$ 2,792,935	$ 1,074,871	$ 1,757,629	$ 682,758	64%	38%	63%	$ 25,840	1%

Notes:

1) Providers may be included in more than one category.

2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.

3) "General Acute" hospitals are those not otherwise categorized as Childrens, CHEP, High Charity, LTAC, Out of state, Rehab, Rural, Teaching or Trauma.

4) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

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Pay-to-Cost by Provider Category

Simulation 17
Pay-to-Cost Ratio by Provider Category

Simulted statewide average is 88%.

Provider Category	Baseline Pay-to-Cost	Simulation Pay-to-Cost
LIP	89%	88%
Trauma	101%	95%
Statutory Teaching	98%	89%
High Charity	83%	86%
Public	106%	104%
General Acute	71%	79%
CHEP	83%	86%
Children	99%	94%
Rural	114%	100%
Rehabilitation	46%	52%
Long Term Acute Care	61%	65%
Out of state	38%	63%

Y-axis: Pay to Cost Ratio (0%–120%); X-axis: Provider Category

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Detailed Results of Simulation 17

Change in Payment by Provider Category

Simulation 17
Percent Change in Reimbursement by Provider Category

Provider Category	Percent Change in Reimbursement
LIP	-1%
Trauma	-6%
Statutory Teaching	-9%
High Charity	3%
Public	-2%
General Acute	12%
CHEP	4%
Children	-5%
Rural	-13%
Rehabilitation	11%
Long Term Acute Care	6%
Out of state	64%

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Detailed Results of Simulation 17

Pay-to-Cost Comparison – IGT vs. non-IGT Providers

Simulation 17
Pay-to-Cost Comparison - IGT and non-IGT Providers

■ Baseline ■ Simulation

Pay to Cost

	Baseline	Simulation
Providers Receiving Per Claim IGTs	0.93	0.91
Providers Not Receiving Per Claim IGTs	0.42	0.56

1.00 0.90 0.80 0.70 0.60 0.50 0.40 0.30 0.20 0.10 0.00

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Detailed Results of Simulation 17

Provider Impact – All Hospitals

Simulation 17 - Hospital Payment Changes
All Participating Hospitals

Percent Change in Medicaid Reimbursement	Number of Hospitals
Reduction 50%+	5
Reduction 20 - 50%	15
Reduction 10 - 20%	12
Reduction 5 - 10%	15
Reduction 0 - 5%	20
Increase 0 - 5%	22
Increase 5 - 10%	19
Increase 10 - 20%	45
Increase 20 - 50%	43
Increase 50%+	33

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Detailed Results of Simulation 17

Provider Impact – Hospitals with > 5% Medicaid

Simulation 17 - Hospital Payment Changes
Hospitals with More Than 5% Utilization

Percent Change in Medicaid Reimbursement	Number of Hospitals
Reduction 50%+	1
Reduction 20 - 50%	9
Reduction 10 - 20%	7
Reduction 5 - 10%	13
Reduction 0 - 5%	19
Increase 0 - 5%	22
Increase 5 - 10%	16
Increase 10 - 20%	40
Increase 20 - 50%	30
Increase 50%+	14

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Detailed Results of Simulation 17

Provider Impact – Hospitals with > 11% Medicaid

Simulation 17 - Hospital Payment Changes
Hospitals with More Than 11% Utilization

Percent Change in Medicaid Reimbursement	Number of Hospitals
Reduction 50%+	1
Reduction 20 - 50%	6
Reduction 10 - 20%	5
Reduction 5 - 10%	11
Reduction 0 - 5%	13
Increase 0 - 5%	13
Increase 5 - 10%	8
Increase 10 - 20%	22
Increase 20 - 50%	14
Increase 50%+	4

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Billing and Authorization Changes

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Billing and Authorization Changes

- Separate claims must always be submitted for birth of newborns (recipient is the baby) and associated delivery (recipient is the mother)
- Present On Admission (POA) indicators (billed with diagnosis codes) will become required data elements
- Patient must be discharged before claim is submitted (interim claims will no longer be accepted)
- On most stays, prior authorization will be required only for the admission, not for the length of stay

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Health Care Acquired Condition Payment Adjustments

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Current Method

- Statute: “The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions …”
- Providers self report by identifying a number of non-covered days resulting from a HCAC

or

- HCAC identified through post payment review by QIO and “… days are identified that are associated with a lengthened stay due to a PPC.”

Note: PPC is a “Potentially Preventable Condition” and is synonymous with a HCAC in this context.

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Using DRGs - Example with Payment Adjustment

Diag Code	Description	POA Indicator	HCAC?
715.35	Loc osteoarth NOS-pelvis	Y	N
820.20	Trochanteric fx NOS-clos	**N**	**Y**

HCAC Category: 05 - Falls and Trauma

DRG Assignment

Using	Code	Relative Weight
Both diagnosis codes	351-2	0.5911
Ignoring the HCAC diagnosis code	**351-1**	**0.4634**

Price: Base rate * relative weight = $3,100 * **0.4634** = $1,437

Savings: [1 – (RW_2 / RW_1)]* Price = (1 - 0.4634 / 0.5911) * 1,437 = **$554**

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Using DRGs - Example without Payment Adjustment

Code	Type	Description	POA Indicator	HCAC?
806.4	Diag	Cl lumbar fx w cord inj	Y	N
998.59	Diag	Other postop infection	**N**	**Y**
81.05	Proc	Drsl/dslmb fus post/post		

HCAC Category: 12 - Surgical site infection

DRG Assignment

Using	Code	Relative Weight
Both diagnosis codes	023-2	2.0907
Ignoring the HCAC diag and proc	023-2	2.0907

Price: Base rate * relative weight = $3,100 * 2.0907 = $6,481

Savings: **$0**

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Interpretation of Individual Hospital Simulation Results

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What Simulation does NOT Indicate

- Purpose of DRG simulation is to determine base rate and other DRG pricing parameters
- Simulation results are NOT intended as a prediction of total Medicaid reimbursement in 2013/2014
- Simulation dataset does NOT reflect Medicaid volume for 2013/2014 (eligibility changes)
- Even for 2010/2011, the simulation dataset is missing some claims that were intentionally dropped because they did not represent complete hospital stays

How DRG Simulation Can be Used

- Hospitals can apply DRG simulation percent payment change to their own estimates of total Medicaid reimbursement under the per diem method to estimate total reimbursement under DRG payment method
- Hospitals may also estimate total Medicaid reimbursement under the DRG method using the following formula:

Total Reimb = (1 + hospital prcnt pymt from outliers)
* hospital Medicaid volume
* hospital DCI casemix
* base rate

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Public Comment

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Appendix A – Claim Pricing Examples

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Example per claim distribution of IGT funds

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Florida Medicaid DRG Pricing Calculator

Note: **Specific policy values included are for purposes of illustration only.**

Indicates data to be input by the user | *Indicates payment policy parameters set by Medicaid*

Row	Information	Data	Comments or Formula
6	**INFORMATION FROM THE HOSPITAL**		
7	Submitted charges	$44,039.00	UB-04 Field Locator 47 minus FL 48
8	Length of stay	3	Used for transfer pricing and covered days adjustments
9	Medicaid covered days	3	Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)	No	Used for transfer pricing adjustment
11	Patient age (in years)	65	Used for age adjustor
12	Other health coverage	$0.00	UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost	$0.00	Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio	40.34%	Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt	$3,447.88	
16	Hospital average per discharge self-funded IGT add on pymt	$1,304.49	
17	Hospital casemix	1.4432	Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category	All Other	From drop down list - used to determine provider policy adjustor
19	APR-DRG	302-2	From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**		
21	DRG standardized base rate	$3,600	Used for DRG base payment
22	Cost outlier threshold	$27,425	Used for cost outlier adjustments
23	Marginal cost percentage	80%	Used for cost outlier adjustments
24	Casemix adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor	18	
26	**APR-DRG INFORMATION**		
27	APR-DRG description	KNEE JOINT REPLACEMENT	Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid	2.2224	Look up from DRG table
29	Service adjustor	1.000	Look up from DRG table
30	Age adjustor	1.000	Look up from DRG table
31	Average length of stay for this APR-DRG	3.35	Look up from DRG table
32	**HOSPITAL INFORMATION**		
33	Provider adjustor	1.000	Look up from provider adjustor table
34	**DRG BASE PAYMENT**		
35	Maximum policy adjustor	1.000	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment	$8,000.67	E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**		
38	Is a transfer adjustment potentially applicable?	No	IF E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount	N/A	IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?	N/A	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment	$8,000.67	IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**		
43	IGT casemix adjustor	1.54	E28 / E17
44	Full stay automatic IGT add-on payment	$5,309.45	E15 * E43
45	Full stay self-funded IGT add-on payment	$2,008.81	E16 * E43
46	Pre outlier payment amount	$15,318.93	E41 + E44 + E45
47	**COST OUTLIER**		
48	Estimated cost of the stay	$17,765.33	E7 * E14
49	Does this claim require an outlier payment?	No	IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case	N/A	IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase	$0.00	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**		
53	Are covered days less than length of stay	No	IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor	1.0000	IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment	$8,000.67	E41 * E54
56	NCD Adjusted outlier payment	$0.00	E51 * E54
57	NCD Adjusted automatic IGT add-on payment	$5,309.45	E44 * E54
58	NCD Adjusted self-funded IGT add-on payment	$2,008.81	E45 * E54
59	Pre-charge cap allowed amount	$15,318.93	E55 + E56 + E57 + E58
60	**CHARGE CAP**		
61	Does the charge cap apply?	No	IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor	1.0000	IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment	$8,000.67	E55 * E62
64	Final outlier payment	$0.00	E56 * E62
65	Final DRG payment	$8,000.67	E63 + E64
66	Final automatic IGT add-on payment	$5,309.45	E57 * E62
67	Final self funded IGT add-on payment	$2,008.81	E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**		
69	Allowed amount	$15,318.93	E65 + E66 + E67
70	Other health coverage	$0.00	E12
71	Patient share of cost	$0.00	E13
72	Payment amount	**$15,318.93**	IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012		

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

	C	D	E	F	G
1	C	D	E	F	G
2	**Florida Medicaid DRG Pricing Calculator**				
3	***Note:*** **Specific policy values included are for purposes of illustration only.**				
4	***Indicates data to be input by the user***				***Indicates payment policy parameters set by Medicaid***
5	**Information**		**Data**		**Comments or Formula**
6	**INFORMATION FROM THE HOSPITAL**				
7	Submitted charges		$62,435.30		UB-04 Field Locator 47 minus FL 48
8	Length of stay		18		Used for transfer pricing and covered days adjustments
9	Medicaid covered days		18		Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)		No		Used for transfer pricing adjustment
11	Patient age (in years)		55		Used for age adjustor
12	Other health coverage		$0.00		UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost		$0.00		Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio		37.02%		Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt		$4,916.26		
16	Hospital average per discharge self-funded IGT add on pymt		$1,189.85		
17	Hospital casemix		1.2448		Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category		All Other		From drop down list - used to determine provider policy adjustor
19	APR-DRG		860-3		From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**				
21	DRG standardized base rate		$3,600		Used for DRG base payment
22	Cost outlier threshold		$27,425		Used for cost outlier adjustments
23	Marginal cost percentage		80%		Used for cost outlier adjustments
24	Casemix adjustment factor		1.00		Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor		18		
26	**APR-DRG INFORMATION**				
27	APR-DRG description		REHABILITATION		Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid		2.1072		Look up from DRG table
29	Service adjustor		1.350		Look up from DRG table
30	Age adjustor		1.000		Look up from DRG table
31	Average length of stay for this APR-DRG		14.79		Look up from DRG table
32	**HOSPITAL INFORMATION**				
33	Provider adjustor		1.000		Look up from provider adjustor table
34	**DRG BASE PAYMENT**				
35	Maximum policy adjustor		1.350		IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment		$10,241.11		E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**				
38	Is a transfer adjustment potentially applicable?		No		If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount		N/A		IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?		N/A		IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment		$10,241.11		IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**				
43	IGT casemix adjustor		1.69		E28 / E17
44	Full stay automatic IGT add-on payment		$8,322.35		E15 * E43
45	Full stay self-funded IGT add-on payment		$2,014.20		E16 * E43
46	Pre outlier payment amount		$20,577.66		E41 + E44 + E45
47	**COST OUTLIER**				
48	Estimated cost of the stay		$23,113.55		E7 * E14
49	Does this claim require an outlier payment?		No		IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case		N/A		IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase		$0.00		IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**				
53	Are covered days less than length of stay		No		IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor		1.0000		IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment		$10,241.11		E41 * E54
56	NCD Adjusted outlier payment		$0.00		E51 * E54
57	NCD Adjusted automatic IGT add-on payment		$8,322.35		E44 * E54
58	NCD Adjusted self-funded IGT add-on payment		$2,014.20		E45 * E54
59	Pre-charge cap allowed amount		$20,577.66		E55 + E56 + E57 + E58
60	**CHARGE CAP**				
61	Does the charge cap apply?		No		IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor		1.0000		IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment		$10,241.11		E55 * E62
64	Final outlier payment		$0.00		E56 * E62
65	Final DRG payment		$10,241.11		E63 + E64
66	Final automatic IGT add-on payment		$8,322.35		E57 * E62
67	Final self funded IGT add-on payment		$2,014.20		E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**				
69	Allowed amount		$20,577.66		E65 + E66 + E67
70	Other health coverage		$0.00		E12
71	Patient share of cost		$0.00		E13
72	Payment amount		**$20,577.66**		IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012				

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

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Example service adjustor

Example provider adjustor – rural hospital

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#	C	D	E	F	G
1					
2	**Florida Medicaid DRG Pricing Calculator**				
3	*Note:* Specific policy values included are for purposes of illustration only.				
4	*Indicates data to be input by the user*				*Indicates payment policy parameters set by Medicaid*
5	**Information**		**Data**		**Comments or Formula**
6	**INFORMATION FROM THE HOSPITAL**				
7	Submitted charges		$5,563.70		UB-04 Field Locator 47 minus FL 48
8	Length of stay		2		Used for transfer pricing and covered days adjustments
9	Medicaid covered days		2		Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)		No		Used for transfer pricing adjustment
11	Patient age (in years)		46		Used for age adjustor
12	Other health coverage		$0.00		UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost		$0.00		Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio		34.02%		Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt		$0.00		
16	Hospital average per discharge self-funded IGT add on pymt		$0.00		
17	Hospital casemix		0.7458		Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category		Rural		From drop down list - used to determine provider policy adjustor
19	APR-DRG		722-1		From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**				
21	DRG standardized base rate		$3,600		Used for DRG base payment
22	Cost outlier threshold		$27,425		Used for cost outlier adjustments
23	Marginal cost percentage		80%		Used for cost outlier adjustments
24	Casemix adjustment factor		1.00		Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor		18		
26	**APR-DRG INFORMATION**				
27	APR-DRG description		FEVER		Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid		0.4665		Look up from DRG table
29	Service adjustor		1.000		Look up from DRG table
30	Age adjustor		1.000		Look up from DRG table
31	Average length of stay for this APR-DRG		2.22		Look up from DRG table
32	**HOSPITAL INFORMATION**				
33	Provider adjustor		1.757		Look up from provider adjustor table
34	**DRG BASE PAYMENT**				
35	Maximum policy adjustor		1.757		IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment		$2,950.84		E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**				
38	Is a transfer adjustment potentially applicable?		No		If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount		N/A		IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?		N/A		IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment		$2,950.84		IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**				
43	IGT casemix adjustor		0.63		E28 / E17
44	Full stay automatic IGT add-on payment		$0.00		E15 * E43
45	Full stay self-funded IGT add-on payment		$0.00		E16 * E43
46	Pre outlier payment amount		$2,950.84		E41 + E44 + E45
47	**COST OUTLIER**				
48	Estimated cost of the stay		$1,892.77		E7 * E14
49	Does this claim require an outlier payment?		No		IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case		N/A		IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase		$0.00		IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**				
53	Are covered days less than length of stay		No		IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor		1.0000		IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment		$2,950.84		E41 * E54
56	NCD Adjusted outlier payment		$0.00		E51 * E54
57	NCD Adjusted automatic IGT add-on payment		$0.00		E44 * E54
58	NCD Adjusted self-funded IGT add-on payment		$0.00		E45 * E54
59	Pre-charge cap allowed amount		$2,950.84		E55 + E56 + E57 + E58
60	**CHARGE CAP**				
61	Does the charge cap apply?		No		IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor		1.0000		IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment		$2,950.84		E55 * E62
64	Final outlier payment		$0.00		E56 * E62
65	Final DRG payment		$2,950.84		E63 + E64
66	Final automatic IGT add-on payment		$0.00		E57 * E62
67	Final self funded IGT add-on payment		$0.00		E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**				
69	Allowed amount		$2,950.84		E65 + E66 + E67
70	Other health coverage		$0.00		E12
71	Patient share of cost		$0.00		E13
72	Payment amount		**$2,950.84**		IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012				

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

Florida Medicaid DRG Pricing Calculator

Note: **Specific policy values included are for purposes of illustration only.**

Indicates data to be input by the user — *Indicates payment policy parameters set by Medicaid*

Row	Information	Data	Comments or Formula
6	**INFORMATION FROM THE HOSPITAL**		
7	Submitted charges	$17,072.00	UB-04 Field Locator 47 minus FL 48
8	Length of stay	1	Used for transfer pricing and covered days adjustments
9	Medicaid covered days	1	Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)	No	Used for transfer pricing adjustment
11	Patient age (in years)	0	Used for age adjustor
12	Other health coverage	$0.00	UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost	$0.00	Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio	27.51%	Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt	$4,453.85	
16	Hospital average per discharge self-funded IGT add on pymt	$0.00	
17	Hospital casemix	1.4905	Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category	High Medicaid & High Outlier	From drop down list - used to determine provider policy adjustor
19	APR-DRG	850-2	From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**		
21	DRG standardized base rate	$3,600	Used for DRG base payment
22	Cost outlier threshold	$27,425	Used for cost outlier adjustments
23	Marginal cost percentage	80%	Used for cost outlier adjustments
24	Casemix adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor	18	
26	**APR-DRG INFORMATION**		
27	APR-DRG description	PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH	Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid	1.9283	Look up from DRG table
29	Service adjustor	1.350	Look up from DRG table
30	Age adjustor	1.000	Look up from DRG table
31	Average length of stay for this APR-DRG	4.45	Look up from DRG table
32	**HOSPITAL INFORMATION**		
33	Provider adjustor	1.762	Look up from provider adjustor table
34	**DRG BASE PAYMENT**		
35	Maximum policy adjustor	1.762	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment	$12,231.83	E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**		
38	Is a transfer adjustment potentially applicable?	No	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount	N/A	IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?	N/A	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment	$12,231.83	IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**		
43	IGT casemix adjustor	1.29	E28 / E17
44	Full stay automatic IGT add-on payment	$5,762.18	E15 * E43
45	Full stay self-funded IGT add-on payment	$0.00	E16 * E43
46	Pre outlier payment amount	$17,994.01	E41 + E44 + E45
47	**COST OUTLIER**		
48	Estimated cost of the stay	$4,696.51	E7 * E14
49	Does this claim require an outlier payment?	No	IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case	N/A	IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase	$0.00	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**		
53	Are covered days less than length of stay	No	IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor	1.0000	IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment	$12,231.83	E41 * E54
56	NCD Adjusted outlier payment	$0.00	E51 * E54
57	NCD Adjusted automatic IGT add-on payment	$5,762.18	E44 * E54
58	NCD Adjusted self-funded IGT add-on payment	$0.00	E45 * E54
59	Pre-charge cap allowed amount	$17,994.01	E55 + E56 + E57 + E58
60	**CHARGE CAP**		
61	Does the charge cap apply?	Yes	IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor	0.9488	IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment	$11,605.07	E55 * E62
64	Final outlier payment	$0.00	E56 * E62
65	Final DRG payment	$11,605.07	E63 + E64
66	Final automatic IGT add-on payment	$5,466.93	E57 * E62
67	Final self funded IGT add-on payment	$0.00	E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**		
69	Allowed amount	$17,072.00	E65 + E66 + E67
70	Other health coverage	$0.00	E12
71	Patient share of cost	$0.00	E13
72	Payment amount	**$17,072.00**	IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012		

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

Florida Medicaid DRG Pricing Calculator

Note: **Specific policy values included are for purposes of illustration only.**

Indicates data to be input by the user | *Indicates payment policy parameters set by Medicaid*

Row	Information	Data	Comments or Formula
6	**INFORMATION FROM THE HOSPITAL**		
7	Submitted charges	$149,692	UB-04 Field Locator 47 minus FL 48
8	Length of stay	20	Used for transfer pricing and covered days adjustments
9	Medicaid covered days	20	Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)	No	Used for transfer pricing adjustment
11	Patient age (in years)	50	Used for age adjustor
12	Other health coverage	$0.00	UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost	$0.00	Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio	37.02%	Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt	$2,738.41	
16	Hospital average per discharge self-funded IGT add on pymt	$3,116.35	
17	Hospital casemix	1.2448	Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category	High Medicaid & High Outlier	From drop down list - used to determine provider policy adjustor
19	APR-DRG	199-4	From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**		
21	DRG standardized base rate	$3,600	Used for DRG base payment
22	Cost outlier threshold	$27,425	Used for cost outlier adjustments
23	Marginal cost percentage	80%	Used for cost outlier adjustments
24	Casemix adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor	18	
26	**APR-DRG INFORMATION**		
27	APR-DRG description	HYPERTENSION	Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid	2.4697	Look up from DRG table
29	Service adjustor	1.000	Look up from DRG table
30	Age adjustor	1.000	Look up from DRG table
31	Average length of stay for this APR-DRG	7.88	Look up from DRG table
32	**HOSPITAL INFORMATION**		
33	Provider adjustor	1.762	Look up from provider adjustor table
34	**DRG BASE PAYMENT**		
35	Maximum policy adjustor	1.762	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment	$15,665.94	E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**		
38	Is a transfer adjustment potentially applicable?	No	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount	N/A	IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?	N/A	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment	$15,665.94	IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**		
43	IGT casemix adjustor	1.98	E28 / E17
44	Full stay automatic IGT add-on payment	$5,433.09	E15 * E43
45	Full stay self-funded IGT add-on payment	$6,182.94	E16 * E43
46	Pre outlier payment amount	$27,281.97	E41 + E44 + E45
47	**COST OUTLIER**		
48	Estimated cost of the stay	$55,416.07	E7 * E14
49	Does this claim require an outlier payment?	Yes	IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case	$28,134.10	IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase	$567.28	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**		
53	Are covered days less than length of stay	No	IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor	1.0000	IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment	$15,665.94	E41 * E54
56	NCD Adjusted outlier payment	$567.28	E51 * E54
57	NCD Adjusted automatic IGT add-on payment	$5,433.09	E44 * E54
58	NCD Adjusted self-funded IGT add-on payment	$6,182.94	E45 * E54
59	Pre-charge cap allowed amount	$27,849.25	E55 + E56 + E57 + E58
60	**CHARGE CAP**		
61	Does the charge cap apply?	No	IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor	1.0000	IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment	$15,665.94	E55 * E62
64	Final outlier payment	$567.28	E56 * E62
65	Final DRG payment	$16,233.22	E63 + E64
66	Final automatic IGT add-on payment	$5,433.09	E57 * E62
67	Final self funded IGT add-on payment	$6,182.94	E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**		
69	Allowed amount	$27,849.25	E65 + E66 + E67
70	Other health coverage	$0.00	E12
71	Patient share of cost	$0.00	E13
72	Payment amount	**$27,849.25**	IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012		

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

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Example of an outlier payment

Example of a transfer payment reduction

	C	D	E	F	G
2	**Florida Medicaid DRG Pricing Calculator**				
3	***Note:* Specific policy values included are for purposes of illustration only.**				
4	***Indicates data to be input by the user***				***Indicates payment policy parameters set by Medicaid***
5	**Information**		**Data**		**Comments or Formula**
6	**INFORMATION FROM THE HOSPITAL**				
7	Submitted charges		$17,978		UB-04 Field Locator 47 minus FL 48
8	Length of stay		4		Used for transfer pricing and covered days adjustments
9	Medicaid covered days		4		Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)		Yes		Used for transfer pricing adjustment
11	Patient age (in years)		53		Used for age adjustor
12	Other health coverage		$0.00		UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost		$0.00		Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio		40.34%		Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt		$3,447.88		
16	Hospital average per discharge self-funded IGT add on pymt		$1,304.49		
17	Hospital casemix		1.4432		Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category		All Other		From drop down list - used to determine provider policy adjustor
19	APR-DRG		194-3		From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**				
21	DRG standardized base rate		$3,600		Used for DRG base payment
22	Cost outlier threshold		$27,425		Used for cost outlier adjustments
23	Marginal cost percentage		80%		Used for cost outlier adjustments
24	Casemix adjustment factor		1.00		Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor		18		
26	**APR-DRG INFORMATION**				
27	APR-DRG description		HEART FAILURE		Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid		1.3503		Look up from DRG table
29	Service adjustor		1.000		Look up from DRG table
30	Age adjustor		1.000		Look up from DRG table
31	Average length of stay for this APR-DRG		5.58		Look up from DRG table
32	**HOSPITAL INFORMATION**				
33	Provider adjustor		1.000		Look up from provider adjustor table
34	**DRG BASE PAYMENT**				
35	Maximum policy adjustor		1.000		IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment		$4,861.11		E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**				
38	Is a transfer adjustment potentially applicable?		Yes		If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount		$4,355.84		IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?		Yes		IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment		$4,355.84		IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**				
43	IGT casemix adjustor		0.94		E28 / E17
44	Full stay automatic IGT add-on payment		$3,225.96		E15 * E43
45	Full stay self-funded IGT add-on payment		$1,220.53		E16 * E43
46	Pre outlier payment amount		$8,802.33		E41 + E44 + E45
47	**COST OUTLIER**				
48	Estimated cost of the stay		$7,252.86		E7 * E14
49	Does this claim require an outlier payment?		No		IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case		N/A		IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase		$0.00		IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**				
53	Are covered days less than length of stay		No		IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor		1.0000		IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment		$4,355.84		E41 * E54
56	NCD Adjusted outlier payment		$0.00		E51 * E54
57	NCD Adjusted automatic IGT add-on payment		$3,225.96		E44 * E54
58	NCD Adjusted self-funded IGT add-on payment		$1,220.53		E45 * E54
59	Pre-charge cap allowed amount		$8,802.33		E55 + E56 + E57 + E58
60	**CHARGE CAP**				
61	Does the charge cap apply?		No		IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor		1.0000		IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment		$4,355.84		E55 * E62
64	Final outlier payment		$0.00		E56 * E62
65	Final DRG payment		$4,355.84		E63 + E64
66	Final automatic IGT add-on payment		$3,225.96		E57 * E62
67	Final self funded IGT add-on payment		$1,220.53		E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**				
69	Allowed amount		$8,802.33		E65 + E66 + E67
70	Other health coverage		$0.00		E12
71	Patient share of cost		$0.00		E13
72	Payment amount		**$8,802.33**		IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012				

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

Example of non-covered day payment reduction

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1	C	D	E	F	G
2	**Florida Medicaid DRG Pricing Calculator**				
3	***Note:*** **Specific policy values included are for purposes of illustration only.**				
4	***Indicates data to be input by the user***				***Indicates payment policy parameters set by Medicaid***

	Information	Data	Comments or Formula
6	**INFORMATION FROM THE HOSPITAL**		
7	Submitted charges	$19,760	UB-04 Field Locator 47 minus FL 48
8	Length of stay	4	Used for transfer pricing and covered days adjustments
9	Medicaid covered days	2	Used for covered days adjustment
10	Patient discharge status = 02, 05, 65 or 66? (transfer)	No	Used for transfer pricing adjustment
11	Patient age (in years)	36	Used for age adjustor
12	Other health coverage	$0.00	UB-04 Field Locator 54 for payments by third parties
13	Patient share of cost	$0.00	Includes spend-down or copayment
14	Hospital-specific cost-to-charge ratio	27.67%	Used to estimate the hospital's cost of this stay
15	Hospital average per discharge automatic IGT add on pymt	$2,788.77	
16	Hospital average per discharge self-funded IGT add on pymt	$904.91	
17	Hospital casemix	1.1634	Hospital's annual average FL Medicaid APR-DRG relative weight
18	Hospital category	All Other	From drop down list - used to determine provider policy adjustor
19	APR-DRG	320-2	From separate APR-DRG grouping software
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**		
21	DRG standardized base rate	$3,600	Used for DRG base payment
22	Cost outlier threshold	$27,425	Used for cost outlier adjustments
23	Marginal cost percentage	80%	Used for cost outlier adjustments
24	Casemix adjustment factor	1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
25	Age cut-off for age policy adjustor	18	
26	**APR-DRG INFORMATION**		
27	APR-DRG description	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE	Look up from DRG table
28	Casemix relative weight--re-centered for FL Medicaid	1.8603	Look up from DRG table
29	Service adjustor	1.000	Look up from DRG table
30	Age adjustor	1.000	Look up from DRG table
31	Average length of stay for this APR-DRG	4.36	Look up from DRG table
32	**HOSPITAL INFORMATION**		
33	Provider adjustor	1.000	Look up from provider adjustor table
34	**DRG BASE PAYMENT**		
35	Maximum policy adjustor	1.000	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
36	Pre Transfer DRG base payment	$6,697.09	E21 * E28 * E24 * E35
37	**TRANSFER PAYMENT ADJUSTMENT**		
38	Is a transfer adjustment potentially applicable?	No	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"
39	Per diem payment amount	N/A	IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"
40	Is per diem payment amount < full stay base payment?	N/A	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"
41	Full stay DRG base payment	$6,697.09	IF E40 = "Yes" Then E39 Else E36
42	**FULL STAY ADD-ON IGT PAYMENTS**		
43	IGT casemix adjustor	1.60	E28 / E17
44	Full stay automatic IGT add-on payment	$4,459.31	E15 * E43
45	Full stay self-funded IGT add-on payment	$1,446.97	E16 * E43
46	Pre outlier payment amount	$12,603.37	E41 + E44 + E45
47	**COST OUTLIER**		
48	Estimated cost of the stay	$5,467.65	E7 * E14
49	Does this claim require an outlier payment?	No	IF (E48-E46) > E22 Then "Yes" Else "No"
50	Estimated loss on this case	N/A	IF E49 = "Yes" Then E48 - E46 Else "N/A"
51	DRG cost outlier payment increase	$0.00	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**		
53	Are covered days less than length of stay	Yes	IF E9 < E8 Then "Yes" Else "No"
54	Non-covered day reduction factor	0.5000	IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment	$3,348.55	E41 * E54
56	NCD Adjusted outlier payment	$0.00	E51 * E54
57	NCD Adjusted automatic IGT add-on payment	$2,229.65	E44 * E54
58	NCD Adjusted self-funded IGT add-on payment	$723.49	E45 * E54
59	Pre-charge cap allowed amount	$6,301.69	E55 + E56 + E57 + E58
60	**CHARGE CAP**		
61	Does the charge cap apply?	No	IF E59 > E7 Then "Yes" Else "No"
62	Charge cap reduction factor	1.0000	IF E61 = "Yes" Then E7 / E59 Else 1.0
63	Final DRG base payment	$3,348.55	E55 * E62
64	Final outlier payment	$0.00	E56 * E62
65	Final DRG payment	$3,348.55	E63 + E64
66	Final automatic IGT add-on payment	$2,229.65	E57 * E62
67	Final self funded IGT add-on payment	$723.49	E58 * E62
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**		
69	Allowed amount	$6,301.69	E65 + E66 + E67
70	Other health coverage	$0.00	E12
71	Patient share of cost	$0.00	E13
72	Payment amount	**$6,301.69**	IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
73	12/20/2012		

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

Example of charge cap payment reduction

MGT OF AMERICA, INC. NAVIGANT

1	C	D	E	F	G
2	**Florida Medicaid DRG Pricing Calculator**				
3	***Note:*** **Specific policy values included are for purposes of illustration only.**				
4	***Indicates data to be input by the user***			***Indicates payment policy parameters set by Medicaid***	
5	**Information**		**Data**	**Comments or Formula**	
6	**INFORMATION FROM THE HOSPITAL**				
7	Submitted charges		$8,593	UB-04 Field Locator 47 minus FL 48	
8	Length of stay		1	Used for transfer pricing and covered days adjustments	
9	Medicaid covered days		1	Used for covered days adjustment	
10	Patient discharge status = 02, 05, 65 or 66? (transfer)		No	Used for transfer pricing adjustment	
11	Patient age (in years)		27	Used for age adjustor	
12	Other health coverage		$0.00	UB-04 Field Locator 54 for payments by third parties	
13	Patient share of cost		$0.00	Includes spend-down or copayment	
14	Hospital-specific cost-to-charge ratio		40.34%	Used to estimate the hospital's cost of this stay	
15	Hospital average per discharge automatic IGT add on pymt		$3,447.88		
16	Hospital average per discharge self-funded IGT add on pymt		$1,304.49		
17	Hospital casemix		1.4432	Hospital's annual average FL Medicaid APR-DRG relative weight	
18	Hospital category		All Other	From drop down list - used to determine provider policy adjustor	
19	APR-DRG		207-3	From separate APR-DRG grouping software	
20	**PAYMENT POLICY PARAMETERS SET BY MEDICAID**				
21	DRG standardized base rate		$3,600	Used for DRG base payment	
22	Cost outlier threshold		$27,425	Used for cost outlier adjustments	
23	Marginal cost percentage		80%	Used for cost outlier adjustments	
24	Casemix adjustment factor		1.00	Used to adjust DRG relative weights should a need arise, else leave set to 1.00.	
25	Age cut-off for age policy adjustor		18		
26	**APR-DRG INFORMATION**				
27	APR-DRG description		OTHER CIRCULATORY SYSTEM DIAGNOSES	Look up from DRG table	
28	Casemix relative weight--re-centered for FL Medicaid		1.3406	Look up from DRG table	
29	Service adjustor		1.000	Look up from DRG table	
30	Age adjustor		1.000	Look up from DRG table	
31	Average length of stay for this APR-DRG		4.79	Look up from DRG table	
32	**HOSPITAL INFORMATION**				
33	Provider adjustor		1.000	Look up from provider adjustor table	
34	**DRG BASE PAYMENT**				
35	Maximum policy adjustor		1.000	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)	
36	Pre Transfer DRG base payment		$4,826.12	E21 * E28 * E24 * E35	
37	**TRANSFER PAYMENT ADJUSTMENT**				
38	Is a transfer adjustment potentially applicable?		No	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"	
39	Per diem payment amount		N/A	IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A"	
40	Is per diem payment amount < full stay base payment?		N/A	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A"	
41	Full stay DRG base payment		$4,826.12	IF E40 = "Yes" Then E39 Else E36	
42	**FULL STAY ADD-ON IGT PAYMENTS**				
43	IGT casemix adjustor		0.93	E28 / E17	
44	Full stay automatic IGT add-on payment		$3,202.74	E15 * E43	
45	Full stay self-funded IGT add-on payment		$1,211.74	E16 * E43	
46	Pre outlier payment amount		$9,240.61	E41 + E44 + E45	
47	**COST OUTLIER**				
48	Estimated cost of the stay		$3,466.23	E7 * E14	
49	Does this claim require an outlier payment?		No	IF (E48-E46) > E22 Then "Yes" Else "No"	
50	Estimated loss on this case		N/A	IF E49 = "Yes" Then E48 - E46 Else "N/A"	
51	DRG cost outlier payment increase		$0.00	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0	
52	**NON-COVERED DAYS PAYMENT ADJUSTMENT**				
53	Are covered days less than length of stay		No	IF E9 < E8 Then "Yes" Else "No"	
54	Non-covered day reduction factor		1.0000	IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0	
55	NCD Adjusted DRG base payment		$4,826.12	E41 * E54	
56	NCD Adjusted outlier payment		$0.00	E51 * E54	
57	NCD Adjusted automatic IGT add-on payment		$3,202.74	E44 * E54	
58	NCD Adjusted self-funded IGT add-on payment		$1,211.74	E45 * E54	
59	Pre-charge cap allowed amount		$9,240.61	E55 + E56 + E57 + E58	
60	**CHARGE CAP**				
61	Does the charge cap apply?		Yes	IF E59 > E7 Then "Yes" Else "No"	
62	Charge cap reduction factor		0.9299	IF E61 = "Yes" Then E7 / E59 Else 1.0	
63	Final DRG base payment		$4,487.66	E55 * E62	
64	Final outlier payment		$0.00	E56 * E62	
65	Final DRG payment		$4,487.66	E63 + E64	
66	Final automatic IGT add-on payment		$2,978.12	E57 * E62	
67	Final self funded IGT add-on payment		$1,126.76	E58 * E62	
68	**CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT**				
69	Allowed amount		$8,592.54	E65 + E66 + E67	
70	Other health coverage		$0.00	E12	
71	Patient share of cost		$0.00	E13	
72	Payment amount		**$8,592.54**	IF (E69-E70-E71) > 0, then E69-E70-E71, else 0	
73	12/20/2012				

CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.

Appendix B – Dataset Summary

MGT OF AMERICA, INC.

NAVIGANT

Historical Payments by Service Line SFY 2010/2011

Historical Payments by Service Line SFY 2010/2011									
Service Line	Stays	Covered Days	Charges	Estimated Cost	Baseline Payment	Average Length of Stay	APR-DRG Casemix Re-centered	APR-DRG Casemix	Pay / Cost
Misc Adult	72,745	430,937	$ 4,067,402,015	$ 973,696,869	$ 723,688,401	5.9	1.70	1.30	74%
Obstetrics	111,700	304,709	$ 1,792,392,804	$ 429,991,911	$ 447,708,629	2.7	0.57	0.44	104%
Neonate	11,641	279,492	$ 1,372,529,305	$ 355,356,941	$ 446,142,293	24.0	4.10	3.12	126%
Pediatric	46,320	192,319	$ 1,475,565,071	$ 389,232,185	$ 381,580,487	4.2	1.11	0.85	98%
Gastroent Adult	27,910	133,911	$ 1,279,570,546	$ 292,298,322	$ 218,235,942	4.8	1.34	1.02	75%
Circulatory Adult	24,525	105,517	$ 1,323,558,703	$ 299,764,304	$ 170,486,175	4.3	1.69	1.28	57%
Resp Adult	18,092	98,915	$ 800,916,237	$ 184,602,807	$ 156,705,564	5.5	1.31	0.99	85%
Normal newborn	90,713	254,255	$ 305,504,589	$ 74,862,289	$ 111,028,700	2.8	0.16	0.12	148%
Mental Health	12,442	62,549	$ 174,544,903	$ 40,411,740	$ 100,628,645	5.0	0.68	0.52	249%
Rehab	1,787	25,884	$ 85,244,013	$ 25,783,035	$ 39,097,427	14.5	1.92	1.47	152%
Transplant Pediatric	51	2,570	$ 33,770,844	$ 10,580,108	$ 6,245,353	50.4	14.60	11.12	59%
Transplant Adult	81	1,539	$ 19,051,300	$ 6,825,349	$ 3,688,051	19.0	10.49	7.98	54%
Total	**418,007**	**1,892,597**	**$12,730,050,330**	**$ 3,083,405,860**	**$2,805,235,667**	**4.5**	**1.00**	**0.76**	**91%**

Notes:

1) Transplant includes only those cases paid per diem, not through the global period.

MGT OF AMERICA, INC.   NAVIGANT

Appendix B – Dataset Summary

Est Per Diem Pymts by Svc Line SFY 2013/2014

Estimated Payments by Service Line SFY 2013/2014									
Service Line	Stays	Covered Days	Charges	Estimated Cost	Baseline Payment	Average Length of Stay	APR-DRG Casemix Re-centered	APR-DRG Casemix	Pay / Cost
Misc Adult	72,745	430,937	$ 4,383,378,547	$ 1,049,338,607	$ 758,939,658	5.9	1.70	1.30	72%
Neonate	11,641	279,492	$ 1,479,154,381	$ 382,962,880	$ 460,717,205	24.0	4.10	3.12	120%
Obstetrics	111,700	304,709	$ 1,931,635,018	$ 463,395,877	$ 457,674,917	2.7	0.57	0.44	99%
Pediatric	46,320	192,319	$ 1,590,194,491	$ 419,469,726	$ 402,818,179	4.2	1.11	0.85	96%
Gastroent Adult	27,910	133,911	$ 1,378,974,112	$ 315,005,545	$ 226,189,382	4.8	1.34	1.02	72%
Circulatory Adult	24,525	105,517	$ 1,426,379,493	$ 323,051,525	$ 176,606,751	4.3	1.69	1.28	55%
Resp Adult	18,092	98,915	$ 863,135,495	$ 198,943,694	$ 162,254,933	5.5	1.31	0.99	82%
Normal newborn	90,713	254,255	$ 329,237,744	$ 80,677,975	$ 113,891,255	2.8	0.16	0.12	141%
Mental Health	12,442	62,549	$ 188,104,440	$ 43,551,130	$ 104,004,283	5.0	0.68	0.52	239%
Rehab	1,787	25,884	$ 91,866,203	$ 27,785,993	$ 42,432,034	14.5	1.92	1.47	153%
Transplant Pediatric	51	2,570	$ 36,394,336	$ 11,402,025	$ 7,036,233	50.4	14.60	11.12	62%
Transplant Adult	81	1,539	$ 20,531,302	$ 7,355,577	$ 4,541,658	19.0	10.49	7.98	62%
Total	**418,007**	**1,892,597**	**$ 13,718,985,562**	**$ 3,322,940,554**	**$2,917,106,490**	**4.5**	**1.00**	**0.76**	**88%**

Notes:

1) Transplant includes only those cases paid per diem, not through the global period.

2) Estimates created using SFY 2012/2013 per diem rates increased to meet projections presented at November 2012 Social Services Estimating

MGT OF AMERICA, INC. NAVIGANT

Historical Payments by Prov Category SFY 2010/2011

Historical Payments by Provider Category SFY 2010/2011									
Provider Category	Stays	Covered Days	Charges	Estimated Cost	Baseline Payment	Average Length of Stay	APR-DRG Casemix Re-centered	APR-DRG Casemix	Pay / Cost
LIP	404,620	1,825,270	$ 12,273,490,495	$ 2,980,430,760	$ 2,741,413,441	4.5	0.99	0.76	92%
Trauma	167,942	894,050	$ 5,729,279,915	$ 1,595,763,765	$ 1,579,657,176	5.3	1.19	0.90	99%
Statutory Teaching	98,530	528,296	$ 3,461,858,815	$ 1,011,414,746	$ 1,010,532,422	5.4	1.19	0.91	100%
High Charity	112,464	498,287	$ 3,514,253,578	$ 731,618,588	$ 680,768,661	4.4	0.91	0.70	93%
CHEP	75,786	348,461	$ 2,328,633,989	$ 532,603,382	$ 509,827,242	4.6	1.01	0.77	96%
Public	76,884	349,815	$ 2,061,120,676	$ 515,531,094	$ 508,160,115	4.5	0.96	0.73	99%
General Acute	123,619	475,803	$ 3,173,274,957	$ 688,279,631	$ 505,461,403	3.8	0.88	0.67	73%
Children's	9,263	66,717	$ 658,838,503	$ 177,764,206	$ 172,011,952	7.2	1.79	1.36	97%
Rural	11,140	32,338	$ 141,465,570	$ 46,496,367	$ 45,610,156	2.9	0.66	0.51	98%
Rehabilitation	525	7,547	$ 16,986,833	$ 7,821,288	$ 4,184,588	14.4	1.85	1.41	54%
Long Term Acute Care	86	1,633	$ 7,839,316	$ 2,494,916	$ 1,641,069	19.0	2.87	2.19	66%
Out of state	412	1,621	$ 9,480,132	$ 2,591,606	$ 1,064,107	3.9	1.22	0.93	41%

Notes:

1) Providers may be included in more than one category.

2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.

3) "General Acute" hospitals are those not otherwise categorized as Children's, CHEP, High Charity, LTAC, Out of state, Rehabilitation, Rural, Teaching or Trauma.

MGT OF AMERICA, INC. NAVIGANT

Appendix B – Dataset Summary

Est Per Diem Pymts by Prov Categ SFY 2013/2014

Estimated Payments by Provider Category SFY 2013/2014									
Provider Category	Stays	Covered Days	Charges	Estimated Cost	Baseline Payment	Average Length of Stay	APR-DRG Casemix Re-centered	APR-DRG Casemix	Pay / Cost
LIP	404,620	1,825,270	$ 13,226,957,831	$ 3,211,965,823	$ 2,860,291,083	4.5	0.99	0.76	89%
Trauma	167,942	894,050	$ 6,174,359,596	$ 1,719,730,833	$ 1,730,385,472	5.3	1.19	0.90	101%
Statutory Teaching	98,530	528,296	$ 3,730,793,662	$ 1,089,986,603	$ 1,067,045,755	5.4	1.19	0.91	98%
High Charity	112,464	498,287	$ 3,787,258,719	$ 788,454,451	$ 657,824,339	4.4	0.91	0.70	83%
Public	76,884	349,815	$ 2,221,239,042	$ 555,580,178	$ 587,410,570	4.5	0.96	0.73	106%
General Acute	123,619	475,803	$ 3,419,791,140	$ 741,748,703	$ 523,577,680	3.8	0.88	0.67	71%
CHEP	75,786	348,461	$ 2,509,534,154	$ 573,978,730	$ 475,370,010	4.6	1.01	0.77	83%
Children	9,263	66,717	$ 710,020,437	$ 191,573,836	$ 190,581,597	7.2	1.79	1.36	99%
Rural	11,140	32,338	$ 152,455,337	$ 50,108,442	$ 57,125,068	2.9	0.66	0.51	114%
Rehabilitation	525	7,547	$ 18,306,457	$ 8,428,885	$ 3,915,175	14.4	1.85	1.41	46%
Long Term Acute Care	86	1,633	$ 8,448,314	$ 2,688,734	$ 1,648,369	19.0	2.87	2.19	61%
Out of state	412	1,621	$ 10,216,597	$ 2,792,935	$ 1,074,871	3.9	1.22	0.93	38%

Notes:

1) Providers may be included in more than one category.

2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.

3) "General Acute" hospitals are those not otherwise categorized as Children's, CHEP, High Charity, LTAC, Out of state, Rehabilitation, Rural, Teaching or Trauma.

4) Estimates created using SFY 2012/2013 per diem rates increased to meet projections presented at November 2012 Social Services Estimating Conference.

Appendix C – Simulation 14

MGT OF AMERICA, INC.

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Simulation 14 Budget Goals

	A	B	C	D	E	F	G	H	I	J
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Estimated Cost	Historical Pay-to-Cost	Percentage of Cost Goal	Total Budget Goal with IGTs	DRG Reimbursement from GR and PMATF
1	Rural	11,140	$ 45,610,156	$ -	$ -	$ 46,496,367	98%	98%	$ 45,566,440	**$ 45,566,440**
2	LTAC	86	$ 1,517,291	$ 36,065	$ 87,713	$ 2,494,916	66%	66%	$ 1,646,645	**$ 1,522,867**
3	High Medicaid & High Outlier	9,229	$ 119,252,071	$ 43,757,522	$ 8,863,176	$ 177,012,181	97%	95%	$ 168,161,572	**$ 115,540,874**
4	All Other	397,552	$ 1,572,452,882	$ 837,192,259	$ 176,466,531	$2,857,402,396	91%		$2,589,861,011	**$ 1,576,202,220**
5										
6	**Totals:**	418,007	$ 1,738,832,401	$ 880,985,847	$ 185,417,420					
7										
8		Overall Total Historical Baseline Payment:			$2,805,235,667					

Notes:

1) For rural, LTAC, and high-Medicaid-high-outlier hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals a percentage of estimated cost minus any per-claim payments being made via IGTs. For example, J1 = [I1 - (D1 + E1)].

2) For "All Other" hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals the total historical allowed amount from GR and assessment minus the total planned DRG reimbursement from GR and assessment for rural, LTAC, and high-Medicaid-high-outlier hospitals.
J4 = [C6 - (J1 + J2 + J3)].

Simulation 14 was the last run with 2010/2011 dollars. It contains final policy design decisions, uses 2010/2011 dollars, and does NOT include any casemix adjustment.

Appendix C – Simulation 14

Simulation 14 Parameters

DRG Payment Simulation 14b - Rerun					
Simulation Parameters	**Value - Overall**	**Value - All Other Hospitals**	**Value - Rural Hospitals**	**Value - LTAC Hospitals**	**Value - High Medicaid High Outlier Hospitals**
Baseline payment, total	$2,805,235,667	$2,586,111,673	$45,610,156	$1,641,069	$171,872,769
Baseline payment, general revenue and PMATF	$1,738,832,401	$1,572,452,882	$45,610,156	$1,517,291	$119,252,071
Baseline payment, automatic IGTs	$880,985,847	$837,192,259	$0	$36,065	$43,757,522
Baseline payment, self-funded IGTs	$185,417,420	$176,466,531	$0	$87,713	$8,863,176
Simulation payment goal	$2,805,235,667	$2,589,861,011	$45,566,440	$1,646,645	$168,161,572
Simulation payment, result	$2,790,292,916	$2,576,307,570	$45,559,529	$1,646,873	$166,778,944
Difference	-$14,942,752	-$13,553,441	-$6,911	$228	-$1,382,628
Simulation payment, general revenue and PMATF	$1,738,839,703	$1,576,201,804	$45,559,529	$1,523,095	$115,555,275
Simulation payment,automatic IGTs	$868,903,276	$826,211,784	$0	$36,065	$42,655,426
Simulation payment, self-funded IGTs	$182,549,937	$173,893,981	$0	$87,713	$8,568,243
DRG base price	$3,611.75	$3,611.75	$3,611.75	$3,611.75	$3,611.75
Cost outlier pool (percentage of total payments)	7.4%	7%	1%	7%	20%
Wage index adjustment of base price	None				
Policy adjustor - Provider	n/a	None	1.754	1.634	1.418
Policy adjustor - DRG (service)	Rehabilitation - 1.35				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	APR v.30 national re-centered to 1.0 for FL Medicaid				
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost (MC) percentage	$27,425 80%				
Low side (provider gain) threshold and marginal cost (MC) percentage	None				
Charge Cap	Yes - adjusting state share and IGT payments				
Undocumented non-citizen non-covered day adjustment	Yes - adjusting state share and IGT payments				

Summary by Service Line

Simulation 14b - Rerun Summary of Simulation by Service Line											
Service Line	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,745	1.70	$ 973,696,869	$ 723,688,401	$ 821,909,615	$ 98,221,214	14%	74%	84%	$ 68,710,115	8%
Obstetrics	111,700	0.57	$ 429,991,911	$ 447,708,629	$ 397,932,797	$ (49,775,832)	-11%	104%	93%	$ 2,524,913	1%
Neonate	11,641	4.10	$ 355,356,941	$ 446,142,293	$ 358,451,517	$ (87,690,775)	-20%	126%	101%	$ 52,386,684	15%
Pediatric	46,320	1.11	$ 389,232,185	$ 381,580,487	$ 388,516,416	$ 6,935,930	2%	98%	100%	$ 43,751,707	11%
Gastroent Adult	27,910	1.34	$ 292,298,322	$ 218,235,942	$ 235,271,445	$ 17,035,503	8%	75%	80%	$ 11,743,478	5%
Circulatory Adult	24,525	1.69	$ 299,764,304	$ 170,486,175	$ 259,140,628	$ 88,654,454	52%	57%	86%	$ 12,685,481	5%
Resp Adult	18,092	1.31	$ 184,602,807	$ 156,705,564	$ 148,840,864	$ (7,864,700)	-5%	85%	81%	$ 8,717,327	6%
Normal newborn	90,713	0.16	$ 74,862,289	$ 111,028,700	$ 91,796,135	$ (19,232,565)	-17%	148%	123%	$ 1,121,996	1%
Mental Health	12,442	0.68	$ 40,411,740	$ 100,628,645	$ 48,899,953	$ (51,728,692)	-51%	249%	121%	$ 254,625	1%
Rehab	1,787	1.92	$ 25,783,035	$ 39,097,427	$ 24,019,037	$ (15,078,391)	-39%	152%	93%	$ 669,478	3%
Transplant Pediatric	51	14.60	$ 10,580,108	$ 6,245,353	$ 9,506,331	$ 3,260,978	52%	59%	90%	$ 3,805,600	40%
Transplant Adult	81	10.49	$ 6,825,349	$ 3,688,051	$ 6,008,177	$ 2,320,126	63%	54%	88%	$ 920,606	15%
Total	**418,007**	**1.00**	**$3,083,405,860**	**$ 2,805,235,667**	**$ 2,790,292,916**	**$ (14,942,752)**	**-1%**	**91%**	**90%**	**$ 207,292,008**	**7%**

Notes:
1) "Transplant" includes only those cases paid per diem, not through the global period.
2) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011.

* Corrected version, slightly different than version included in 12/21/2012 DRG Conversion and Implementation Plan.

Summary by Provider Category

Simulation 14b - Rerun
Summary of Simulation by Provider Category

Provider Category	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,620	0.99	$ 2,980,430,760	$ 2,741,413,441	$ 2,715,449,611	$ (25,963,830)	-1%	92%	91%	$ 201,853,796	7%
Trauma	167,942	1.19	$ 1,595,763,765	$ 1,579,657,176	$ 1,486,560,615	$ (93,096,561)	-6%	99%	93%	$ 144,788,357	10%
Statutory Teaching	98,530	1.19	$ 1,011,414,746	$ 1,010,532,422	$ 923,575,109	$ (86,957,312)	-9%	100%	91%	$ 87,691,344	9%
High Charity	112,464	0.91	$ 731,618,588	$ 680,768,661	$ 695,538,919	$ 14,770,257	2%	93%	95%	$ 39,080,228	6%
CHEP	75,786	1.01	$ 532,603,382	$ 509,827,242	$ 521,623,172	$ 11,795,930	2%	96%	98%	$ 29,072,327	6%
Public	76,884	0.96	$ 515,531,094	$ 508,160,115	$ 494,815,450	$ (13,344,664)	-3%	99%	96%	$ 32,989,647	7%
General Acute	123,619	0.88	$ 688,279,631	$ 505,461,403	$ 555,929,394	$ 50,467,992	10%	73%	81%	$ 27,347,808	5%
Children	9,263	1.79	$ 177,764,206	$ 172,011,952	$ 166,967,542	$ (5,044,410)	-3%	97%	94%	$ 33,442,853	20%
Rural	11,140	0.66	$ 46,496,367	$ 45,610,156	$ 45,559,529	$ (50,627)	0%	98%	98%	$ 387,539	1%
Rehabilitation	525	1.85	$ 7,821,288	$ 4,184,588	$ 4,636,411	$ 451,823	11%	54%	59%	$ 184,918	4%
Long Term Acute Care	86	2.87	$ 2,494,916	$ 1,641,069	$ 1,646,873	$ 5,803	0%	66%	66%	$ 122,818	7%
Out of state	412	1.22	$ 2,591,606	$ 1,064,107	$ 1,821,340	$ 757,234	71%	41%	70%	$ 23,170	1%

Notes:
1) Providers may be included in more than one category.
2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.
3) "General Acute" hospitals are those not otherwise categorized as Childrens, CHEP, High Charity, LTAC, Out of state, Rehab, Rural, Teaching or Trauma.
4) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011.

* Corrected version, slightly different than version included in 12/21/2012 DRG Conversion and Implementation Plan.

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Appendix D – Simulation 16

MGT OF AMERICA, INC.

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Simulation 16 Budget Goals

	A	B	C	D	E	F	G	H	I
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Estimated Cost	Percentage of Cost Goal	Total Budget Goal with IGTs	DRG Reimbursement from GR and PMATF
1	Rural	11,140	$ 50,266,032	$ 6,556,021	$ 303,015	$ 50,108,442	100%	$ 50,108,442	**$ 43,249,407**
2	LTAC	86	$ 1,365,292	$ -	$ 283,076	$ 2,688,734	65%	$ 1,747,677	**$ 1,464,601**
3	High Medicaid & High Outlier	9,229	$ 142,780,176	$ 45,760,831	$ 1,864,429	$ 190,763,390	95%	$ 181,225,220	**$ 133,599,960**
4	All Other	397,552	$ 1,520,363,917	$ 487,810,761	$ 659,752,940	$ 3,079,379,988			**$1,536,461,450**
5									
6	**Totals:**	418,007	$ 1,714,775,417	$ 540,127,612	$ 662,203,460				
7									
8			Total Budgeted Payment:		$ 2,917,106,490				

Notes:

1) For rural, LTAC, and high-Medicaid-high-outlier hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals a percentage of estimated cost minus any per-claim payments being made via IGTs. For example, I1 = [H1 - (D1 + E1)].

2) For "All Other" hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals the total historical allowed amount from GR and assessment minus the total planned DRG reimbursement from GR and assessment for rural, LTAC, and high-Medicaid-high-outlier hospitals.
I4 = [C6 - (I1 + I2 + I3)].

Simulation 16 contains final policy design decisions, uses 2010/2011 dollars, and does NOT include any casemix adjustment.

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Simulation 16 Parameters

DRG Payment Simulation 16					
Simulation Parameters	Value - Overall	Value - All Other Hospitals	Value - Rural Hospitals	Value - LTAC Hospitals	Medicaid High Outlier Hospitals
Baseline payment, total	$2,917,106,490	$2,667,927,618	$57,125,068	$1,648,369	$190,405,436
Baseline payment, general revenue and PMATF	$1,714,775,417	$1,520,363,917	$50,266,032	$1,365,292	$142,780,176
Baseline payment, automatic IGTs	$540,127,612	$487,810,761	$6,556,021	$0	$45,760,831
Baseline payment, self-funded IGTs	$662,203,460	$659,752,940	$303,015	$283,076	$1,864,429
Simulation payment goal	$2,917,106,490	$2,684,025,151	$50,108,442	$1,747,677	$181,225,220
Simulation payment, result	$2,898,139,622	$2,666,406,187	$49,945,709	$1,747,616	$180,040,111
Difference	-$18,966,868	-$17,618,964	-$162,733	-$62	-$1,185,109
Simulation payment, general revenue and PMATF	$1,714,777,908	$1,536,462,664	$43,256,746	$1,464,539	$133,593,958
Simulation payment,automatic IGTs	$531,841,216	$480,812,248	$6,391,896	$0	$44,637,072
Simulation payment, self-funded IGTs	$651,520,498	$649,131,275	$297,066	$283,077	$1,809,080
DRG base price	$3,472.94	$3,472.94	$3,472.94	$3,472.94	$3,472.94
Cost outlier pool (percentage of total payments)	7.7%	7%	1%	7%	20%
Wage index adjustment of base price	None				
Policy adjustor - Provider	n/a	None	1.733	1.633	1.762
Policy adjustor - DRG (service)	Rehabilitation - 1.3				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	APR v.30 national re-centered to 1.0 for FL Medicaid				
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost (MC) percentage	$31,000 80%				
Low side (provider gain) threshold and marginal cost (MC) percentage	None				
Charge Cap	Yes - adjusting state share and IGT payments				
Undocumented non-citizen non-covered day adjustment	Yes - adjusting state share and IGT payments				

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Summary by Service Line

Simulation 16 Summary of Simulation by Service Line											
Service Line	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,745	1.70	$1,049,338,607	$ 758,939,658	$ 860,110,635	$ 101,170,976	13%	72%	82%	$ 73,775,221	9%
Neonate	11,641	4.10	$ 382,962,880	$ 460,717,205	$ 372,611,901	$ (88,105,304)	-19%	120%	97%	$ 58,184,360	16%
Obstetrics	111,700	0.57	$ 463,395,877	$ 457,674,917	$ 408,328,907	$ (49,346,011)	-11%	99%	88%	$ 2,624,618	1%
Pediatric	46,320	1.11	$ 419,469,726	$ 402,818,179	$ 407,201,210	$ 4,383,031	1%	96%	97%	$ 46,299,531	11%
Gastroent Adult	27,910	1.34	$ 315,005,545	$ 226,189,382	$ 242,541,859	$ 16,352,477	7%	72%	77%	$ 12,795,005	5%
Circulatory Adult	24,525	1.69	$ 323,051,525	$ 176,606,751	$ 267,428,466	$ 90,821,715	51%	55%	83%	$ 13,902,960	5%
Resp Adult	18,092	1.31	$ 198,943,694	$ 162,254,933	$ 153,613,215	$ (8,641,719)	-5%	82%	77%	$ 9,628,005	6%
Normal newborn	90,713	0.16	$ 80,677,975	$ 113,891,255	$ 94,444,109	$ (19,447,146)	-17%	141%	117%	$ 1,180,581	1%
Mental Health	12,442	0.68	$ 43,551,130	$ 104,004,283	$ 49,897,960	$ (54,106,323)	-52%	239%	115%	$ 255,998	1%
Rehab	1,787	1.92	$ 27,785,993	$ 42,432,034	$ 24,782,175	$ (17,649,859)	-42%	153%	89%	$ 697,808	3%
Transplant Pediatric	51	14.60	$ 11,402,025	$ 7,036,233	$ 10,383,258	$ 3,347,025	48%	62%	91%	$ 4,109,176	40%
Transplant Adult	81	10.49	$ 7,355,577	$ 4,541,658	$ 6,795,927	$ 2,254,269	50%	62%	92%	$ 707,303	10%
Total	**418,007**	**1.00**	**$3,322,940,554**	**$ 2,917,106,490**	**$ 2,898,139,622**	**$ (18,966,868)**	**-1%**	**88%**	**87%**	**$ 224,160,564**	**8%**

Notes:
1) "Transplant" includes only those cases paid per diem, not through the global period.
2) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

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Summary by Provider Category

Simulation 16 Summary of Simulation by Provider Category											
Provider Category	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,620	0.99	$ 3,211,965,823	$ 2,860,291,083	$ 2,826,601,259	$ (33,689,824)	-1%	89%	88%	$ 217,492,035	8%
Trauma	167,942	1.19	$ 1,719,730,833	$ 1,730,385,472	$ 1,626,314,719	$ (104,070,752)	-6%	101%	95%	$ 149,525,950	9%
Statutory Teaching	98,530	1.19	$ 1,089,986,603	$ 1,067,045,755	$ 967,357,435	$ (99,688,320)	-9%	98%	89%	$ 93,386,236	10%
High Charity	112,464	0.91	$ 788,454,451	$ 657,824,339	$ 678,185,745	$ 20,361,406	3%	83%	86%	$ 44,582,819	7%
Public	76,884	0.96	$ 555,580,178	$ 587,410,570	$ 577,476,066	$ (9,934,505)	-2%	106%	104%	$ 32,244,979	6%
General Acute	123,619	0.88	$ 741,748,703	$ 523,577,680	$ 588,367,310	$ 64,789,630	12%	71%	79%	$ 30,268,405	5%
CHEP	75,786	1.01	$ 573,978,730	$ 475,370,010	$ 494,714,073	$ 19,344,064	4%	83%	86%	$ 33,861,032	7%
Children	9,263	1.79	$ 191,573,836	$ 190,581,597	$ 180,245,668	$ (10,335,929)	-5%	99%	94%	$ 35,439,960	20%
Rural	11,140	0.66	$ 50,108,442	$ 57,125,068	$ 49,945,709	$ (7,179,359)	-13%	114%	100%	$ 391,489	1%
Rehabilitation	525	1.85	$ 8,428,885	$ 3,915,175	$ 4,343,024	$ 427,850	11%	46%	52%	$ 201,899	5%
Long Term Acute Care	86	2.87	$ 2,688,734	$ 1,648,369	$ 1,747,616	$ 99,247	6%	61%	65%	$ 116,898	7%
Out of state	412	1.22	$ 2,792,935	$ 1,074,871	$ 1,757,630	$ 682,759	64%	38%	63%	$ 25,840	1%

Notes:
1) Providers may be included in more than one category.
2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.
3) "General Acute" hospitals are those not otherwise categorized as Childrens, CHEP, High Charity, LTAC, Out of state, Rehab, Rural, Teaching or Trauma.
4) Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

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