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.





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





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?



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





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



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



Payment Design Decisions 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



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



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 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 Non-Covered Days days / length of stay)] 45-day benefit limit For 45-day benefit limit reduce payment only if none Undocumented non-citizens of the days of the stay are covered within the benefit Medicaid fee-for-service limit. If the limit is not exhausted at time of eligibility for part of a stay 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



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



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



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



Payment Design Decisions

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.



Pay-to-Cost Changes

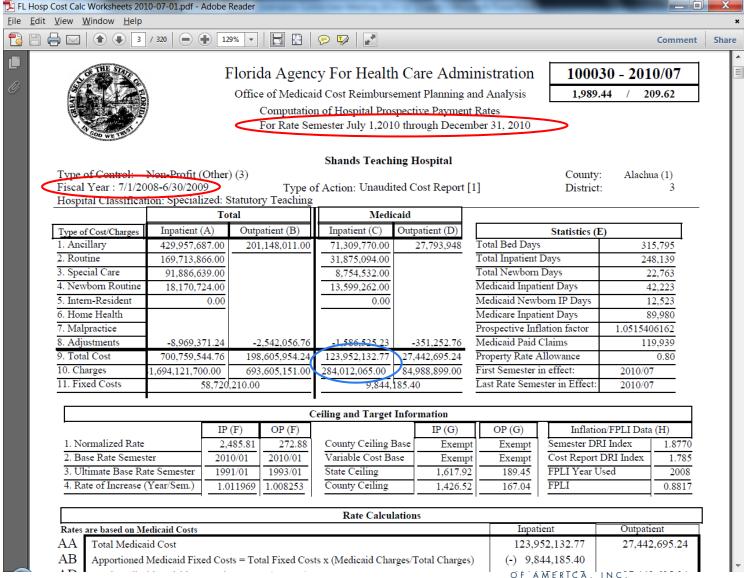




Pay-to-Cost Changes

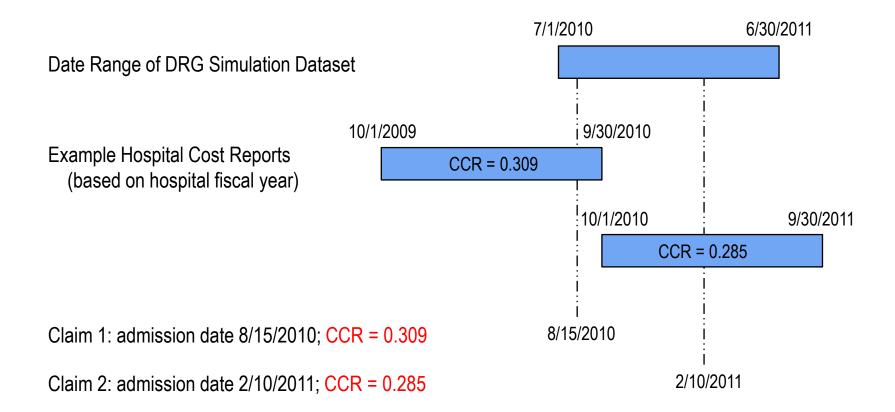
CCRs Calculated for Previous Simulations





CCRs Calculated for Latest Simulations







Pay-to-Cost Changes

New Pay-to-Cost Figures¹



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





Adjustment from 2010/2011 to 2013/2014





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



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							
	Ва	seline Payment	Ва	seline Payment	Pa	yment From							
		From GR and	Fi	rom Automatic	5	Self-Funded							
		PMATF		IGTs		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

Changes in Simulations Since Last Public Meeting





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 noncovered 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

Detailed Results of Simulation 17





Calculation of Budget Goals by Provider Category



	A	В	С	D	E	F	G	Н	I
			Baseline Payment From	Baseline Payment From Automatic	Self-Funded		Percentage of Cost	Total Budget	DRG Reimbursement from GR and
	Provider Classification	Stays	GR and PMATF		IGTs	Estimated Cost	Goal	Goal with IGTs	-
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 Bud	geted Payment:	\$ 2,917,106,490				

Notes:

14 = [C6 - (11 + 12 + 13)].





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.

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 rea	l casemix change a	nd 6% for documen	tation and coding in	nprovement
Relative weights	APR v.30 national re	e-centered to 1.0 for	FL Medicaid		
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost	\$31,000				
(MC) percentage	80%				
Low side (provider gain) threshold and marginal cost					
(MC) percentage	None				
Charge Cap	Yes - adjusting state	e share and IGT pay	ments		
Undocumented non-citizen non-covered day adjustment	Yes - adjusting state	e share and IGT pay	ments		

Detailed Results of Simulation 17

Summary by Service Line - Total



Simulation 17 Summary of Simulation by Service Line

																Simulated	Sim
		Casemix	Casemix				Baseline		Simulated			Percent	Baseline	Simulated		Outlier	Outlier %
Service Line	Stays	Recentered	DCI	Е	stimated Cost		Payment		Payment		Change	Change	Pay / Cost	Pay / Cost		Payment	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%	\$ 2	224,160,618	8%
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Notes:



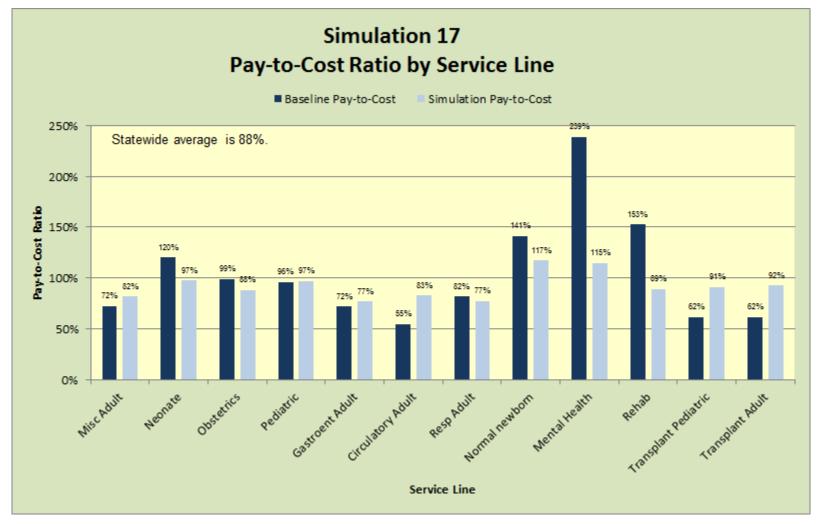


^{1) &}quot;Transplant" includes only those cases paid per diem, not through the global period.

²⁾ Estimated cost determined using AHCA cost-to-charge ratios from SFY 2010/2011 then inflated to midpoint of 2013/2014.

Pay-to-Cost by Service Line - Total



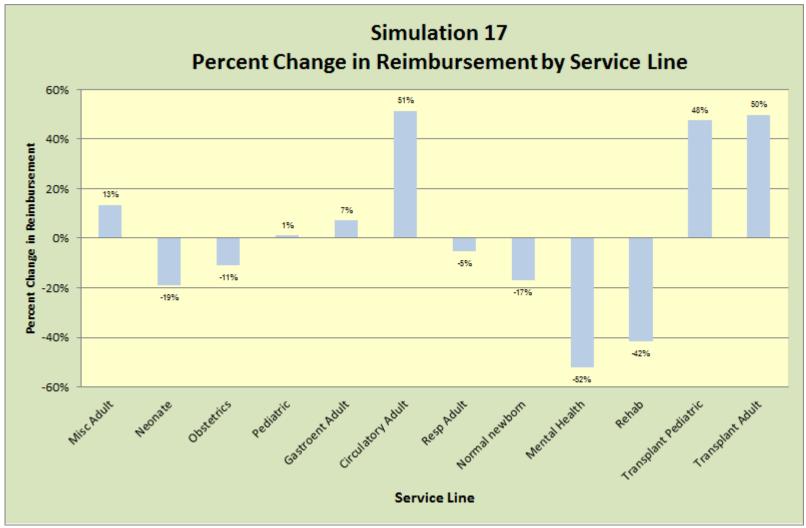






Change in Payment by Service Line







Detailed Results of Simulation 17

Summary by Provider Category



Simulation 17 Summary of Simulation by Provider Category

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		Casemix	Casemix		Baseline		Simulated				Percent	Baseline	Simulated	Simulated Outlier	Sim Outlier %
Provider Category	Stays	Recentered	DCI	Estimated Cost		Payment		Payment		Change	Change	Pay / Cost	Pay / Cost	Payment	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:

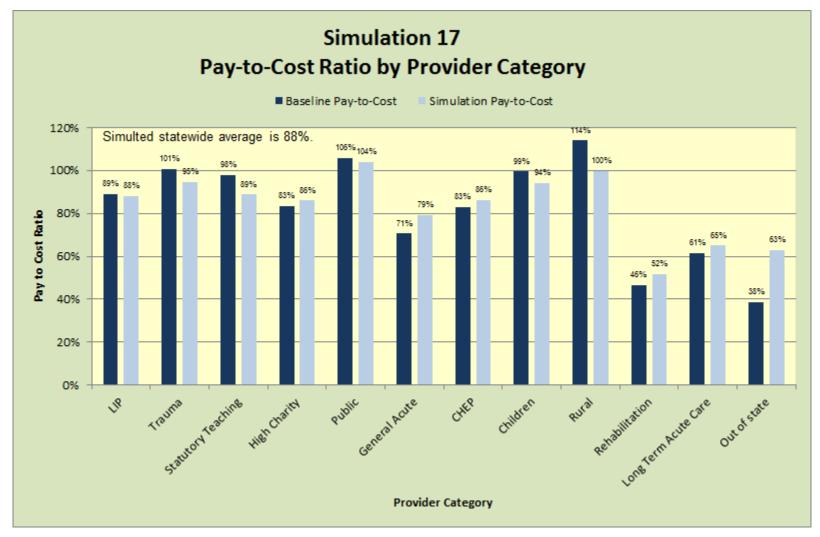
- 1) Providers may be included in more than one category.
- 2) "High Charity" is any hospital with 11% or more market share from Medicaid and uninsured recipients.
- 3) "General Acute" hospitals are those not otherwise categorized as Childrens, CHEP, High Charity, LTAC, Out of state, Rehab, Rural, Teaching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





Pay-to-Cost by Provider Category



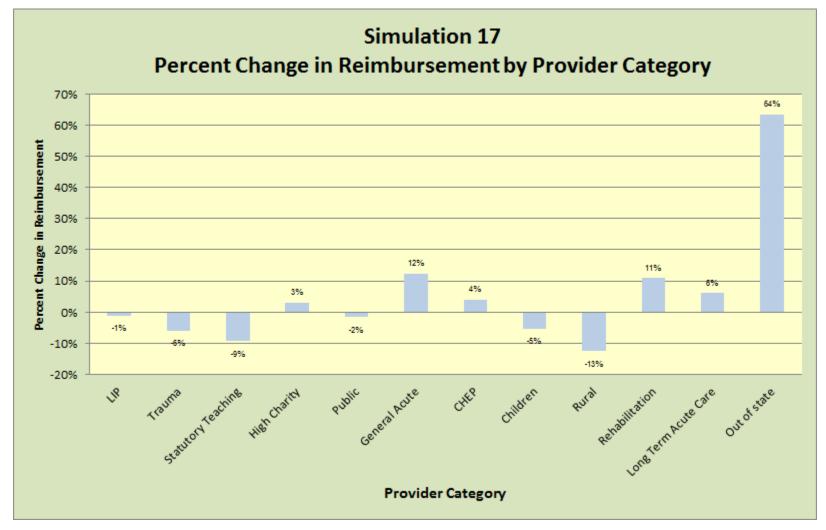






Change in Payment by Provider Category



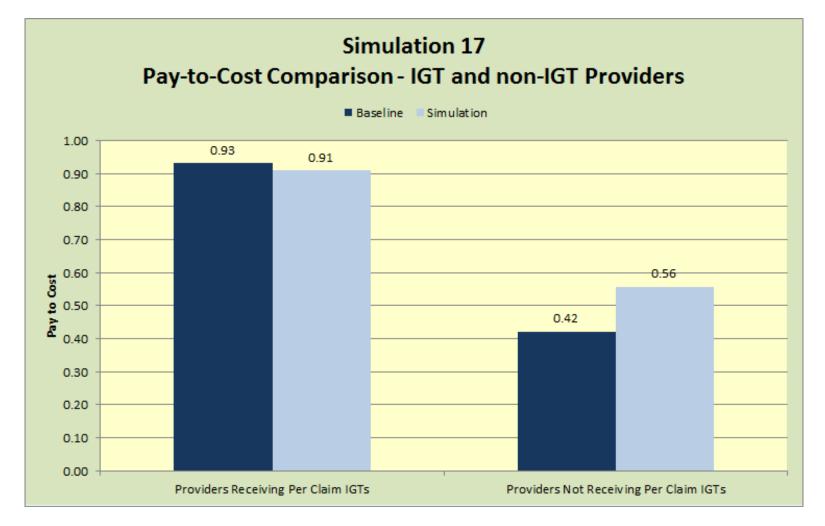






Pay-to-Cost Comparison – IGT vs. non-IGT Providers

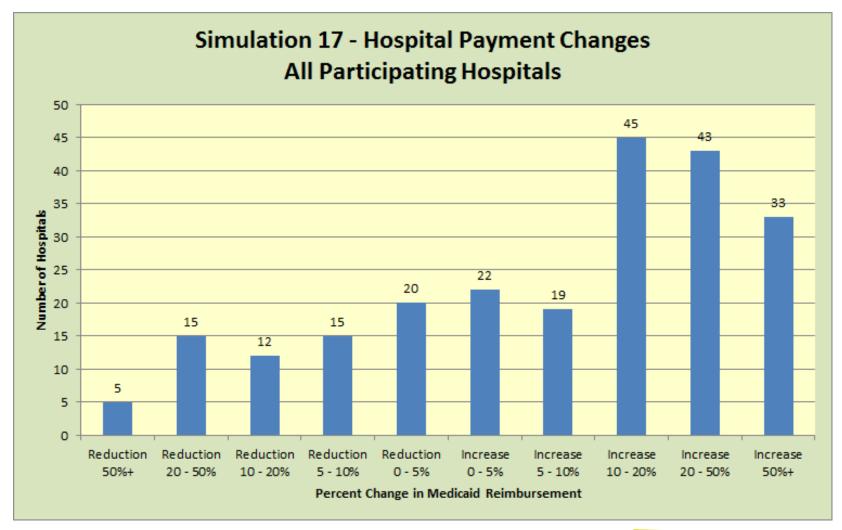






Provider Impact – All Hospitals



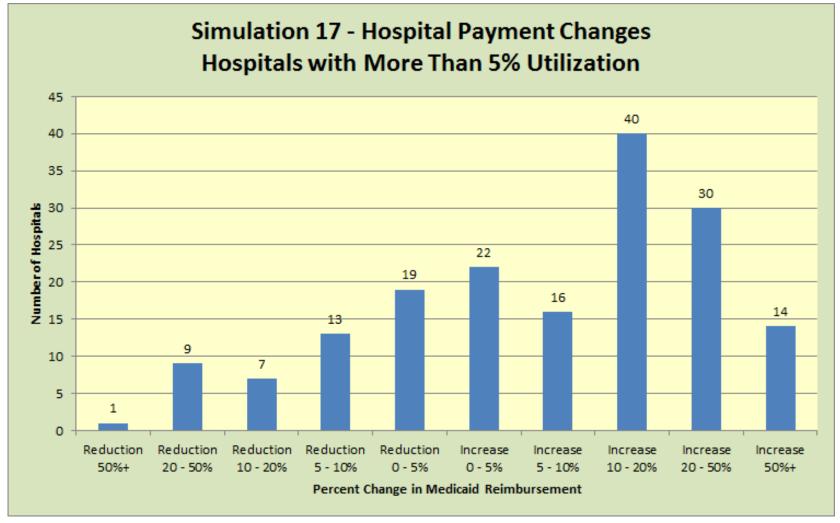






Provider Impact – Hospitals with > 5% Medicaid

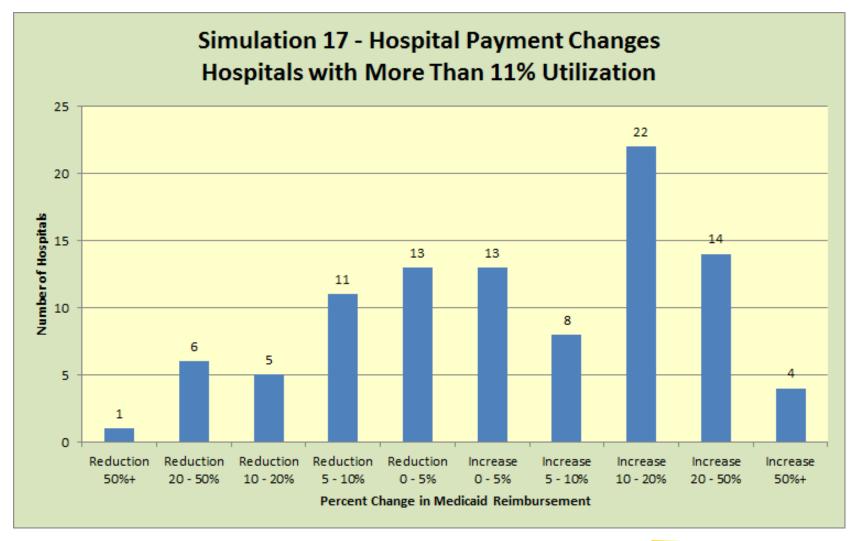






Provider Impact – Hospitals with > 11% Medicaid









Billing and Authorization Changes





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



Health Care Acquired Condition Payment Adjustments





Health Care Acquired Condition Payment Adjustments

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.



Health Care Acquired Condition Payment Adjustments

Using DRGs - Example with Payment Adjustment



Diag Code	<u>Description</u>	POA Indicator	HCAC?
715.35	Loc osteoarth NOS-pelvis	Υ	N
820.20	Trochanteric fx NOS-clos	N	Υ

HCAC Category: 05 - Falls and Trauma

DRG Assignment

<u>Using</u>	<u>Code</u>	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



Health Care Acquired Condition Adjustments with DRGs

Using DRGs - Example without Payment Adjustment



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

HCAC Category: 12 - Surgical site infection

DRG Assignment

<u>Using</u>	<u>Code</u>	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



Interpretation of Individual Hospital Simulation Results





Interpretation of Individual Hospital Simulation Results

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)
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- * hospital Medicaid volume
- * hospital DCI casemix
- * base rate



Public Comment





Appendix A – Claim Pricing Examples





48 Estimated cost of the stay 48 Estimated cost of the stay 49 Does this claim require an outlier payment? 40 Estimated boss on this case 50 Estimated boss on this case 50 NON-COVERED DAYS PAYMENT ADJUSTMENT 51 DRG cost outlier payment increase 50 NON-COVERED DAYS PAYMENT ADJUSTMENT 52 Non-covered days less than length of stay 53 Are covered days less than length of stay 54 Non-covered days less than length of stay 55 NCD Adjusted DRG base payment 56 NCD Adjusted autionatic IGT add-on payment 57 NCD Adjusted self-funded IGT add-on payment 58 NCD Adjusted self-funded IGT add-on payment 59 Per-charge cap allowed amount 50 CHARGE CAP 61 Does the charge cap apply? 62 Charge cap reduction factor 63 Final DRG base payment 64 Final DRG base payment 65 Final DRG base payment 66 Final DRG base payment 67 Final self funded IGT add-on payment 68 Final Self payment 69 Final Self payment 69 Final Self payment 60 Final DRG payment 60 Final DRG payment 61 Final self funded IGT add-on payment 62 Self Self Self Self Self Self Self Self	Estimated cost of the stay Does this claim require an outlier payment? 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Estimated cost of the stay		COST OUTLER		Pre outlier navment amount	nt .	44 Full stay automatic IGT add-on payment \$5,309.45	IGT casemix adjustor	FULL STAY ADD-ON IGT PAYMENTS		Full stay DDC base payment	40 Is per diem payment amount < full stay base payment? N/A	39 Per diem payment amount N/A	Is a transfer adjustment potentially applicable?	IKANSFER PAYMEN I AUGUS IMEN I		waxiiriurii policy aujusioi	Maximum policy adjustor	DDC BASE BAYMENT		32 HOSPITAL INFORMATION	31 Average length of stay for this APR-DRG 3.35	Age adjustor 1.	Service adjustor	28 Casemix relative weightre-centered for FL Medicaid 2.2224	וובו באילבושבואי	27 APR-DRG description REPLACEMENT	26 APR-DRG INFORMATION	Casemix adjustment factor		COSt odnier unesticia		ETERS SET BY MEDICAID		Hospital category	Hospital casellix	Hospital casemix	16 Hospital average per discharge self-funded IGT add on pymt \$1.304.49	15 Hospital average per discharge automatic IGT add on pymt \$3,447.88	14 Hospital-specific cost-to-charge ratio 40.34%	Patient share of cost	Other Health Coverage	Other health covered	Patient age (in years)	Patient discharge status = 02, 05, 65 or 66? (transfer)	9 Medicaid covered days 3			6 INFORMATION FROM THE HOSPITAL		Indicates data to be input by the user	Wote: specific policy values illicitated are for par poses of illustration oring.		2 Florida Medicaid DRG Pricing Calculator			
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* E24 * E35 Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" res", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "NA" res" then [if (E39 < E36), then "Yes" else "No"] Else "N/A" res" Then E39 Else E36	225 Then maximum of (E29, E30, E33) Else maximum of (E29, E3 \$ * E24 * E35 Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A" Yes" Then [if (E39 < E36), then "Yes" else "No"] Else "N/A" "Yes" Then E39 Else E36	225 Then maximum of (E29, E30, E33) Else maximum of (E29, E3) * E24 * E35 Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" 'es", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A" 'Yes" then (If (E39 < E36), then "Yes" else "No"] Else "N/A" 'Yes" then (F36) * E36).	2:25 Then maximum of (E29, E30, E33) Else maximum of (E29, E3) * E24 * E35 * E24 * E35 * E34 * E35 * E34 * E35 * E35 * E3	225 Then maximum of (E29, E30, E33) Else maximum of (E29, E3) * E24 * E35 ** E24 * E35 ** Pass ** Pas	257 Then maximum of (E29, E30, E33) Else maximum of (E29, E3) 1 * E24 * E35 Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No"	E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E3) * E24 * E35	E25 Then maximum of (E29, E30, E33)	E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E3:	TOE Then mentioned of (TOO TOO TOO) The mentioned of (TOO TO)		on provider adjacen ware	l ook up from provider adjustor table		Look up from DRG table	om DRG table	l ook up from DRG table	Look up from DRG table		Look up from DRG table		djust DRG relative weights should a need arise, else leave set to 1.0	Used for cost outlier adjustments	Used for cost outlier adjustments	Used for URG base payment		arate APR-DRG grouping software	From drop down list - used to determine provider policy adjustor	Liosphiais allitudi avetage i Elimedicala AFN-DNO telative weight	annual average El Medicaid ADD_DDG relative weight			Used to estimate the hospital's cost of this stay	Includes spend-down or copayment	OD-04 Fleid Edicator of for payments by unite parties	Cook for ago adjacer	ne adjustor	Used for transfer pricing adjustment	Used for covered days adjustment	ransfer pricing and covered days adjustments	UB-04 Field Locator 47 minus FL 48		Comments or Formula	Indicates payment policy parameters set by Medicaid				c	n.	





C	E	F
Florida Medicaid DRG Pricing Calculator		
Note: Specific policy values included are for purposes of illustration only	tration only.	
Indicates data to be input by the user		Indicates payment policy parameters set by Medicaid
Information 6 INFORMATION FROM THE HOSPITAL	Data	Comments or Formula
	\$62,435.30 18	UB-04 Field Locator 47 minus FL 48 Used for transfer pricing and covered days adjustments
0	No 13 5	Used for covered days adjustment Used for transfer pricing adjustment Used for transfer pricing adjustment
	55 \$ 0 00	Used for age adjustor IIB-04 Field I grather 4 for navments by third parties
	\$0.00	Includes spend-down or or payment
14 nospital-specinic cost-to-citatige ratio 15 Hospital average per discharge automatic IGT add on pymt 16 Hospital average per discharge self-funded IGT add on pymt	\$4,916.26 \$1,189.85	used to estillate the includes cost of this stay
	1.2448 All Other	Hospital's annual average FL Medicaid APR-DRG relative weight From drop down list - used to determine provider policy adjustor
_	000-3	riuii sepalale Ark-uko gioupiiig suiware
21 DRG standardized base rate 22 Cost outlier threshold	\$3,600 \$27,425	Used for DRG base payment Used for cost outlier adjustments
	80% 1.00	Used for cost outlier adjustments Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
26 APR-DRG INFORMATION	ō	
27 APR-DRG description	REHABILITATION	Look up from DRG table
28 Casemix relative weight-re-centered for FL Medicaid	2.1072 1.350	Look up from DRG table
30 Age adjustor 31 Average length of stay for this APR-DRG	1.000 14.79	Look up from DRG table Look up from DRG table
	1.000	Look up from provider adjustor table
		IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33)
37 TRANSFER PAYMENT ADJUSTMENT	\$10,241.11	EZ1 - EZ8 - EZ4 - E35
38 Is a transfer adjustment potentially applicable?39 Per diem payment amount	No N/A	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" 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? 41 Full stay DRG base payment	N/A \$10,241.11	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "NA" IF E40 = "Yes" Then E39 Else E36
	1.69	E28 / E17
	\$8,322.35 \$2,014.20	E10 * E43 E16 * E43
	\$E0,011.00	[T] . [T]
	\$23,113.55 No	E7 * E14 IF (E48-E46) > E22 Then "Yes" Else "No"
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 F9 < F8 Then "Yes" FIse "No"
	1.0000	IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
	\$0.00	E51 * E54
57 NCD Adjusted automatic IGT add-on payment 58 NCD Adjusted self-funded IGT add-on payment	\$8,322.35 \$2,014.20	E44 * E54 E45 * E54
	\$20,577.66	E55 + E56 + E57 + E58
	No	IF E59 > E7 Then "Yes" Else "No"
63 Final DRG base payment	\$10,241.11	If E01 = TeS THEH E7 / E39 EISE 1.0 E55 * E62
	\$0.00 \$10.241.11	E56 * E62 E63 + F64
	\$8,322.35	E57 * E62
67 Final self funded IGT add-on payment \$2,01	\$2,014.20 NT AMOUNT	E58 * E62
69 Allowed amount 70 Other health coverage	\$20,577.66 \$0.00	E65 + E66 + E67 F12
	\$0.00	180 E70 E71) < 0 than E80 E70 E74 also
71 Patient share of cost		IT (E09-E70-E71) < 0, IIIeII E09-E70-E71, else 0





2	Florida Medicaid DRG Pricing Calculator	tor -	G
ω	Note: Specific policy values included are for purposes of illustration only	ation only.	
4	Indicates data to be input by the user		Indicates payment policy parameters set by Medicaid
6	Information INFORMATION FROM THE HOSPITAL	Data	Comments or Formula
8	Submitted charges Length of stay	\$5,563.70 2	UB-04 Field Locator 47 minus FL 48 Used for transfer pricing and covered days adjustments
9	Medicaid covered days Patient discharge status = 02, 05, 65 or 66? (transfer)		Used for covered days adjustment Used for transfer pricing adjustment
12	e	46 \$0.00	Used for age adjustor UB-04 Field Locator 54 for payments by third parties
14	Patient share of cost Hospital-specific cost-to-charge ratio	\$0.00 34.02%	Includes spend-down or copayment Used to estimate the hospital's cost of this stay
16	Hospital average per discharge automatic IGT add on pymt Hospital average per discharge self-funded IGT add on pymt	\$0.00 \$0.00	
19 18 7	nospital casettiix Hospital casegory APR-DRG	0.7456 Rural 722-1	ruspitat s attituat average r. medicatio Ark-Diko relative weigiti. From drop down list - used to determine provider policy adjustor From separate APR-DRG grouping software
21	PAYMENT POLICY PARAMETERS SET BY MEDICAID DRG standardized base rate	\$3,600	Used for DRG base payment
2 23 23	Cost outlier threshold Marginal cost percentage Cost percentage	\$27,425 80%	Used for cost outlier adjustments Used for cost outlier adjustments Used for cost outlier adjustments
25 26	Age cut-off for age policy adjustor APR-DRG INFORMATION	18	
27	APR-DRG description	FEVER	Look up from DRG table
28 29 30 31	Casemix relative weightre-centered for FL Medicaid Service adjustor Age adjustor Average length of stay for this APR-DRG	0.4665 1.000 1.000 2.22	Look up from DRG table
33 8	Provider adjustor Provider adjustor	1.757	Look up from provider adjustor table
35	Maximum policy adjustor Pre Transfer DRG base payment	1.757 \$2,950.84	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33) E21 * E28 * E24 * E35
37 38 39	RANSPER PAYMEN ADJUSTIMENT Is a transfer adjustment potentially applicable? Per diem payment amount Is per diem payment amount < full slav base payment?	N/A N/A	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "NA" IF E38 = "Yes" then If (E39 < E36), then "Yes" else "No" Else "NA"
42	FULL STAY ADD-ON IGT PAYMENTS	\$2,950.84	IF EAU = Tes THEILESS EISE ESO
44	GI casemix adjustor Full stay automatic IGT add-on payment	\$0.00	E28 / E17 E15 * E43
46	Full Stay self-funded IG1 add-on payment Pre outlier payment amount	\$0.00 \$2,950.84	E16 × E43 E41 + E44 + E45
47	COST OUTLIER Estimated cost of the stav	¢1 000 77	C7 * C4.4
49 50	Estimated loss or the stay Does this claim require an outlier payment? Estimated loss on this case	No No No	F
51 52	DRG cost outlier payment increase NON-COVERED DAYS PAYMENT ADJUSTMENT	\$0.00	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
53 54	Are covered days less than length of stay Non-covered day reduction factor	No 1.0000	IF E9 < E8 Then "Yes" Else "No" IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
55	NCD Adjusted DRG base payment	\$2,950.84	E41 * E54
57	NCD Adjusted automatic IGT add-on payment NCD Adjusted automatic IGT add-on payment	\$0.00	E44 * E54
59	Pre-charge cap allowed amount	\$2,950.84	E55 + E56 + E57 + E58
61	Does the charge cap apply?	No	IF E59 > E7 Then "Yes" Else "No"
₀ දි	Charge cap reduction factor Final DRG base payment	1.0000 \$2,950.84	IF E61 = "Yes" Then E7 / E59 Else 1.0 E55 * E62
65 20	Final Outlier payment Final DRG payment	\$0.00 \$2.950.84	E56 * E62 E63 + E64
99	Final automatic IGT add-on payment	\$0.00	E57 * E62
67 68	Final self funded IGT add-on payment \$0. CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT	\$0.00	E58 * E62
69	Allowed amount	\$2,950.84	E65 + E66 + E67
71	Patient share of cost	\$0.00	Et3
73	Payment amount 12/20/2012	\$2,950.84	IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
	CALCULATOR VA	LUES ARE FOR PURP	CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.





5 6 6 6 7 7 7 9 9 9 110 111 111 111 111 111 111 111 1	Information Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 66? (transfer) Patient age (in years) Other health coverage Patient share of cost Hospital-specific cost-to-charge ratio Hospital average per discharge automatic IGT add on pymt Hospital casemix	\$17,072.00 1 1 No 0 \$0.00 27,51% \$4,433.85 \$0.00 1,4905 High Medicaid & High Outlier 850-2 \$3,600 \$77,455	UB-04 Field Locator 47 minus FL 48 Used for transfer pricing and covered days adjustments Used for transfer pricing adjustment Used for transfer pricing adjustment Used for a get adjustor UB-04 Field Locator 54 for payments by third parties Includes spend-down or copayment Used to estimate the hospital's cost of this stay Hospital's annual average FL Medicaid APR-DRG relative weight From drop down list - used to determine provider policy adjustor From separate APR-DRG grouping software Used for CRG base payment Used for CRG base payment Used for Cost Juditier adjustments Used for Cost Juditier adjustments
21 22 22 22 22 22 22 22 22 22 22 22 22 2	DRG standardized base rate Cost outlier threshold Marginal cost percentage Casemix adjustment factor Age cut-off for age policy adjustor APR-DRG INFORMATION APR-DRG INFORMATION APR-DRG description Casemix relative weight—re-centered for FL Medicaid Service adjustor Age adjustor Age adjustor Age adjustor Age adjustor	\$3,600 \$27,425 80% 1.00 18 PROCEDURE W DIAG OF REHAB, AFTERCARE OR OTH CONTACT W HEALTH 1.9283 1.350 1.000 4.45	Used for DRG base payment Used for cost outlier adjustments Used for cost outlier adjustments Used for cost outlier adjustments Used to adjust DRG relative weights should a need arise, else leave set to 1.00. Look up from DRG table
36 35 33 33	HOSPITAL INFORMATION Provider adjustor DRG BASE PAYMENT Maximum policy adjustor Pre Transfer DRG base payment	1.762 1.762 \$12,231.83	Look up from provider adjustor table IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33) E21 * E28 * E24 * E35
38 39 39 41 42 42 43	Is a transfer adjustment potentially applicable? Per diem payment amount stull stay base payment? Eult stay DRG base payment Full stay automatic IGT add-on payment Full stay automatic IGT add-on payment	NO N/A N/A \$12,231.83 1.29 \$5,762.18	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A" IF E38 = "Yes" then (If (E39 < E36), then "Yes" else "No"] Else "N/A" IF E40 = "Yes" Then E39 Else E36 E28 / E17 E28 / E17
45 46 46 47 48 49 50 51	Full stay automatic IGT add-on payment Full stay self-funded IGT add-on payment Pre outlier payment amount COST OUTLIER Estimated cost of the stay Does this claim require an outlier payment? Estimated toss on this case DRG cost outlier payment increase DRG cost outlier payment increase	\$5,762.18 \$0.00 \$17,994.01 \$4,696.51 No N/A \$0.00	E15 * E43 E41 * E44 + E45 E41 + E44 + E45 E7 * E14 IF (E48-E46) > E22 Then "Yes" Else "No" IF E49 = "Yes" Then E48 - E46 Else "NA" IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
53 54 55 56 57 58	Are covered days less than length of stay Non-covered day reduction factor NCD Adjusted DRG base payment NCD Adjusted outlier payment NCD Adjusted automatic IGT add-on payment NCD Adjusted automatic IGT add-on payment Pre-charge cap allowed amount	No 1.0000 \$12.231.83 \$0.00 \$5,762.18 \$0.00 \$17,994.01	IF E9 < E8 Then "Yes" Else "No" IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0 E41 * E54 E51 * E54 E44 * E54 E45 * E54 E45 * E56
9 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	Does the charge cap apply? Charge cap reduction factor Final DRG base payment Final DRG payment Final automatic IGT add-on payment Final self funded IGT add-on payment	Yes 0.9488 \$11,605.07 \$0.00 \$11,605.07 \$51,606.93 \$0.00	IF E59 > E7 Then "Yes" Else "No" IF E61 = "Yes" Then E7 / E59 Else 1.0 E55 * E62 E56 * E62 E63 * E64 E57 * E62 E58 * E62
73 73	CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT Allowed amount \$17,0 Other health coverage \$0 Patient share of cost Payment amount \$17,0 \$0 CALCULATOR VALUES ARE	REIMBURSEMENT AMOUNT \$17,072.00 \$0.00 \$0.00 E12 \$0.00 E13 \$17,072.00 IF (E69-E70-E71) > 0, then	E65 + E66 + E67 E12 E13 IF (E69-E70-E71) > 0, then E69-E70-E71, else 0





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10	Florida Medicaid DRG Pricing Calculator		
-	Note: Specific policy values included are for purposes of illustration only	ustration only.	
-	Indicates data to be input by the user		Indicates payment policy parameters set by Medicaid
0, 0.	Information INFORMATION FROM THE HOSPITAL	Data	Comments or Formula
~ ~	Submitted charges Length of stay	\$149,692 20	UB-04 Field Locator 47 minus FL 48 Used for transfer pricing and covered days adjustments
10	Medicaid covered days Patient discharge status = 02, 05, 65 or 667 (transfer)	20 No	Used for covered days adjustment Used for transfer pricing adjustment
3 7 =	raueni aye (iii yeers) Other health coverage Palient share of cost	\$0.00 \$0.00	used for age adjustor UB-04 Field Locator 54 for payments by third parties Inclides spend-down or consyment
4 70	Hospital-specific cost-to-charge ratio Hospital average per discharge automatic IGT add on pymt	37.02% \$2,738.41	Used to estimate the hospital's cost of this stay
17	Hospital casemix Hospital casegory	1.2448 High Medicaid & High Outlier	Hospital's annual average FL Medicaid APR-DRG relative weight From drop down list - used to determine provider policy adjustor
20	APR-DRG PAYMENT POLICY PARAMETERS SET BY MEDICAID	199-4	From separate APR-DRG grouping software
22	DRG standardized base rate Cost outlier threshold	\$3,600 \$27,425	Used for DRG base payment Used for cost outlier adjustments
22	Marginal cost percentage Casemix adjustment factor	80% 1.00	Used for cost outlier adjustments Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
8	APR-DRG INFORMATION	ō	
27	APR-DRG description	HYPERTENSION	Look up from DRG table
28	Casemix relative weight-re-centered for FL Medicaid Service adjustor Age adjustor Average lendth of stav for this APR-DRG	2.4697 1.000 1.000 7.88	Look up from DRG table
8 8	Provider adjustor	1.762	Look up from provider adjustor table
2 8 8 4	Maximum policy adjustor Pre Transfer DRG base payment	1.762 \$15,665.94	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33) E21 * E28 * E24 * E35
40 39 38	IX ANNA PER PAYMEN ADJUSTIMENT Is a transfer adjustment potentially applicable? Per diem payment amount Is per diem payment amount < full stay base payment? Full stay DRG base payment Full stay TRAY ADDON IGT DRAYMENTS.	No N/A N/A \$15,665.94	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "NA" IF E38 = "Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A" IF E40 = "Yes" Then E39 Else E36
6 4 4 4 6	IGT casemix adjustor Full stay automatic IGT add-on payment Full stay self-funded IGT add-on payment Pre outlier payment amount	1.98 \$5,433.09 \$6,182.94 \$27,281.97	E28 / E17 E15 * E43 E16 * E43 E41 + E44 + E45
49 49 50 51	COST OUTLER Estimated cost of the stay Does this claim require an outlier payment? Estimated loss on this case DRG cost outlier payment increase	\$55,416.07 Yes \$28,134.10 \$567.28	E7 * E14 IF (E48-£46) > E22 Then "Yes" Else "No" IF E49 = "Yes" Then E48 - E46 Else "NVA" IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
1 2 4	Are covered days less than length of stay Non-covered day reduction factor	No 1.0000	IF E9 < E8 Then "Yes" Else "No" IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0
7 8 8	NCD Adjusted DRG base payment NCD Adjusted outlier payment NCD Adjusted automatic IGT add-on navment	\$15,665.94 \$567.28 \$5 433 09	E41 * E54 E51 * E54 F44 * E54
56	NCD Adjusted self-funded IGT add-on payment Pre-charge cap allowed amount CHARGE CAP	\$6,182.94 \$27,849.25	E45 * E54 E55 + E56 + E57 + E58
8 8 9	Does the charge cap apply? Charge cap reduction factor Final DRG base payment	No 1.0000 \$15,665,94	IF E59 > E7 Then "Yes" Else "No" IF E61 = "Yes" Then E7 / E59 Else 1.0 E55 * E62
2 2 2	Final outlier payment Final DRG payment	\$567.28 \$16,233.22	E56 * E62 E63 + E64
3 27	Final self funded IGT add-on payment \$6,18 CALCULA TOO OF ALL OWED AMOUNT AND DEBUGUETAT AMOUNT AND DEBUGUETAT AMOUNT AND DEBUGUETAT AMOUNT AND DEBUGUETAT AMOUNT AMOUNT AND DEBUGUETAT AMOUNT	\$6,182.94	E58 * E62
30	Allowed amount Other health coverses	\$27,849.25 \$0.00	E65 + E66 + E67
3 = 3	Patient share occupy Patient share of cost Payment amount	\$0.00 \$0.00	E13 E13 IF (FRO.E70.E71) > 0 than ERO.E70.E71 also 0
73	12/20/2012	VALUES ARE EOR BURBOS	TO OF ILLINSTRATION ONLY
	CALCULATOR	R VALUES ARE FOR PURPOS	CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.





Florida Medicaid DRG Pricing Calculator Mode. Specific policy values included are for purposes of illustration only. Indicates date to be input by the user Incommon and age (in years) Shamind change status = 02, 05, 65 or 667 (transfer) Shamind change status = 02, 05, 65 or 667 (transfer) Shamind change status = 02, 05, 65 or 667 (transfer) Hospital average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange saldomatic (GT add on pyrmt thousand average per dischange) Casamin relative weight-re-centerage per per dischange (GT add on pyrmt thousand average population thousand average population thousand average per dischange (GT add on pyrment thousand average per per dischange to the saldomatic (GT add on pyrment thousand average per per dischange to the saldomatic (GT add on pyrment thousand average per per dischange (GT add on pyrment thousand average per per per per per per per per per pe	C
Participated Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of fillustration only. Inflormation Information	Florida Medicaid DRG Pricing Calculator Andre Specific policy values included are for purposes of illustration only. Indicates date to be input by the sear Indicate date to be input by the sear Indicates date on the sear Indicates date and the sear and search searc
Florida Medicaid DRG Pricing Calculator Mote: Specific policy values included are for purposes of illustration only. More Specific policy values included are for purposes of illustration only. Microbust Property of the Control of Stay Information only. Microbust Charges status = 02, 05, 65 or 687 (tansfer) Definition of Stay Information Private Specific policy status = 02, 05, 65 or 687 (tansfer) Private Specific policy status = 02, 05, 05 or 687 (tansfer) Private Specific policy status = 02, 05, 05 or 687 (tansfer) Private Specific policy status = 02, 05, 05 or 687 (tansfer) Private Specific policy status = 02, 05, 05 or 687 (tansfer) Private Specific policy status = 02, 05, 05 or 687 (tansfer) Private Specific policy sta	Florida Medicaid DRG Pricing Calculator More Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Data Medicaid covered days Longin of stay Deland dachings paths = 02, 05, 65 or 88? (transfer) Palend age (in years) Palend achieving salido be charge rate Proposition of stay Deland start of cost Acquired achieving salidonable (GT add on pyrint Hospital careing Hospital careing Hospital careing Hospital careing Proposition of stay for this APR-DRG Apa equision Apa equision Proposition and solution an
Florida Medicaid DRG Pricing Calculator More: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Bothmitted charges Langta of sky Medicaid covered days England discharge self-the charge ratio Record discharge self-the charge ratio Respirate specific code and specific code charge ratio Respirate specific code charge self-funded (GT add on pyrint Respirate shapes per discharge self-funded (GT add on pyrint Respirate shapes per discharge self-funded (GT add on pyrint Respirate shapes per discharge self-funded (GT add on pyrint Respirate shapes per discharge self-funded (GT add on pyrint Respirate shapes per discharge self-funded (GT add on pyrint Respirate shapes per discharge self-funded (GT add-on pyrint Respirate pyrint) Respirate pyrint pour pyrint Respirate pyrint pyrint pyrint Respirate pyrint pyrint Respirate pyrint pyrint Respirate pyrint pyrint R	FIORIDA Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Balantic charges Sammind charges Alternatic covered days Palant discharge status - 02, 05, 65 or 80? (transfer) Sammind charges Alternatic covered days Palant discharge status - 02, 05, 65 or 80? (transfer) Cher health coverage Palant discharge status - 02, 05, 65 or 80? (transfer) Palant discharge status - 02, 05, 65 or 80? (transfer) Cher health coverage Palant discharge status - 02, 05, 65 or 80? (transfer) Alternatic covered days Palant discharge status - 02, 05, 65 or 80? (transfer) Palant discharge status - 02, 05, 65 or 80? (transfer) Cher health coverage Palant discharge status - 02, 05, 65 or 80? (transfer) Alternatic covered days Palant discharge status - 02, 05, 65 or 80? (transfer) Alternatic covered days Palant discharge status - 02, 05, 65 or 80? (transfer) Alternatic covered days Palant discharge status - 02, 05, 65 or 80? (transfer) Alternatic coverage Palant share of cost occasions Alternatic coverage Palant share of cost occasions Alternatic coverage Palant share of cost occasions Alternatic discharge automatic IGT add on pymt Alternatic pyment amount Alternatic pyment pyment Alternatic pyment
DRG Pricing Calculator Included are for purposes of illustration only. be imput by the user be defined by the user be unionable IGT add on pymt a self-funded IGT add on pymt a self-funded IGT add on pymt self-funded IGT add on pymt a self-funded IGT add on pymt by self-funded IGT add on pymt a self-funded IGT add on pymt by self-funded IGT add on pymt a self-funded IGT add on pymt by self-funded IGT	DRG Pricing Calculator included are for purposes of illustration only. be input by the user Data OS, 65 or 667 (transfer) Salif-funded IGT add on pymt a self-funded IGT add on pymt b self-funded IGT add on pymt 1.4432 All Other 1.000 \$3,000 \$27,425 80% 1.000 1.000 APR-DRG APR-
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 data to be input by the user by medical Indicates data to be input by the user by medical Indicates data to be user data to be indicated Indicates data to be user data to be indicated Indicates data to be user data to be used to be use	Florida Medicaid DRG Pricing Calculator More: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Information Information Information only. Information Informati
DRG Pricing Calculator Included are for purposes of illustration only. be input by the user Deta OS-PITAL S17,978 4 4 4 4 4 4 4 4 4 50, 65 or 66? (transfer) S17,978 4 4 4 4 4 4 4 4 50 00 \$0,000 \$1,443 \$0,000 \$1,443 \$1,200 \$1,250 \$3,255 \$4,355 \$4,355 \$4,355 \$4,355 \$4,355 \$4,355 \$6,4355 \$6,	DRG Pricing Calculator included are for purposes of illustration only. Data Dos, 65 or 667 (transfer) Be automatic IGT add on pymt as self-funded IGT add on pymt as self-funded IGT add on pymt be self-funded IGT add on pymt as self-funded IGT add on pymt as self-funded IGT add on pymt be as the material IGT add on pymt as self-funded IGT add on pymt be as the material IGT add on pymt be as the m
DRG Pricing Calculator	DRG Pricing Calculator included are for purposes of illustration only. Data Dos, 65 or 667 (transfer) Be automatic IGT add on pymt a self-funded IGT add on pymt a self-funded IGT add on pymt be self-funded IGT add on pymt a self-funded IGT add on pymt be self-funded IGT add o
DRG Pricing Calculator	DRG Pricing Calculator
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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 Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Medicaid covered days Patient discharge status = 02, 05, 65 or 66? (transfer) Patient share of cost Hospital average per discharge automatic IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital casemix Hospital c	Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Information Info
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Florida Medicaid DRG Pricing Calculator Mote: Specific policy values included are for purposes of illustration only. Indicates data to be Input by the user Information NFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 667 (transfer) Patient den years) Other health coverage Patient share of cost Hospital-specific cost-to-charge ratio Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital average per discharge self-funded IGT add on pymt Hospital self	Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be Input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 667 (transfer) Patient discharge status = 02, 05, 65 or 667 (transfer) Patient share of cost Hospital-specific cost-to-charge ratio Hospital average per discharge self-funded IGT add on pymt Hospital average per dis
Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be Input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicate days Patient discharge status = 02, 05, 65 or 667 (transfer) Other health coverage Hospital-specific cost-to-charge ratio Hospital average per discharge automatic IGT add on pymt Example Calculator Bate UB-04 Fleit Used for transfer)	Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be Input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 66? (transfer) Other health coverage Hospital-specific cost-to-charge ratio Hospital average per discharge automatic IGT add on pymt Fig. 2 B F F F F F F F F F F F F F
Florida Medicaid DRG Pricing Calculator Mote: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Length of stay Patient discharige status = 02, 05, 65 or 667 (transfer) Patient discharige status = 02, 05, 65 or 667 (transfer) Other health coverage Patient share of cost. Used for its Patient share of cost. Used for its Us	Florida Medicaid DRG Pricing Calculator Wote: Specific policy values included are for purposes of illustration only. Indicates data to be Input by the user Information Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Patient discharge status = 02, 05, 65 or 667 (transfer) Other health coverage Patient share of cost. The horper station Uncludes status = 02, 05, 65 or 667 (transfer) Used for its Used for its Used for its Patient age (in years) Other health coverage Used for its Used for its Used for its Patient share of cost. The horper station of the cost-th-charge status = 02, 05, 65 or 667 (transfer) Used for its Used
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C D E F Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 667 (transfer) Patient ace for ware? Design of the property of the user	Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only. Indicates data to be input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 667 (transfer) Patient age (in ware) Data Used for to Used for to Used for the User Canada and Inverse Canada and
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Medicaid DRG Pricing Calculator policy values included are for purposes of illustration only. Information N FROM THE HOSPITAL UB-04 Field 1985	Medicaid DRG Pricing Calculator policy values included are for purposes of illustration only. Information N FROM THE HOSPITAL Data UB-04 Field UB-04 Field UB-04 Field Used for tall UB-04 Field
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1 2 2 2 2 3 3 3 3 7 7 7 7 7 10 10 10 10 10 10 10 10 10 10 10 10 10	Florida Medicaid DRG Pricing Calculator Note: Specific policy values included are for purposes of illustration only Indicates data to be input by the user Information INFORMATION FROM THE HOSPITAL Submitted charges Length of stay Medicaid covered days Patient discharge status = 02, 05, 65 or 66? (transfer) Patient age (in years) Other health coverage Patient share of cost Hospital-specific cost-to-charge ratio	E lator Stration only. Data \$19,760 4 4 2 No 36 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicates payment policy parameters set by Medicaid Comments or Formula UB-04 Field Locator 47 minus FL 48 Used for transfer pricing and covered days adjustments Used for transfer pricing adjustment Used for age adjustor UB-04 Field Locator 54 for payments by third parties Includes spend-down or copayment Used to estimate the hospital's cost of this stay
15 16 17 17 18 19 20 21	Hospital average per discharge automatic lGT add on pyrnt Hospital average per discharge self-funded IGT add on pyrnt Hospital casemix Hospital calegory APR-DRG PAYMENT POLICY PARAMETIERS SET BY MEDICAID DRG standardized base rate	\$2,788.77 \$904.91 1.1634 All Other 320-2 \$3,600	Hospital's annual average FL Medicaid APR-DRG relative weight From drop down list - used to determine provider policy adjustor From separate APR-DRG grouping software Used for DRG base payment
22 23 22 23 25 25 25 25 25 25 25 25 25 25 25 25 25	DRG standardized base rate Cost outlier threshold Marginal cost percentage Casemix adjustment factor Age cut-off for age policy adjustor	\$3,600 \$27,425 80% 1.00 18	Used for DRG base payment Used for cost outlier adjustments Used for cost outlier adjustments Used for cost outlier adjustments Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
26 27 27 28 28 29 30 31		OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE 1.8603 1.000 1.000 4.36	Look up from DRG table
38 33 33 33	HOSPITAL INFORMATION Provider adjustor DRG BASE PAYMENT Maximum policy adjustor Pre Transfer DRG base payment	1.000 1.000 \$6,697.09	Look up from provider adjustor table IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33) E21 * E28 * E24 * E35
38 38 39 41	IRANSFER PAYMENT ADJUSTIMENT IRANSFER PAYMENT ADJUSTIMENT Is a transfer adjustment potentially applicable? Per diem payment amount < full stay base payment? Full stay DRG base payment Full stay DRG base payment	No N/A N/A \$6,697.09	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" IF E38="Yes", then (E36 / E31) * (E9 + 1) rounded to 2 places, else "N/A" IF E38 = "Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A" IF E40 = "Yes" Then E39 Else E36
1 6 5 4 5 4	IGT casemix adjustor IGT casemix adjustor Full stay automatic IGT add-on payment Full stay self-funded IGT add-on payment Pre outlier payment amount	1.60 \$4,459.31 \$1,446.97 \$12,603.37	E28 / E17 E15 * E43 E16 * E43 E41 + E44 + E45
48 49 50 51	Estimated cost of the stay Does this claim require an outlier payment? Estimated loss on this case DRG cost outlier payment increase NRC OVEREND DAYS DAYS DAYS DAYS DAYS DAYS DAYS DAY	\$5,467.65 No N/A \$0.00	E7 * E14 IF (E48-E46) > E22 Then "Yes" Else "No" IF E49 = "Yes" Then E48 - E46 Else "N/A" IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
53 54 55 56 57 58	Are covered days less than length of stay Non-covered day reduction factor NCD Adjusted DRG base payment NCD Adjusted outlier payment NCD Adjusted automatic IGT add-on payment NCD Adjusted self-funded IGT add-on payment Pre-charge cap allowed amount	Yes 0.5000 \$3,348.55 \$0.00 \$2,229.65 \$723.49 \$6,301.69	IF E9 < E8 Then "Yes" Else "No" IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0 E41 * E64 E51 * E54 E44 * E64 E45 * E56 E55 + E56 + E57 + E58
62 63 64 66 67	CHARGE CAP Does the charge cap apply? Charge cap reduction factor Final DRG base payment Final outlier payment Final DRG payment Final BRG payment Final automatic IGT add-on payment Final self funded IGT add-on payment	No 1.0000 \$3,348.55 \$0.00 \$3,348.55 \$2,229.65 \$723.49	IF E59 > E7 Then "Yes" Else "No" IF E61 = "Yes" Then E7 / E59 Else 1.0 E55 * E62 E56 * E62 E63 + E64 E57 * E62 E58 * E62
68 69 71 72 73	UNT AND	ENT AMOUNT \$6,301.69 \$0.00 \$0.00 \$6,301.69 VALUES ARE FOR PURPOS	### REIMBURSEMENT AMOUNT \$6,301.69
	CALCULATOR	VALUES ARE FOR PURPOS	SES OF ILLUSTRATION ONLY.





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Note: Specific policy values included are for purposes of illustration only	stration only.	
		Indicates payment policy parameters set by Medicaid
INFORMATION FROM THE HOSPITAL	Data	Comments or Formula
Submitted charges	\$8,593 1	UB-04 Field Locator 47 minus FL 48 I lead for transfer miching and covered days adjustments
Leight of sery Medicaid covered days Patient discharge status = 02, 05, 65 or 667 (transfer)		used for covered days adjustment Used for transfer pricing adjustment Used for transfer pricing adjustment
12 Other health coverage 13 Patient share of cost	\$0.00 \$0.00	UB-04 Field Locator 54 for payments by third parties Includes spend-down or consument
	40.34% \$3,447.88	Used to estimate the hospital's cost of this stay
	\$1,304.49 1.4432	Hospital's annual average FL Medicaid APR-DRG relative weight
18 HOSDINI CANEGORY 19 APR-DRG 19 PAYMENT POLICY PARAMETERS SET BY MEDICAID	All Other 207-3	r rom drop down list - used to determine provider policy adjustor From separate APR-DRG grouping software
	\$3,600 \$27 425	Used for DRG base payment Used for cost outlier adjustments
	80% 1.00 18	Used for cost outlier adjustments Used to adjust DRG relative weights should a need arise, else leave set to 1.00.
27 APR-DRG description	OTHER CIRCULATORY SYSTEM DIAGNOSES	Look up from DRG table
28 Casemix relative weight—re-centered for FL Medicaid 29 Service adjustor 30 Age adjustor	1.3406 1.000 1.000	Look up from DRG table Look up from DRG table Look up from DRG table
32 HOSPITAL INFORMATION 33 Provider adjustor	1.000	Look up from provider adjustor table
35 Maximum policy adjustor 36 Pre Transfer DRG base payment	1.000 \$4,826.12	IF E11 < E25 Then maximum of (E29, E30, E33) Else maximum of (E29, E33) E21 * E28 * E24 * E35
37 TRANSFER PAYMENT ADJUSTMENT 38 Is a transfer adjustment potentially applicable? 39 Per diem payment amount	N/A	If E10 = "Yes" AND DRG Base Not IN ("580", "581") Then "Yes", Else "No" 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? 41 Full stay DRG base payment 42 FULL STAY ADD-ON IGT PAYMENTS	N/A \$4,826.12	IF E38 ="Yes" then [if (E39 < E36), then "Yes" else "No"] Else "N/A" IF E40 = "Yes" Then E39 Else E36
	0.93 \$3,202.74 \$1,211.74 \$9,240.61	E28 / E17 E15 * E43 E16 * E43 F41 + F44 + F45
_	Ψυ,ΕΠυ.υ.	CT1 - CTT - CTV
48 Estimated cost of the stay 49 Does this claim require an outlier payment? 50 Estimated loss on this case	\$3,466.23 No N/A	E7 * E14 IF (E48-E46) > E22 Then "Yes" Else "No" IF E49 = "Yes" Then E48 - E46 Else "N/A"
51 DRG cost outlier payment increase 52 NON-COVERED DAYS PAYMENT ADJUSTMENT	\$0.00	IF E49 = "Yes" Then (E50 - E22) * E23 rounded to 2 places, Else 0
53 Are covered days less than length of stay 54 Non-covered day reduction factor 55 NCD Affirsted DRG base navment	No 1.0000 \$4.826.12	II+ E9 < E8 Ihen "Yes" Else "No" IF E53 = "Yes" Then E9 / E8 rounded to 4 places Else 1.0 E41 * F54
	\$0.00	E51 * E54
57 NCD Adjusted automatic IGT add-on payment 58 NCD Adjusted self-funded IGT add-on payment 60 Proceedings on allowed amount	\$3,202.74 \$1,211.74 \$0,240.81	E44 * E64 E45 * E64 E65 + E65 + E67 + E60
	Vos	IE EEO > E7 Thon "Yos" Elon "Nio"
62 Charge cap reduction factor 63 Charge cap reduction factor 64 Einel DDC base normals	res 0.9299 ¢4.487.66	IF E39 > E7 III6I1 1785 E388 NO IF E61 = "Yes" Then E7 / E59 Else 1.0 E46 * E60
64 Final outlier payment	\$0.00 \$0.00	E53 * E62 E53 * E62
	\$2,978.12	E57 * E62
68 CALCULATION OF ALLOWED AMOUNT AND REIMBURSEMENT AMOUNT	NT AMOUNT	LOC . LOO . LOO .
70 Other health coverage	\$6,592.54	E65 + E66 + E67 E12
71 Patient share of cost 72 Payment amount	\$0.00 \$8,592.54	E13 IF (E69-E70-E71) > 0, then E69-E70-E71, else 0
12/20/2012	VALUES ARE FOR PURPO	CALCULATOR VALUES ARE FOR PURPOSES OF ILLUSTRATION ONLY.
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Appendix B – Dataset Summary





Historical Payments by Service Line SFY 2010/2011



Historical Payments by Service Line SFY 2010/2011

				1 1 2010/2011					
						Average	APR-DRG		
		Covered			Baseline	Length	Casemix	APR-DRG	Pay /
Service Line	Stays	Days	Charges	Estimated Cost	Payment	of Stay	Re-centered	Casemix	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.





Est Per Diem Pymts by Svc Line SFY 2013/2014



Estimated Payments by Service Line SFY 2013/2014

Service Line	Stays	Covered Days	Charges	Es	stimated Cost		Baseline Payment	Average Length of Stav	APR-DRG Casemix Re-centered	APR-DRG Casemix	Pay /
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	2,917,106,490	4.5	1.00	0.76	88%

- 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





Historical Payments by Prov Category SFY 2010/2011



Historical Payments by Provider Category SFY 2010/2011

		Covered			Baseline	Average Length	APR-DRG Casemix	APR-DRG	Pay /
Provider Category	Stays	Days	Charges	Estimated Cost	Payment		Re-centered		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%

- 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.





Est Per Diem Pymts by Prov Categ SFY 2013/2014



Estimated Payments by Provider Category SFY 2013/2014

						Average	APR-DRG		
		Covered			Baseline	Length		APR-DRG	Pay /
Provider Category	Stays	Days	Charges	Estimated Cost	Payment		Re-centered		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%

- 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.









Simulation 14 Budget Goals



	Α	В	С	D	E	F	G	Н	1	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		Over	all Total Historical E	Baseline Payment:	\$2,805,235,667					

Notes:

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.





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 Parameters



	DRG Payment Sim	ulation 14b - Rerui	1							
Simulation Parameters	Value - Overall	Value - All Other Hospitals	Value - Rural Hospitals	Value - LTAC Hospitals	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 - 1.3	5								
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	\$27,425									
(MC) percentage	80%									
Low side (provider gain) threshold and marginal cost										
(MC) percentage	None									
Charge Cap	Yes - adjusting state	e share and IGT pay	ments							
Undocumented non-citizen non-covered day adjustment	Yes - adjusting state	e share and IGT pay	ments							

Summary by Service Line



Simulation 14b - Rerun Summary of Simulation by Service Line

									,							
Service Line	Stays	Casemix Recentered	Es	stimated 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	3,083,405,860	\$	2,805,235,667	\$	2,790,292,916	\$	(14,942,752)	-1%	91%	90%	\$	207,292,008	7%
Notes.																

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



^{1) &}quot;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.

Summary by Provider Category



Simulation 14b - Rerun Summary of Simulation by Provider Category

					-	,	~		чь		· · ,					
														;	Simulated	
		Casemix				Baseline		Simulated			Percent	Baseline	Simulated		Outlier	Sim Outlier
Provider Category	Stays	Recentered	E	stimated Cost		Payment		Payment		Change	Change	Pay / Cost	Pay / Cost		Payment	% 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.









Simulation 16 Budget Goals



	A	В	С	D	E	F	G	Н	1
			Baseline	Baseline Payment From	Baseline Payment From				DRG Reimbursement
			Payment From	Automatic	Self-Funded		Percentage of	Total Budget	from GR and
	Provider Classification	Stays	GR and PMATF	IGTs	IGTs	Estimated Cost	Cost Goal	Goal with IGTs	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 Bud	geted Payment:	\$ 2,917,106,490				
3 4 5 6 7	LTAC High Medicaid & High Outlier All Other	86 9,229 397,552	\$ 1,365,292 \$ 142,780,176 \$ 1,520,363,917 \$ 1,714,775,417	\$ - \$ 45,760,831 \$ 487,810,761 \$ 540,127,612	\$ 283,076 \$ 1,864,429 \$ 659,752,940 \$ 662,203,460	\$ 2,688,734 \$ 190,763,390	65%	\$ 1	1,747,677

Notes:

|4 = [C6 - (11 + 12 + 13)].

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



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.

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 r	e-centered to 1.0 for	FL Medicaid		
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost	\$31,000				
(MC) percentage	80%				
Low side (provider gain) threshold and marginal cost					
(MC) percentage	None				
Charge Cap	Yes - adjusting state	e share and IGT pay	ments		
Undocumented non-citizen non-covered day adjustment	Yes - adjusting state	e share and IGT pay	ments		

Summary by Service Line



Simulation 16 **Summary of Simulation by Service Line**

												\$	Simulated	
		Casemix			Baseline		Simulated		Percent	Baseline	Simulated		Outlier	Sim Outlier
Service Line	Stays	Recentered	Estimated Cost		Payment		Payment	Change	Change	Pay / Cost	Pay / Cost		Payment	% 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%	\$ 2	224,160,564	8%





^{1) &}quot;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.

Summary by Provider Category



Simulation 16 Summary of Simulation by Provider Category

				, , , , , , , , , , , , , , , , , , , ,					- · <i>J</i>					
												S	imulated	
	Casemix			Baseline		Simulated			Percent	Baseline	Simulated		Outlier	Sim Outlier
Stays	Recentered	Estimated 0	ost	Payment		Payment		Change	Change	Pay / Cost	Pay / Cost	ا	Payment	% of Pymt
404,620	0.99	\$ 3,211,965	,823	\$ 2,860,291,083	\$	2,826,601,259	\$	(33,689,824)	-1%	89%	88%	\$2	17,492,035	8%
167,942	1.19	\$ 1,719,730	,833	\$ 1,730,385,472	\$	1,626,314,719	\$	(104,070,752)	-6%	101%	95%	\$1	49,525,950	9%
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%
112,464	0.91	\$ 788,454	451	\$ 657,824,339	\$	678,185,745	\$	20,361,406	3%	83%	86%	\$	44,582,819	7%
76,884	0.96	\$ 555,580	,178	\$ 587,410,570	\$	577,476,066	\$	(9,934,505)	-2%	106%	104%	\$	32,244,979	6%
123,619	0.88	\$ 741,748	,703	\$ 523,577,680	\$	588,367,310	\$	64,789,630	12%	71%	79%	\$	30,268,405	5%
75,786	1.01	\$ 573,978	,730	\$ 475,370,010	\$	494,714,073	\$	19,344,064	4%	83%	86%	\$	33,861,032	7%
9,263	1.79	\$ 191,573	,836	\$ 190,581,597	\$	180,245,668	\$	(10,335,929)	-5%	99%	94%	\$	35,439,960	20%
11,140	0.66	\$ 50,108	,442	\$ 57,125,068	\$	49,945,709	\$	(7,179,359)	-13%	114%	100%	\$	391,489	1%
525	1.85	\$ 8,428	,885	\$ 3,915,175	\$	4,343,024	\$	427,850	11%	46%	52%	\$	201,899	5%
86	2.87	\$ 2,688	734	\$ 1,648,369	\$	1,747,616	\$	99,247	6%	61%	65%	\$	116,898	7%
412	1.22	\$ 2,792	,935	\$ 1,074,871	\$	1,757,630	\$	682,759	64%	38%	63%	\$	25,840	1%
	404,620 167,942 98,530 112,464 76,884 123,619 75,786 9,263 11,140 525 86	Stays Recentered 404,620 0.99 167,942 1.19 98,530 1.19 112,464 0.91 76,884 0.96 123,619 0.88 75,786 1.01 9,263 1.79 11,140 0.66 525 1.85 86 2.87	Stays Recentered Estimated Company 404,620 0.99 \$ 3,211,965 167,942 1.19 \$ 1,719,730 98,530 1.19 \$ 1,089,986 112,464 0.91 \$ 788,454 76,884 0.96 \$ 555,580 123,619 0.88 \$ 741,748 75,786 1.01 \$ 573,978 9,263 1.79 \$ 191,573 11,140 0.66 \$ 50,108 525 1.85 \$ 8,428 86 2.87 \$ 2,688	Stays Recentered Estimated Cost 404,620 0.99 \$ 3,211,965,823 167,942 1.19 \$ 1,719,730,833 98,530 1.19 \$ 1,089,986,603 112,464 0.91 \$ 788,454,451 76,884 0.96 \$ 555,580,178 123,619 0.88 \$ 741,748,703 75,786 1.01 \$ 573,978,730 9,263 1.79 \$ 191,573,836 11,140 0.66 \$ 50,108,442 525 1.85 \$ 8,428,885 86 2.87 \$ 2,688,734	Casemix Baseline 404,620 0.99 \$ 3,211,965,823 \$ 2,860,291,083 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 98,530 1.19 \$ 1,089,986,603 \$ 1,067,045,755 112,464 0.91 \$ 788,454,451 \$ 657,824,339 76,884 0.96 \$ 555,580,178 \$ 587,410,570 123,619 0.88 \$ 741,748,703 \$ 523,577,680 75,786 1.01 \$ 573,978,730 \$ 475,370,010 9,263 1.79 \$ 191,573,836 \$ 190,581,597 11,140 0.66 \$ 50,108,442 \$ 57,125,068 525 1.85 \$ 8,428,885 \$ 3,915,175 86 2.87 \$ 2,688,734 \$ 1,648,369	Casemix Stays Recentered Estimated Cost Payment 404,620 0.99 \$ 3,211,965,823 \$ 2,860,291,083 \$ 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 \$ 98,530 1.19 \$ 1,089,986,603 \$ 1,067,045,755 \$ 112,464 0.91 \$ 788,454,451 \$ 657,824,339 \$ 76,884 0.96 \$ 555,580,178 \$ 587,410,570 \$ 123,619 0.88 \$ 741,748,703 \$ 523,577,680 \$ 75,786 1.01 \$ 573,978,730 \$ 475,370,010 \$ 9,263 1.79 \$ 191,573,836 \$ 190,581,597 \$ 11,140 0.66 \$ 50,108,442 \$ 57,125,068 \$ 525 1.85 \$ 8,428,885 \$ 3,915,175 \$ 8,428,885 \$ 3,915,175 \$ 2,688,734 \$ 1,648,369 \$	Stays Recentered Estimated Cost Payment Simulated Payment 404,620 0.99 \$ 3,211,965,823 \$ 2,860,291,083 \$ 2,826,601,259 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 \$ 1,626,314,719 98,530 1.19 \$ 1,089,986,603 \$ 1,067,045,755 \$ 967,357,435 112,464 0.91 \$ 788,454,451 \$ 657,824,339 \$ 678,185,745 76,884 0.96 \$ 555,580,178 \$ 587,410,570 \$ 577,476,066 123,619 0.88 \$ 741,748,703 \$ 523,577,680 \$ 588,367,310 75,786 1.01 \$ 573,978,730 \$ 475,370,010 \$ 494,714,073 9,263 1.79 \$ 191,573,836 \$ 190,581,597 \$ 180,245,668 11,140 0.66 \$ 50,108,442 \$ 57,125,068 \$ 49,945,709 525 1.85 \$ 8,428,885 \$ 3,915,175 \$ 4,343,024 86 2.87 \$ 2,688,734 \$ 1,648,369 \$ 1,747,616	Stays Recentered Estimated Cost Payment Simulated Payment 404,620 0.99 \$ 3,211,965,823 \$ 2,860,291,083 \$ 2,826,601,259 \$ 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 \$ 1,626,314,719 \$ 98,530 1.19 \$ 1,089,986,603 \$ 1,067,045,755 \$ 967,357,435 \$ 112,464 0.91 \$ 788,454,451 \$ 657,824,339 \$ 678,185,745 \$ 76,884 0.96 \$ 555,580,178 \$ 587,410,570 \$ 577,476,066 \$ 123,619 0.88 \$ 741,748,703 \$ 523,577,680 \$ 588,367,310 \$ 75,786 1.01 \$ 573,978,730 \$ 475,370,010 \$ 494,714,073 \$ 9,263 1.79 \$ 191,573,836 \$ 190,581,597 \$ 180,245,668 \$ 11,140 0.66 \$ 50,108,442 \$ 57,125,068 \$ 49,945,709 \$ 525 1.85 \$ 8,428,885 \$ 3,915,175 \$ 4,343,024 \$ 1,747,616 \$ 1,747,616	Stays Recentered Estimated Cost Payment Simulated Payment Change 404,620 0.99 \$ 3,211,965,823 \$ 2,860,291,083 \$ 2,826,601,259 \$ (33,689,824) 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 \$ 1,626,314,719 \$ (104,070,752) 98,530 1.19 \$ 1,089,986,603 \$ 1,067,045,755 \$ 967,357,435 \$ (99,688,320) 112,464 0.91 \$ 788,454,451 \$ 657,824,339 \$ 678,185,745 \$ 20,361,406 76,884 0.96 \$ 555,580,178 \$ 587,410,570 \$ 577,476,066 \$ (9,934,505) 123,619 0.88 \$ 741,748,703 \$ 523,577,680 \$ 588,367,310 \$ 64,789,630 75,786 1.01 \$ 573,978,730 \$ 475,370,010 \$ 494,714,073 \$ 19,344,064 9,263 1.79 \$ 191,573,836 \$ 190,581,597 \$ 180,245,668 \$ (10,335,929) 11,140 0.66 \$ 50,108,442 \$ 57,125,068 \$ 49,945,709 \$ (7,179,359) 525 1.85 \$ 8,428,885 \$ 3,915,175 \$ 4,343,024	Stays Recentered Estimated Cost Payment Simulated Payment Change Change 404,620 0.99 \$ 3,211,965,823 \$ 2,860,291,083 \$ 2,826,601,259 \$ (33,689,824) -1% 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 \$ 1,626,314,719 \$ (104,070,752) -6% 98,530 1.19 \$ 1,089,986,603 \$ 1,067,045,755 \$ 967,357,435 \$ (99,688,320) -9% 112,464 0.91 \$ 788,454,451 \$ 657,824,339 \$ 678,185,745 \$ 20,361,406 3% 76,884 0.96 \$ 555,580,178 \$ 587,410,570 \$ 577,476,066 \$ (9,934,505) -2% 123,619 0.88 \$ 741,748,703 \$ 523,577,680 \$ 588,367,310 \$ 64,789,630 12% 75,786 1.01 \$ 573,978,730 \$ 475,370,010 \$ 494,714,073 \$ 19,344,064 4% 9,263 1.79 \$ 191,573,836 \$ 190,581,597 \$ 180,245,668 \$ (10,335,929) -5% 11,140 0.66 \$ 50,108,442 \$ 57,125,068 \$ 49,945,709	Stays Recentered Estimated Cost Payment Simulated Payment Change Percent Change Baseline Pay / Cost 404,620 0.99 \$ 3,211,965,823 \$ 2,866,291,083 \$ 2,826,601,259 \$ (33,689,824) -1% 89% 167,942 1.19 \$ 1,719,730,833 \$ 1,730,385,472 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76,884 0.96 \$ 555,580,178 \$ 587,410,570 \$ 577,476,066 \$ (9,934,505) -2% 106% 104% 123,619 0.88 \$ 741,748,703 \$ 523,577,680 \$ 588,367,310 \$ 64,789,630 12% 71% 79% 75,786 1.01 \$ 573,978,730 \$ 475,370,010 \$ 494,714,073 \$ 19,344,064 4% <td>Stays Recentered Estimated Cost Payment Simulated Payment Change Change Percent Change Pay / Cost Simulated Pay / Cost Payment Change Change Percent Change Baseline Pay / Cost Simulated Pay / Cost Payment Payment Change Change Pay / Cost Pay / Cost</td> <td>Stays Recentered Estimated Cost Payment Simulated Payment Change Change Change Recentered Change Pay / Cost Baseline Pay / Cost Payment Simulated Pay / Cost Payment Payment Payment Simulated Change Pay / Cost Payment Payment</td>	Stays Recentered Estimated Cost Payment Simulated Payment Change Change Percent Change Pay / Cost Simulated Pay / Cost Payment Change Change Percent Change Baseline Pay / Cost Simulated Pay / Cost Payment Payment Change Change Pay / Cost Pay / Cost	Stays Recentered Estimated Cost Payment Simulated Payment Change Change Change Recentered Change Pay / Cost Baseline Pay / Cost Payment Simulated Pay / Cost Payment Payment Payment Simulated Change Pay / Cost Payment Payment

- 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.



