

DRG Conversion Implementation Plan Final

Prepared for:

Florida Agency for Health Care Administration

December 21, 2012



navigant.com/healthcare

NAVIGANT
HEALTHCARE

DISPUTES & INVESTIGATIONS • ECONOMICS • FINANCIAL ADVISORY • MANAGEMENT CONSULTING

Table of Contents

Introduction	6
1 Evaluating a DRG Payment Method – Guiding Principles	7
2 Basics of a DRG Payment Method.....	10
2.1 DRG Codes and Weights	10
2.2 Summary of the DRG Pricing Formulas	11
2.3 Basic DRG Pricing Calculation.....	11
2.4 Policy Adjustors	12
2.5 Adjustments to DRG Base Payment	13
2.5.1 Transfer Claims	13
2.5.2 Partial Eligibility.....	14
2.6 Outlier Payments	14
2.7 DRG Price versus Final Reimbursement	15
2.8 Non-DRG Paid Claims	15
3 Scope of DRG Payment Method.....	16
3.1 Affected Providers	16
3.1.1 Affected Providers - Discussion.....	16
3.1.2 Affected Providers - Recommendation.....	17
3.2 Affected Services	19
3.2.1 Affected Services - Discussion.....	19
3.2.2 Affected Services - Recommendation.....	20
3.3 Affected Beneficiaries / Medicaid Programs	21
3.3.1 Affected Beneficiaries / Medicaid Programs - Discussion.....	21
3.3.2 Affected Beneficiaries / Medicaid Programs - Recommendation.....	22
3.4 Prior Authorization Changes	22
3.4.1 Prior Authorization Changes - Discussion.....	22
3.4.2 Prior Authorization Changes - Recommendation.....	23
4 Cost Estimation	24
4.1 Cost Estimation - Discussion.....	24
4.2 Cost Estimation - Recommendation	25
5 DRG Grouping.....	27

5.1	DRG Grouper.....	27
5.1.1	DRG Grouper - Discussion	27
5.1.2	DRG Grouping - Recommendation.....	35
5.2	DRG Relative Weights.....	36
5.2.1	DRG Relative Weights - Discussion	36
5.2.2	DRG Relative Weights - Recommendation	38
6	Provider Base Rates	40
6.1	Provider Base Rate Categories	40
6.1.1	Provider Base Rate Categories - Discussion.....	40
6.1.2	Provider Base Rate Categories - Recommendation.....	41
6.2	Provider Base Rate Wage Area Adjustments.....	41
6.2.1	Provider Base Rate Wage Area Adjustments - Discussion	41
6.2.2	Provider Base Rate Wage Area Adjustments - Recommendation	42
6.3	Funding for Provider Base Rates	42
6.3.1	Funding for Provider Base Rates - Discussion.....	42
6.3.2	Funding for Provider Base Rates - Recommendation.....	43
6.4	Per Diem Base Rates	43
6.4.1	Per Diem Base Rate - Discussion.....	43
6.4.2	Per Diem Base Rate - Recommendation.....	43
7	Pricing Logic.....	44
7.1	Pricing Flow	44
7.2	Policy Adjustors	45
7.2.1	Policy Adjustors - Discussion.....	45
7.2.2	Policy Adjustors - Recommendation.....	46
7.3	Transfer Payment Adjustments	49
7.3.1	Transfer Payment Adjustments - Discussion.....	49
7.3.2	Transfer Payment Adjustments - Recommendation.....	51
7.4	Payment of IGT Funds Distributed on a Claim-by-Claim Basis	54
7.4.1	Payment of IGT Funds Distributed on a Claim-by-Claim Basis - Discussion.....	54
7.4.2	Payment of IGT Funds Distributed on a Claim-by-Claim Basis - Recommendation	54
7.5	Outlier Payments	55
7.5.1	Outlier Payments - Discussion.....	55

7.5.2	Outlier Payments - Recommendation	57
7.6	Non-Covered Days Adjustments.....	58
7.6.1	Non-Covered Days Adjustments - Discussion	58
7.6.2	Non-Covered Days Adjustments - Recommendation	59
7.7	Per Claim Add-On Payments.....	60
7.7.1	Per Claim Add-On Payments - Discussion	60
7.7.2	Per Claim Add-On Payments - Recommendation	61
7.8	Transitional Period.....	61
7.8.1	Transitional Period - Discussion	61
7.8.2	Transitional Period - Recommendation	62
7.9	Documentation and Coding Adjustment	62
7.9.1	Documentation and Coding Adjustment - Discussion.....	62
7.9.2	Documentation and Coding Adjustment – Recommendation	66
7.10	Interim Claims and Late Charges	67
7.10.1	Interim Claims and Late Charges – Discussion.....	67
7.10.2	Interim Claims and Late Charges – Recommendation.....	68
7.11	Charge Cap	68
7.11.1	Charge Cap – Discussion	68
7.11.2	Charge Cap – Recommendation	69
7.12	Medicare Crossover Comparison Pricing.....	69
7.12.1	Medicare Crossover Comparison Pricing – Discussion.....	69
7.12.2	Medicare Crossover Comparison Pricing – Recommendation.....	69
7.13	45-Day Benefit Limit.....	69
7.14	Reimbursement for Undocumented Non-Citizens	69
7.15	County Billing Rate.....	70
7.15.1	County Billing Rate - Discussion	70
7.15.2	County Billing Rate - Recommendation	70
8	Specifics for Florida Medicaid	71
8.1	Budget Neutrality	71
8.2	Interaction of DRG Payment and IGT Funding.....	71
8.3	Per Claim Distribution of IGT Funds	72
8.4	Recipient Out of Pocket Expenses	72

8.5	Effect of Transition to Managed Care	72
	Appendix A – Summary DRG Payment Method Options.....	73
	Appendix B - Sample State Medicaid DRG Implementations.....	84
	Appendix C – DRG Simulation Dataset.....	89
	Appendix D – Summary of DRG Pricing Simulation Results	90
D.1	Budget Calculations.....	90
D.2	Payment Parameters and Summary Results	91
D.3	Summary by Service Line	92
D.4	Summary by Provider Category	93
	Appendix E – Summary of DRG Pricing Simulation Results – Excluding IGT Payments.....	94
E.1	Budget Calculations.....	94
E.2	Payment Parameters and Summary Results	95
E.3	Summary by Service Line	96
E.4	Summary by Provider Category	97
	Appendix F – Provider Specific Payment Estimates from DRG Pricing Simulations.....	98
	Appendix G – APR-DRGs.....	105

Introduction

This document describes Navigant’s recommendations to the Florida Agency for Health Care Administration (AHCA) for a new inpatient payment method utilizing Diagnosis Related Groups (DRGs). The document describes which types of providers and services are recommended for change from the current per diem payment method to DRG payment, as well as the numerical calculations and pricing factors to be included in AHCA’s new DRG payment method. The recommendations in this document are the result of several months’ time spent discussing AHCA’s current payment method, discussing goals for the new payment method and performing DRG pricing simulations.

This document is intended as a final version of the payment method recommendations. However, numbers presented in this document are values from simulations run through the middle of December 2012. These simulations use state fiscal year 2010/2011 historical claims and historical payment amounts. The final rates and adjustors planned for the first year of implementation (scheduled for July 1, 2013) have not yet been finalized and are not included in this document. The year one values will be calculated in January 2013 using funding levels more closely aligned with what is anticipated for state fiscal year 2013/2014, which begins on July 1, 2013.

Navigant and MGT of America have worked closely with AHCA to reach the conclusions listed in the document. The recommendations included within came from consensus reached between the DRG project team including AHCA Finance staff, an ad hoc AHCA DRG Governance Committee, and consultants from Navigant and MGT of America. We expect these recommendations to be forwarded on to the Florida Legislature in early January, 2013. The Florida Legislature can accept these recommendations as is or offer further instructions on how it would like to see the new payment method implemented. Our hope is that the design we have developed is sufficiently flexible to react to any changes requested by the legislature through changes in configuration data, such as rates and policy adjustors, without requiring any additional changes to the software used to adjudicate claims.

This document carries forward a format used in prior deliverables for this project. The first two chapters of the document provide background on DRG pricing that is helpful in evaluating the various pricing design considerations. Chapter 1 lists a series of criteria helpful in evaluating any Medicaid payment method and describes some of the areas in which options in a DRG pricing method affect the criteria. Chapter 2 describes the components of a standard DRG pricing calculation, including a few optional components, such as policy adjustors. Chapters 3 through 7 provide a comprehensive list of options available to customize a DRG pricing method considering the experience of other state Medicaid agencies and Medicare. Some, but not all of these options are being recommended for Florida Medicaid. Also, with each option, discussion and recommendation sections are provided. The recommendations have been developed based on quantitative review using historical claims data and with consideration of the guiding principles described in Chapter 1. Next, Chapter 8 discusses a few items specific to Florida Medicaid. Finally, several appendices are provided. Appendix A is a table summarizing all of

the DRG payment method options and recommendations described in this report. Appendix B includes examples of the options selected by a half dozen states that either have implemented or are in the process of implementing a new DRG payment method. States included in the matrix are California, New York, Texas, Virginia, Pennsylvania and Illinois. The next five appendices show numerical results of pricing simulations.

1 Evaluating a DRG Payment Method – Guiding Principles

Developing a Medicaid payment method requires balancing a variety of trade-offs and competing priorities. Payment methods have an impact on beneficiaries, medical providers, taxpayers, and program administrators, each with their own point of view on what makes a payment method successful. To balance the priorities of these different stakeholders, it is helpful to establish a set of guiding principles that describe the goals of the payment method and offer a structure against which various system design options can be evaluated. The list below offers a series of guiding principles and discusses how these principles can affect a DRG payment method.

- » **Efficiency.** A payment method should be consistent with promoting hospital efficiency, rewarding hospitals that increase efficiency while continuing to provide quality care. To enable this, the payment method should minimize reliance on individual hospital charges or costs, and create opportunities for providers to increase margins by more effectively managing resources. For example, in the design of a DRG payment system, selecting a single standardized base rate can create incentives for hospitals to better manage their resources to achieve improved margins. Conversely, establishing facility-specific base rates that fluctuate annually with increases or decreases in facility-specific costs would provide little incentive for cost effectiveness.
- » **Access.** A payment method should promote beneficiary access to care. This guiding principle is consistent with the requirements specified in federal regulation. In the State Plan for Medical Assistance (State Plan), AHCA must make certain assurances to the federal Centers for Medicare and Medicaid Services (CMS) with respect to its level of payments to Medicaid providers. In particular, the State Plan must:

“... provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care *and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area[.]*” 42 U.S.C. § 1396a(a)(30)(A) (“Section 30(A)”) (emphasis added).

Within a DRG payment method, policy adjustors, provider peer groups (used for setting base rates), and outlier payment parameters are items that can be adjusted to affect access to care.

- » **Equity.** A payment method should generate fair payments across both hospitals and types of care. Generally, hospitals should be paid similar amounts for the same services, with the potential exception being when there are necessary and measurable differences in the costs associated with those similar services. Within a DRG payment method, the bulk of the payment amount for an individual hospital stay is calculated by multiplying a hospital base price times a DRG relative weight. The DRG relative weights are determined using average costs from many hospitals, so the relative weights help ensure similar payment for similar services, independent of where those services are provided. If adjustments do need to be made for reasonable, measurable differences in hospital cost structures, those can be made through modifications to the hospital base price via rate adjustments (for example, wage area adjustments) and/or provider peer groupings (for example, giving all children’s hospitals or all rural hospitals their own provider base rate).
- » **Predictability.** A payment method should generate stable, predictable payments. Both the state Medicaid agency and the hospitals have to manage their budgets, and that can best be facilitated through a payment method which generates consistent, predictable reimbursements. DRG payment methods are predictable if patient acuity and volume are understood.
- » **Transparency.** A payment method that is transparent promotes trust from hospital administrators, hospital clinicians, legislators, and Medicaid program administrators. A DRG payment method can be made transparent by selecting a DRG algorithm that is openly documented, and by making DRG relative weights, provider base rates, and pricing logic publicly available.
- » **Simplicity.** A payment method that is relatively simple will be easier to implement, easier for hospitals to understand, and easier to administer and maintain. For a Medicaid program, implementing a new DRG payment method will require significant MMIS changes, regulation changes, and program monitoring changes. For hospitals, a new DRG payment method may impact medical coding practices, billing procedures, and internal information systems. The complexity of these changes is limited if the payment method is kept relatively simple. At the same time, over-simplifying the payment method may negatively impact payment equity and, in turn, negatively impact access to care.
- » **Quality.** It is generally known that it is a mission of all hospitals to provide high quality care. Payment methods should be consistent with promoting quality care where possible. In truth, very few payment methods specifically reward quality. Most

payment methods, including DRG payment methods, pay the same without regard to the provision of high quality care being provided. At the same time, some payment components, such as outlier payment parameters, can contribute to (or detract from) facilitating the effective use of hospital resources in a way that is consistent with a hospital's mission to provide high quality care.

From a logistical point of view, a payment method is a framework or structure created to determine reimbursement for medical services and supplies. The structure includes organization of data, numerical formulas, and specific parameters or values used in the formulas. This structure should be carefully developed as it controls the distribution of large amounts of state and federal funding, and is intended to meet the needs of people and organizations with competing priorities. The guiding principles presented above can be helpful in evaluating various options for the payment structure so that the final design best meets the needs of beneficiaries, providers, taxpayers and program administrators.

2 Basics of a DRG Payment Method

This section describes the calculations performed in a typical DRG payment method. Ultimately, a payment method can be described as a series of calculations. As such, this section offers a context for how decisions on the various pricing options are applied to actually price claims. Discussions and recommendations for each component within these calculations are provided in Chapter 7. Chapter 7 also describes areas in which we are recommending customizing the pricing calculation for Florida Medicaid.

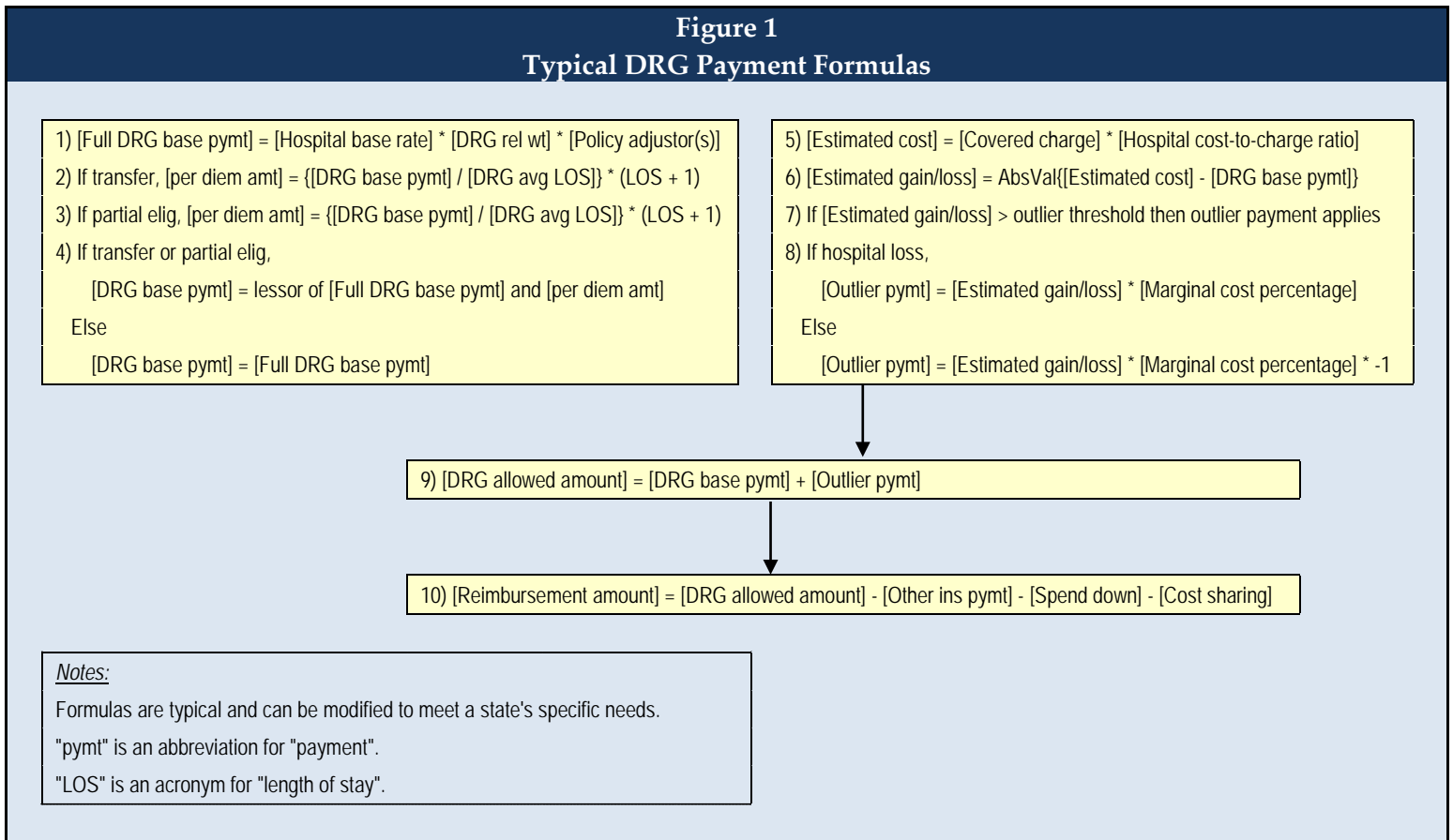
2.1 DRG Codes and Weights

DRG payment methods involve classifying inpatient stays and then determining a price based on a combination of the classification and the hospital where the services were performed. Classification of the hospital stay is based on the diagnoses describing the patient's condition, the surgical procedures performed (if any), patient age, and discharge status. The classifications are labeled using codes referred to as DRG codes and the number of codes varies depending on the selected patient classification model. For example, the MS-DRG grouping method has 746 total codes including 335 base codes separated by severity into "no CC", "with CC" or "with major CC" (where "CC" stands for complications and comorbidities). Similarly, the APR-DRG grouping method has 1,254 codes including 314 base codes each separated into four levels of severity: minor, moderate, major and extreme.

Each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category. These weights are relative to the overall average amount of hospital resources needed to treat a patient when looking across the full range of patients treated within an acute care inpatient setting. For example, a DRG weight of 2.0 would indicate an admission that requires twice the level of resources as an average admission, while a DRG weight of 0.5 would indicate an admission that requires half the level of resources as an average admission.

2.2 Summary of the DRG Pricing Formulas

A summary of a typical DRG pricing calculation is shown in Figure 1 and the formulas are described in more detail in the following sections.



2.3 Basic DRG Pricing Calculation

In a DRG pricing method, the vast majority of hospital stays are priced using a very simple formula. The formula is:

$$[\text{DRG Base Payment}] = [\text{Hospital base rate}] * [\text{DRG relative weight}] * [\text{Policy adjustor(s)}]$$

Policy adjustors, which are discussed in the next section, are optional and in many cases are set to 1.0, indicating no adjustment. If a policy adjustor of 1.0 is assumed, an example claim from a provider with a DRG base rate of \$8,000 and a DRG with relative weight of 2.0 would yield a payment of \$16,000. Similarly, an admission to the same provider that gets assigned a DRG with relative weight of 0.5 would yield a payment of \$4,000. Although this calculation is quite

simple, a great deal of effort goes into development of the DRG grouping algorithm (which determines the DRG code), assignment of relative weights to DRG codes, and assignment of base prices to hospitals.

2.4 Policy Adjustors

Medicaid agencies can make a policy decision to increase (or decrease) payments for particular types of hospital admissions to protect access for Medicaid beneficiaries. When increasing payment for types of services, policy adjustors are used. There are three types of adjustors commonly used, and should be considered as options:

- Service adjustors
- Age/service adjustors
- Provider/service adjustors

If implementing all three options for policy adjustors, the calculation of DRG base payment becomes:

$$\begin{aligned}
 \text{[DRG Base Payment]} &= \text{[Hospital base rate]} * \text{[DRG relative weight]} \\
 &\quad * \text{[Service adjustor]} * \text{[Age/service adjustor]} \\
 &\quad * \text{[Provider/service adjustor]}
 \end{aligned}$$

or

$$\begin{aligned}
 \text{[DRG Base Payment]} &= \text{[Hospital base rate]} * \text{[DRG relative weight]} \\
 &\quad * \text{Maximum of ([Service adjustor], [Age/service adjustor],} \\
 &\quad \text{[Provider/service adjustor])}
 \end{aligned}$$

Policy adjustors, in general, modify payment for specific types of services, patient ages and hospital types. Service adjustors apply for specific types of care independent of the recipient and provider. Age/service adjustors apply only for recipients within a specific age range. Any age range can be used, but Medicaid programs generally use this to increase payment for pediatric care. Provider/service adjustors apply only for certain categories of providers.

For example, if a Medicaid agency decided to increase payments for neonatal care using a service adjustor of 1.5, then the claim payment would be increased by 50 percent. In this situation, a claim submitted from a provider with base rate \$8,000 and mapping to APR-DRG 622-3 (Neonate birth weight 2000-2499 grams with major respiratory condition; relative weight = 2.9453) the DRG base payment would be calculated as follows:

$$\begin{aligned}
 \text{[Maximum adjustor]} &= \text{Max}(1.5, 1.0, 1.0) = 1.5 \\
 \text{[DRG Base Payment]} &= \$8,000 * 2.9453 * 1.5 \\
 &= \$35,343.60
 \end{aligned}$$

As a separate example, a Medicaid agency might decide to increase payment for pediatric care using an age/service adjustor of 1.25. In that case, a claim submitted from a provider with base rate \$8,000, for a recipient age 10, and mapping to APR-DRG 141-2 (Asthma; relative weight = 0.4946) the DRG base payment would be:

$$\begin{aligned} \text{[Maximum adjustor]} &= \text{Max}(1.0, 1.25, 1.0) = 1.25 \\ \text{[DRG Base Payment]} &= \$8,000 * 0.4946 * 1.25 \\ &= \$4,946.00 \end{aligned}$$

A separate claim from the same hospital for a recipient age 35 (above the age adjustor cut-off) and mapping to the same APR-DRG, 141-2, would generate a DRG base payment of:

$$\begin{aligned} \text{[Maximum adjustor]} &= \text{Max}(1.0, 1.0, 1.0) = 1.0 \\ \text{[DRG Base Payment]} &= \$8,000 * 0.4946 * 1.0 \\ &= \$3,956.80 \end{aligned}$$

2.5 Adjustments to DRG Base Payment

2.5.1 Transfer Claims

When processing claims for recipients transferred from one acute facility to another, most Medicaid DRG implementations have followed the Medicare model for payment adjustments. In this model, a payment amount is calculated using a per diem method and then compared to the DRG base payment. If the per diem payment, referred to as a transfer-adjusted base payment, is less than the DRG base payment, then the transfer-adjusted base payment is used. Using the DRG base payment and the DRG's average length of stay, a transfer-adjusted payment can be calculated as:

$$\begin{aligned} \text{Transfer-adjusted base payment} &= \{[\text{DRG base payment}] / [\text{DRG average length of stay}]\} \\ &\quad * \{[\text{length of stay}] + 1\} \end{aligned}$$

Adding one to the length of stay takes into account the disproportionate amount of costs required in the first day of admission to complete the admission process and perform an initial diagnostic evaluation.

For example, APR-DRG 602-3 (neonate birth weight 1000-1249 grams with respiratory distress syndrome, other major respiratory anomaly or other major anomaly) has relative weight 8.3857 and average length of stay equal to 52.16 days (in version 29). If a baby with this DRG is transferred out of a hospital after two days and the hospital's base price is \$8,000 then,

$$\begin{aligned} \text{Full DRG base payment} &= \$8,000 * 8.3857 = \$67,085.60 \\ \text{Transfer-adjusted base payment} &= (67,085.60 / 52.16) * (2 + 1) = \$3,858.45 \end{aligned}$$

In this example, the transfer-adjusted base payment is less and would be used in place of the full DRG base payment.

2.5.2 Partial Eligibility

If a recipient is only eligible for Medicaid fee-for-service for part of a hospital stay, then a full DRG payment may not be appropriate. A smaller payment may be acceptable as the hospital will be getting reimbursement for part of the stay from other sources, such as a managed care organization.

Payment in a partial eligibility situation can be determined very much the same way it is determined on transfer claims – a per diem payment is calculated, compared to the full DRG base payment, and the lower of the two is used. The calculation of eligibility-adjusted base payment can be exactly the same as the transfer-adjusted base payment. That is,

$$\text{Eligibility-adjusted base payment} = \{[\text{DRG base payment}] / [\text{DRG average length of stay}]\} \\ * \{[\text{length of stay}] + 1\}$$

Another option is to remove the “+ 1” from the number of days multiplier in cases where the Medicaid fee-for-service eligibility did not begin until after the day of admission. In that case the formula is,

$$\text{Eligibility-adjusted base payment} = \{[\text{DRG base payment}] / [\text{DRG average length of stay}]\} \\ * [\text{length of stay}]$$

Payment in a partial eligibility situation can also be determined using a different method – a proration based on the number of days for which the recipient had eligibility. Under this method, a simple percentage is calculated by dividing the number of days of eligibility by the total days of the hospital stay. And then the full DRG payment gets reduced by this percentage. The formula under this method is,

$$\text{Eligibility-adjusted base payment} = \{[\text{Days of eligibility}] / [\text{length of stay}]\} \\ * [\text{DRG base payment}]$$

2.6 Outlier Payments

Inevitably, some claims will be submitted for extreme and unpredictable cases in which the standard DRG payment differs greatly from the level of resources expended by the hospital. For these cases, referred to as outliers, a DRG payment method can adjust payment upward to share in hospital losses or downward to share in hospital gains. The Medicare model, also adopted by several states, is to employ a stop-loss threshold which generates outlier payments whenever the hospital’s estimated loss is above a threshold. With this method, the formula for an outlier payment adjustment is:

$$\begin{aligned}
 \text{[Hospital loss/gain]} &= \text{AbsVal}\{([\text{Billed Charges}] * [\text{Cost to Charge Ratio}]) \\
 &\quad - [\text{DRG base payment}]\} \\
 \text{If } [\text{Hospital loss/gain}] > [\text{Outlier Threshold}] &\text{ Then} \\
 \quad \text{If hospital loss Then} \\
 \quad \quad \text{[Outlier pymt adjstmnt]} &= \{([\text{Hospital loss/gain}] - [\text{Outlier threshold}]) \\
 &\quad * [\text{Marginal cost \%}]\} \\
 \quad \text{Else} \\
 \quad \quad \text{[Outlier pymt adjstmnt]} &= \{([\text{Hospital loss/gain}] - [\text{Outlier threshold}]) \\
 &\quad * [\text{Marginal cost \%}]\} * -1 \\
 \text{Else} \\
 \quad \text{[Outlier payment adjstmnt]} &= 0
 \end{aligned}$$

For example, an admission with charges of \$200,000, at a hospital with cost-to-charge ratio equal to 0.30 and a DRG base payment of \$5,000 has a hospital loss equal to \$55,000 $\{(\$200,000 * 0.3) - \$5,000\}$. If the Medicaid DRG policy included an outlier threshold of \$30,000 and a marginal cost percentage of 70 percent then the outlier payment would be $\{(\$55,000 - \$30,000) * 0.7\} = \$17,500$. Thus the final payment to the provider would be $(\$5,000 + \$17,500) = \$22,500$.

Medicare does not apply payment reductions when the hospital gain is above the threshold. But this is an option AHCA can consider, either using the same or a different threshold amount as used for hospital losses.

2.7 DRG Price versus Final Reimbursement

The previous sections in Chapter 2 describe how the DRG price is calculated. This is the amount of money Medicaid is willing to pay for the services without consideration of any other forms of payment. This price is sometimes referred to as the Medicaid allowed amount. Final reimbursement for a claim equals the DRG price minus any other forms of payment such as payment from another insurance carrier, recipient spend down, and patient cost sharing, such as copays. Thus,

$$\begin{aligned}
 \text{[Final reimbursement]} &= [\text{Allowed amount}] - [\text{Other ins pymt}] - [\text{Spend down}] \\
 &\quad - [\text{cost sharing}]
 \end{aligned}$$

2.8 Non-DRG Paid Claims

Depending on the payment policies set by the state, some acute care inpatient claims may fall outside the DRG payment. These may be claims for services or providers carved out of the DRG payment method, or they may be interim claims from providers for services that are included in DRG payment. Both carved out items and interim claims are commonly paid per diem model, although they can also be paid as a percentage of charges. Unlike carved-out services, the per diem for interim claims is set relatively low as it is intended to be a temporary, partial payment. The interim claim per diem gives hospitals some reimbursement for cash flow purposes, while still leaving the hospital incentive to submit a final claim when the recipient is discharged.

3 Scope of DRG Payment Method

3.1 Affected Providers

3.1.1 *Affected Providers - Discussion*

DRG payment methods typically cover payments to general acute care inpatient facilities. Nursing home care and hospice care are normally paid outside of a DRG payment method.

There are other provider types, however, where the decision of inclusion or exclusion in DRG payment is less clear and varies among states using DRG payments. These provider types include:

- Physical rehabilitation
- Long term acute care
- Mental health and substance abuse facilities
- Critical access or rural hospitals
- Children’s hospitals
- Cancer hospitals
- Federally Qualified Health Centers
- Rural Health Clinics
- In-state / out-of-state / border hospitals
- Native American Indian hospitals
- Public hospitals

The first three provider types in the list above, physical rehabilitation, long term acute care, and mental health / substance abuse facilities all treat patients with highly variable and unpredictable lengths-of-stay. Because of this, some states choose to pay these providers with another method, such as a per diem method, instead of paying via DRGs. In addition, a hybrid option is possible where providers are paid per diem and the per diem amount is adjusted based on patient acuity, using DRG grouping to measure patient acuity. The APR-DRG patient classification model, for example, contains 72 different APR-DRG classifications and relative weights intended to reflect the resource intensity of different types of psychiatric patient care. The relative weights associated with the APR-DRG classifications can be used to adjust the per diem, offering a higher per diem for above average relative weight and a lower per diem for below average relative weight.

The next five providers, critical access, children’s, cancer, Federally Qualified Health Centers, and Rural Health Clinics are all excluded from the Medicare DRG inpatient prospective payment system. For that reason, states get some push back when including these providers in the Medicaid DRG payment method. Payment simulations are a valuable tool for reviewing payments to these providers under a DRG method and help to show whether or not DRGs will offer fair reimbursement. With the robustness of some DRG models, such as that reflected in the APR-DRG algorithm, the simulations often do show DRG payment is a reasonable option. In addition, special considerations within the DRG payment method can be reviewed to ensure

fair reimbursement if needed. For example, separate hospital base rates can be given for some or all of these categories of providers. Also certain services can be given a service or age adjustor. In addition, certain services can be defined as separately billable on outpatient claims, such as organ search and acquisition costs, and blood factors, which is particularly appealing to cancer institutions. Making these kinds of payment adjustments within the overall DRG payment method allows for special considerations to be made while still maintaining the simplicity of all or nearly all providers paid using the same method.

Similarly to maintain simplicity, most states pay in-state, border hospitals, and out-of-state hospitals via DRGs. The only decisions normally made based on general location of each hospital are selection of hospital base price and determination of cost-to-charge ratio. For out-of-state hospitals, normally a single hospital base price and a default cost-to-charge ratio are used. For example, the state’s standard Medicare urban or rural cost-to-charge ratio can be assigned to each out-of-state hospital. However, border hospitals may have a sufficiently high volume of Medicaid recipients to justify treating them like in-state hospitals for the purpose of assigning base rates and cost-to-charge ratios.

Finally, many Medicaid agencies have separate policies associated with Native American Indian hospitals and public hospitals, so decisions need to be made on how these categories of providers will be affected by a DRG payment method.

3.1.2 Affected Providers - Recommendation

Consistent with guiding principles related to simplicity, fairness and incenting efficiency, we recommend including the majority of hospital inpatient stays in the new DRG payment method. A DRG payment method can promote hospital efficiency and can offer fair payment for the majority of inpatient stays. In addition, keeping the majority of hospital stays under a single payment method improves simplicity of program administration, including rate setting, software implementation and maintenance, and program operations. Specifically, we recommend the following types of providers be included in the DRG payment method:

- General acute care
- Rural hospitals, including critical access hospitals
- Children’s hospitals
- Cancer hospitals
- Teaching hospitals
- In-state / out-of-state / border hospitals
- Long term acute care
- Rehabilitation hospitals and distinct part units
- Psychiatric specialty distinct part units

The only type of provider we recommend excluding from the new DRG payment method are the state psychiatric facilities. Claims from the state psychiatric facilities are currently billed as long term care claims and have lengths of stay that suggest they are not true acute care

admissions. For example, the average length of stay at the state psychiatric facilities is over one year whereas the average length of stay for mental health services at all other hospitals serving Florida Medicaid recipients is 5 days. In addition, nearly all stays at the state psychiatric facilities would require outlier payments if paid under a DRG pricing method. We believe a per diem payment method is a better fit for admissions to these hospitals. Specifically, the Florida state psychiatric facilities we are recommending to remain in a per diem payment method are,

- Florida State Hospital
- Northeast Florida State Hospital
- South Florida State Hospital
- West Florida Community Care

In terms of providers included in the DRG payment, stays at long term acute care facilities, rehabilitation facilities and psychiatric distinct part units were considered for exclusion from the DRG payment method. Some state Medicaid agencies choose to exclude these from DRG payment because DRGs are not as good at predicting provider cost for stays at these types of facilities. However, the volume of Florida Medicaid stays at these facilities is quite low, 86 stays at long term acute care facilities and 525 stays at specialty rehabilitation facilities in state fiscal year 2010/2011. In addition, AHCA has a strong preference towards keeping the new payment method as simple as possible and keeping as many hospitals as possible on the same payment method promotes simplicity. As a result, the final recommendation for Florida Medicaid is to include long term acute care and rehabilitation facilities in the DRG payment method.

However, we are recommending policy adjustors for free-standing long term acute care facilities and for rehabilitation services (to the benefit of free-standing rehabilitation facilities, as well as any other facility offering rehabilitation services). The policy adjustors will be set to ensure payments in the DRG pricing simulations for these two types of facilities are equal to or greater than they were historically. The simulated payment levels will be equal to or greater than historical levels in aggregate by category of provider (LTAC and rehab). Results for individual facilities within each category may vary. These policy adjustors are discussed in more detail in section 7.2 (Policy Adjustors), and are being recommended to ensure payments are not reduced as compared to historical per diem payments, which would be the case for these two categories of providers if no policy adjustors were applied.

We also recommend a provider policy adjustor for hospitals with a combination of high Medicaid utilization and a high percentage of outlier payments. Hospitals with a very high percentage of Medicaid patients are heavily reliant on Medicaid for their margins and have limited ability to share costs across payments from other sources. If, in addition, these hospitals have a high percentage of outliers, then, by definition, they have a large number of hospital stays for which they are incurring a significant loss. This combination can be difficult to sustain, and generates a concern over access to care for Medicaid recipients. As a result, we recommend a provider policy adjustor for hospitals that keeps payments at least at the same

level they received historically for any hospital with a combination of at least 50 percent Medicaid utilization and at least 30 percent payment from outliers.

3.2 Affected Services

3.2.1 Affected Services - Discussion

The list of services sometimes included and sometimes excluded from DRG payments is similar to the list of provider types open for debate. States vary on inclusion in DRG payment for the following list of services,

- Physical rehabilitation
- Mental health and substance abuse
- Unpredictable and expensive services and supplies such as blood factors and organ search and acquisition
- New technologies

As described in the previous section, a policy decision must be made relating to inclusion or exclusion of specialty rehabilitation and psychiatric institutions within a DRG payment method. In addition, a policy decision must be made for payment of rehabilitation and psychiatric services when performed within a general acute care facility. If volumes are low, the simplicity of including them in the DRG payment method are likely justifiable. However, if volumes are high, it will be more justifiable to pay these services the same way they will be paid within the specialty institutions and distinct part units.

Unpredictable and expensive services and supplies such as blood factors and transplant organ searches create challenges for a DRG payment method. DRG payments are based on average resource usage and work very well when hospital admissions can be grouped into relatively homogeneous categories. However some cases require resources far outside the norm, such as the cost of blood factors required when operating on a patient with a blood clotting problem. Medicare as an example has taken the stance that some unpredictable and/or expensive services do warrant payment above and beyond DRG payment. Specifically, Medicare’s inpatient prospective payment system allows for separate payment for inpatient services under three circumstances:

- **Organ acquisition.** In most cases, these costs are reimbursed through the cost settlement process; for renal transplants, designated renal transplantation hospitals are paid adjusted rates.
- **Blood clotting factors.** Blood factors are paid based on a fee schedule (e.g., 95 percent of average wholesale price).
- **New medical technology.** Devices that meet very specific Medicare criteria related to newness, FDA approval, substantial clinical improvement and unusual costliness criteria may qualify for add-on payments. Very few devices meet these criteria.

State Medicaid DRG payers, in contrast, often do not allow separate payment for unpredictable and expensive services because of both the concern over incentives and the added complexity to the payment method.

From the point of view of Florida Medicaid, items that occur in very low volumes might be reimbursed sufficiently through outlier payments. However, if volumes are high or are heavily concentrated at specific hospitals, outlier payments alone may not be sufficient. Instead, certain services and supplies can be carved out of the DRG payment and made separately payable. However, such a policy can be extremely challenging to implement in an MMIS. Other options such as different provider base rates, service adjustors, or multiple tiers in the outlier payment method (using a higher marginal cost percentage for very high losses) may generate fair payment and prove far simpler to implement.

New technologies can also be a challenge for a DRG payment. In theory they may reduce cost of care, but in practice, they most often increase cost. Furthermore, DRG relative weights may lag slightly behind in capturing these costs because DRG relative weights are calculated using costs from historical claims. Thus, offering separate payment for new technologies is justifiable. However, the task of maintaining an ever-evolving list of new technologies is very challenging.

As with many policy decisions, the topic of unpredictable and expensive services requires a trade-off between the principles used to evaluate a payment method (described in Chapter 1). Allowing separate payment for unpredictable and expensive services diminishes the incentives for efficiency, reduces transparency, increases administrative burden, and increases complexity. On the other hand, access to care may be jeopardized if certain types of cases result in predictable and consistent losses, even with the casemix and outlier adjustments of a DRG payment method. An example is surgery for patients with hemophilia. The need for blood factors can sharply increase the hospital's cost even for otherwise routine surgeries.

3.2.2 Affected Services - Recommendation

We recommend all inpatient services at hospitals included in the DRG payment method be reimbursed via DRGs with two notable exceptions, newborn hearing screening and transplants currently paid via a global fee. Newborn hearing screening is currently reimbursed separately from hospital per diems and we recommend a similar approach, reimbursing this service separately, above and beyond, the DRG payment. Similarly, many transplants are currently paid outside the per diem method using a global fee that covers all related services for a one-year period. A global fee for an episode of care is a progressive strategy for reimbursement that is currently being considered and evaluated more broadly within the U.S. healthcare industry. We recommend AHCA maintain its current reimbursement policy for transplants.

Overall, the recommendation of including nearly all services in the DRG payment method is consistent with AHCA's preference to keep the payment method simple and with the Florida Legislature's desire to move away from cost-based reimbursement.

Specifically related to blood clotting factors, we believe the outlier payment policy will sufficiently cover unusually expensive cases. In fact, the planned outlier marginal cost percentage of 80 percent is relatively close to the overall statewide average pay-to-cost ratio of 91 percent. So outliers are planned to be paid at nearly the statewide average pay-to-cost ratio, after the outlier threshold has been reached.

Organ acquisition costs are incurred through transplants and the majority of transplant services provided to Florida Medicaid recipients will continue to be paid via a global fee and will be carved out of the DRG payment method. For those few transplants reimbursed today under the per diem method (i.e. outside the global payment process), pricing simulations have shown reimbursement will be significantly improved through the move from per diem to DRG payment. We estimate pay-to-cost ratios will improve from just 56 percent to 89 percent. As a result, there is little justification for separate organ acquisition payments above and beyond the DRG payment.

Although Medicare pays separately for new technologies, we do not recommend Florida Medicaid adopt this policy. Maintaining a list of new technologies and identifying appropriate payment for each is a difficult administrative challenge. In addition, it can be troublesome to distinguish new technologies that are in fact beneficial to Medicaid recipients versus those that are simply more costly. Also, add-on payments for new technologies lend themselves to external pressure being applied to Medicaid policy makers on an ongoing basis. Lastly, the current payment method offers no additional payment for new technologies, so our recommendation on this topic is in line with current policy.

In addition, updating DRG relative weights yearly is recommended so that the weights are as up-to-date as possible with advances in technology. New technologies that prove to be successful will gain traction in the industry, thus becoming a factor in the costs of more and more hospitals. As that occurs, their costs will be captured within DRG relative weights.

3.3 Affected Beneficiaries / Medicaid Programs

3.3.1 Affected Beneficiaries / Medicaid Programs - Discussion

Medicaid agencies generally administer a variety of programs, usually with beneficiaries enrolled in only one program at a time. Common programs include fee-for-service, primary care case management, managed care, and Children’s Health Insurance Program (CHIP). States often also administer smaller programs sometimes based on a waiver and sometimes paid for by separate funding sources than used for standard Medicaid. In addition, some Medicaid beneficiaries are eligible only for specific services, most notably emergency-only services. For example, in the Florida Medicaid program undocumented non-citizens and recipients who have exhausted their 45-day inpatient benefit limit are covered only for emergency services. Lastly, some Medicaid beneficiaries are dually eligible for Medicaid and Medicare. For these beneficiaries, most healthcare services are paid primarily by Medicare with Medicaid acting as a supplementary payer, usually paying only the Medicare coinsurance and deductible amounts.

However, there are certain services not covered by Medicare and cases where Medicare benefits have been exhausted, in which case Medicaid becomes the primary payer. As part of a DRG payment method implementation, Medicaid agencies must determine which programs and/or eligibility categories will be included in the new payment method. The new payment policy must also decide how Medicare crossover claims (where Medicare was the primary payer) are affected. For simplicity of the payment methods, Medicaid programs typically aim to include all programs in the DRG payment method and make exceptions only when specific, justifiable reasons are identified.

3.3.2 Affected Beneficiaries / Medicaid Programs - Recommendation

Services for Medicaid fee-for-service recipients are planned for reimbursement under the new DRG methodology. In addition, Medicare versus Medicaid lower-of pricing is recommended for Medicare crossover claims, so the new DRG payment methodology should apply to calculation of the Medicaid allowed amount for dual eligible beneficiaries.

The payment methodology used for services to recipients enrolled in managed care plans will continue to be the decision of the managed care organizations. Medicaid managed care plans can choose to follow fee-for-service and move to a DRG-based inpatient payment method, but are not required to do so.

For recipients eligible only for emergency services, we recommend implementing a payment strategy very similar to partial eligibility. Undocumented non-citizens and recipients who have exhausted their 45-day annual inpatient benefit limit are eligible only for emergency services. To support this recommendation, prior authorization for a specific number of days will need to continue. These more detailed prior authorizations (authorizing length of stay in addition to authorizing an admission) will allow utilization management personnel the ability to identify the emergency-only portion of each hospital stay. Then during claims payment, logic very similar to partial eligibility logic can be executed to prorate payment, reducing it by the percentage of non-covered days.

3.4 Prior Authorization Changes

3.4.1 Prior Authorization Changes - Discussion

When moving from a per diem-based payment method to a DRG-based payment method, the unit of service that is tied to the payment methodology changes from a day to a complete hospital stay, or discharge. This often has implications on the service authorization process. In a per diem payment method, processes and systems are often installed to monitor the number of days of each hospital stay. Under a DRG payment method, length of stay is no longer a major contributor to payment. As a result, the Medicaid program no longer needs to emphasize careful control over the number of days authorized. Instead, Medicaid programs generally choose only to authorize hospital admissions, not the number of days following the admission. Medicaid programs also monitor very expensive stays, sometimes in the pre-payment authorization process and sometimes in post payment review. In addition, Medicaid programs

may choose to monitor stays which are unusually short to prevent inappropriately early discharges, as hospitals are incented to limit the length of stay with DRG payments.

Similarly, a change from per diem to DRG payment may change some of the post-payment review processes and reports. With DRG payments, length of stay is of little concern, but excessive numbers of very short stays, excessive numbers of stays for which outlier payments are made, and excessive readmissions all are a concern. Overall, a DRG payment method may decrease the effort needed in support of prior authorizations, but may also increase the effort needed for post-payment review.

3.4.2 Prior Authorization Changes - Recommendation

We recommend procedures, system edits, and reports be reviewed to determine how they will need to be changed because of the move from per diem to DRG payment for inpatient care. Under the per diem method, many controls likely exist which are concerned with length of stay. However under a DRG payment method, length of stay is of limited importance as it no longer affects the reimbursement amount. Thus, authorizing a specific number of days for a hospital stay will no longer be necessary for those stays being via DRGs. In addition, concurrent reviews required after certain lengths of stay will no longer be necessary. The only exceptions we see are scenarios in which only emergency services are covered by Medicaid. This occurs for undocumented non-citizens and for recipients who have reached their 45-day annual inpatient benefit limit. In both of these cases, only emergency services are reimbursed, and prior authorizations that include an authorized length of stay can be used to identify the portion of the inpatient stay deemed to be emergent. Specifically for the 45-day benefit limit, we recommend requiring authorization for the length of stay only if the recipient has reached his/her benefit limit prior to admission. If the recipient reaches his/her benefit limit during a hospital admission, we are recommending full DRG payment, so authorization of length of stay will be unnecessary. This is discussed in more detail in section 7.13.

4 Cost Estimation

4.1 Cost Estimation - Discussion

Estimating costs for inpatient hospital services is an important step in the design of a DRG-based payment or rate-setting methodology for several reasons. First, for payers planning to develop and implement their own relative weights, knowing the costs of claims is critical if those weights are to be based on relative differences in the average costs of services described by each DRG. Second, even for states that are considering adopting weights from other payers or national sources, understanding the costs of services can be useful for validating the appropriateness of the borrowed relative weight values. Third, understanding the costs of services can be helpful in evaluating the overall fairness and equity of a payment model and related rates.

Finally, costs can be useful as a starting point for establishing DRG base rates (as well as per diem rates that might be used to pay for services that are excluded from the DRG payment method). It should also be understood, however, that when designing a system that is intended to be budget neutral, that it is not necessary to start with the costs of services when establishing base rates. Base rates can be determined through an iterative process using a payment simulation model where rates can be set at a level that will result in an aggregate “spend,” set at a level to be consistent with the payer’s budget neutrality requirements.

Currently, AHCA’s policy for estimating costs uses an aggregated approach that would not be practicable for application on a claim-by-claim basis, which will be a requirement for the current design process. There are several other approaches that can be used to estimate costs on a claim-by-claim basis using generally the same hospital Medicare cost report data and paid claims data relied upon by AHCA for their calculations. Two common approaches require extracting cost and charge data from hospital Medicare cost reports and determining either aggregate or detailed cost-to-charge ratios (CCRs) and per diems to estimate routine and ancillary costs. Regardless of the approach used, Florida hospital Medicare cost report data extracted from the CMS Hospital Cost Reporting Information System (HCRIS) dataset will be necessary.

One approach, an aggregate CCR approach, determines a hospital-specific CCR based on the ratio of total allowable costs to total allowed charges reported on the hospital-specific Medicare cost report. This hospital aggregate CCR is applied to the total charges on a claim to estimate a total cost for the claim. This approach to cost estimation is less precise than the detailed approach described next; however, it is a less resource intensive process, and is very easy to understand.

An alternative approach to the aggregate CCR approach is to use a detailed line-level approach based on Medicare’s detailed cost apportionment methodology, relying on hospital-specific routine cost per diems and ancillary CCRs to estimate costs at a claim-detail level. The detailed line-level costing approach is intuitively considered to be a more precise estimation of costs

because it requires examination of the charges for each detail line within a claim to estimate a total cost for the claim. Additional consideration during rate development should be given to separately calculating for each claim the operating cost, capital cost and direct medical education cost. This can be accomplished by calculating operating, capital and direct medical education-specific routine cost per diems and ancillary CCRs, the data elements for which are readily available in the CMS HCRIS database.

The following steps are needed to estimate costs at the detailed line level:

- Extract Florida hospital Medicare cost report data from the CMS HCRIS database for each in-state acute care hospital with reporting dates matching the dates-of-service of the claims contained in the analytical dataset
- Calculate hospital-specific operating, capital and direct medical education routine per diems and ancillary CCRs for each standard Medicare cost center
- Crosswalk each ancillary CCR or routine cost per diem, by cost center, to the allowable revenue codes in the analytical dataset claims data detail. This will include matching cost reporting periods to claims data based on the claim date of service. Only revenue codes that are identified as allowable under AHCA's current provider billing instructions would be included in the cost calculation.
- Estimate ancillary costs of each claim by multiplying the ancillary claim detail line charges by the applicable ancillary CCR
- Estimate routine costs of each claim by multiplying the routine claim detail line days by the applicable routine cost per diem
- Subtotal the operating, capital and direct medical education costs for each claim at the header level
- Inflate the cost of each claim to the midpoint of the proposed rate year based on changes in CMS hospital input price index levels

Both cost estimation approaches discussed here are acceptable methodologies used by Medicaid agencies for rate determination and impact analyses, and there are many variations of these approaches. The selection of a method for this project will be dependent on a number of factors, including the anticipated methods to be used to determine base rates and relative weights.

4.2 Cost Estimation - Recommendation

For analysis purposes during the design of the DRG payment method, we propose use of AHCA's per-hospital cost numbers that are determined each year using hospital Medicare cost reports. AHCA uses hospital cost information in its process of setting per diems today, so the Agency has an existing procedure in place for determining hospital costs applicable to Medicaid. Using these values for the DRG analysis keeps us consistent with the values used in the current rate setting process. In addition, we have found one of the alternatives, calculation of detailed hospital cost numbers using revenue codes and cost centers, to be extremely labor intensive if done accurately. Hospitals vary in the way they assign costs to cost centers making it difficult to build an accurate, unified mapping of revenue codes to cost centers. This mapping

is needed in the detailed costing process. As a result, detailed costing is error prone unless hospital specific mappings are developed. Unfortunately, development of hospital-specific mappings is an extremely time consuming process for a program the size of Florida Medicaid. We feel this high level of effort is not worthwhile given the fact that cost estimates are only used to help evaluate the fairness of the new DRG payment method. Detailed cost numbers are not used in any of the pricing calculations.

For the purposes of individual claim payment calculations, cost is only used in the determination of outlier payments. For this reason, we recommend adopting AHCA hospital-specific inpatient CCRs which are calculated annually using Medicare cost reports. We recommend CCRs be determined for every hospital with provider agreements to participate in the Florida Medicaid program including high volume out-of-state hospitals. There are currently 18 out-of-state hospitals participating in the Florida Medicaid program. For non-participating out-of-state hospitals, a default CCR will be needed. We recommend setting the default CCR to the most current average AHCA CCR for hospitals with agreements to participate in the Florida Medicaid program. (For state fiscal year 2010/2011, the average AHCA CCR is 0.33, when each hospital is counted equally.)

5 DRG Grouping

The topic of DRG grouping breaks down into two basic decision points. The first is which DRG grouping algorithm to use. Once that is decided, then the source of the DRG relative weights and average lengths of stay can be determined.

5.1 DRG Grouper

5.1.1 DRG Grouper - Discussion

5.1.1.1 Introduction

The goal of diagnosis related groupers is to define patients into categories based on similar clinical conditions and on similar levels of hospital resources required for treatment. These categories are identified using Diagnosis Related Group (DRG) codes, each of which is assigned a relative weight appropriate for the relative amount of hospital resources used to treat the patient. For example, if a DRG grouper assigns “patient A” to DRG 123 with relative weight 0.5, and assigns “patient B” to DRG 321 with relative weight 1.0, this indicates the average amount of hospital resources required to treat “patient A” is a half the amount of resources required to treat “patient B”. These relative weights associated with DRGs are used in the calculation of reimbursement with the intent of paying more when the patient’s care required more resources and less when the patient’s care required fewer resources. Thus, from the point of view of hospital reimbursement, the best DRG grouper for a particular healthcare payer is the one that most accurately predicts the relative hospital resource usage for the full range of services reimbursed by the payer.

Given the importance of generating fair payment for services provided, the primary objective of a DRG grouper is to categorize hospital stays in a way that most accurately predicts relative hospital resource usage for the care provided to each patient. In addition, there are other benefits of DRG grouping such as contributing to measurement of hospital quality and categorizing the types of care reimbursed by the payer. Also, as with any tool, DRG groupers need to be evaluated in terms of long term viability and reliability. With all these thoughts in mind, the criteria recommended for evaluation of different DRG groupers are:

1. Accuracy categorizing relative cost of care for the full range of services reimbursed by the Medicaid agency, with particular concentration on the services for which Medicaid is a major player in the market
2. Long term viability in an ever-evolving healthcare industry
3. Ability to contribute to measurement of hospital quality
4. Familiarity and experience being used in the industry

5.1.1.2 Options

There are six DRG grouping algorithms currently available in the United States as shown in Table 1.

Algorithm	Developer	All-Patient Weights	Planned ICD-10 Compliance	Marketed for Medicaid	Medicaid Payer Use	Other Payer Use	Used to Measure Quality
CMS-DRGs	3M for CMS	No	No	No	Yes	Yes	No
MS-DRGs	3M for CMS	No	Yes	No	Yes	Yes	Yes
AP-DRGs	3M	Yes	No	Yes	Yes	No	No
APR-DRGs	3M / NACHRI	Yes	Yes	Yes	Yes	Yes	Yes
APS-DRGs	OptumInsight	Yes	Yes	Yes	No	No	No
Tricare DRGs	3M	No	Yes	No	Yes	Yes	No

Two of these algorithms, CMS-DRGs and AP-DRGs are being phased out. Neither is actively being updated which means neither will be released with an ICD-10 compliant version. The Tricare DRG algorithm, which was developed and is currently maintained by 3M, uses generally the same DRG grouping logic as MS-DRGs, but has been enhanced to reflect the grouping logic of the obsolete AP-DRG model for pediatric and neonatal services. Based on our discussions with representatives from 3M, there has been relatively little investment focused on the Tricare DRG tool to bring it current with the standards established for more current models, particularly with respect to classifying neonatal and pediatric cases. The DRGs for those types of cases have been the same for many years and have not been (nor are they expected to be) updated with new research. For these reasons, the CMS-DRG, AP-DRG and Tricare DRG algorithms can be considered unacceptable options, leaving only three potential options for Florida Medicaid, MS-DRGs, APR-DRGs, and APS-DRGs. These are compared in greater detail in Table 2.

Table 2
Detailed Comparison of Select DRG Algorithms

Description	MS-DRGs V.28 (CMS - Maintained by 3M)	APR-DRGs V.28 (3M and NACHRI)	APS-DRGs V.28 (OptumInsight – formerly Ingenix)
Intended Population	Medicare (age 65+ or under age 65 with disability)	All patient (based on the Nationwide Inpatient Sample)	All patient (based on the Nationwide Inpatient Sample)
Overall approach and treatment of complications and comorbidities (CCs)	Intended for use in Medicare Population. Includes 335 base DRGs, initially separated by severity into “no CC”, “with CC” or “with major CC”. Low volume DRGs were then combined.	Structure unrelated to Medicare. Includes 314 base DRGs, each with four severity levels. There is no CC or major CC list; instead, severity depends on the number and interaction of CCs.	Structure based on MS-DRGs but adapted to be suitable for an all-patient population. Includes 407 base DRGs, each with three severity levels. Same CC and major CC list as MS-DRGs.
Number of DRGs	746	1,258	1,223
Newborn DRGs	7 DRGs, no use of birth weight	28 base DRGs, each with four levels of severity (total 112)	9 base DRGs, each with three levels of severity, based in part on birth weight (total 27)
Psychiatric DRGs (including chemical dependency)	9 DRGs; most stays group to “psychoses”	18 DRGs, each with four levels of severity (total 72)	10 base DRGs, each with three levels of severity (total 30)
Payment Use by Medicaid	MI, NH, NM, OK, OR, SD, WI	<i>Operational:</i> MA, MD, MS, MT, NY, PA, RI, SC, TX <i>Announced:</i> AZ, CA, CO, FL, IL, ND, OH, WA	None
Payment use by other payers	Commercial plan use	BCBSMA, BCBSTN	Commercial plan use
Other users	Medicare, hospitals	Hospitals, AHRQ, MedPAC, JCAHO, various state “report cards”	Hospitals, AHRQ, various state “report cards”

Table 2 Detailed Comparison of Select DRG Algorithms			
Description	MS-DRGs V.28 (CMS - Maintained by 3M)	APR-DRGs V.28 (3M and NACHRI)	APS-DRGs V.28 (OptumInsight – formerly Ingenix)
Uses in measuring hospital quality	Used as a risk adjustor in measuring readmissions. Used to reduce payment for hospital-acquired conditions.	Used as risk adjustor in measuring mortality, readmissions, complications	Used as risk adjustor in measuring mortality and readmissions and to reduce payment for hospital-acquired conditions
<p><u>Source:</u> Quinn, K., Courts, C. Sound Practices in Medicaid Payment for Hospital Care; Center for Healthcare Strategies, November 2010. Updated by Navigant with additional and more current information.</p>			

5.1.1.3 Accuracy Categorizing Relative Cost with a Medicaid Population

Both the APR- and APS-DRG algorithms are designed for a full beneficiary population. The APR-DRG algorithm even includes significant granularities for sick newborns and pediatrics that are developed and maintained by the National Association of Children’s Hospitals and Related Institutions (NACHRI) for 3M Health Information Systems. Presumably both APR-DRGs and APS-DRGs are reasonably accurate for predicting relative hospital cost given characteristics of the patient. However, more confidence exists in the accuracy of the APR-DRG scheme simply because it is used by many more payers than APS-DRGs.

MS-DRGs, in contrast, are developed specifically for the Medicare population. The DRGs are designed for beneficiaries over the age of 65 or who are disabled or suffering from end stage renal disease. It was in 2004 when the Centers for Medicare and Medicaid Services (CMS) made a policy shift to no longer support the needs of all payers.

“As previously stated, we do not have the data or the expertise to develop more extensive newborn and pediatric DRGs. Our mission in maintaining the Medicare DRGs is to serve the Medicare population.”¹

Then in 2007 when Medicare adopted its new Medical Severity DRG algorithm (MS-DRGs), CMS made several statements underscoring the fact that MS-DRGs were developed only for the Medicare population. For example,

“The MS-DRGs were specifically designed for purposes of Medicare hospital inpatient services payment. As we stated above, we generally use MEDPAR data to evaluate

¹ CMS, “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Final Rule,” *Federal Register* 69:154 (Aug. 11, 2004), p. 48,939.

possible DRG classification changes and recalibrate the DRG weights. The MEDPAR data only represent hospital inpatient utilization by Medicare beneficiaries. We do not have comprehensive data from non-Medicare payers to use for this purpose. The Medicare program only provides health insurance benefits for people over the age of 65 or who are disabled or suffering from end-stage renal disease. Therefore, newborns, maternity, and pediatric patients are not well represented in the MEDPAR data that we used in the design of the MS-DRGs. We simply do not have enough data to establish stable and reliable DRGs and relative weights to address the needs of non-Medicare payers for pediatric, newborn, and maternity patients. For this reason, we encourage those who want to use MS-DRGs for patient populations other than Medicare make the relevant refinements to our system so it better serves the needs of those patients.”²

The number of newborn DRGs provides a useful contrast between the MS-DRG algorithm and an all-patient algorithm such as APR-DRGs. MS-DRGs provide seven (7) DRG codes for the care of newborns while APR-DRGs provide 112 DRG codes (28 base DRGs, each with four (4) levels of severity). In addition, MS-DRGs do not take birth weight into consideration when assigning a DRG despite the fact that birth weight has been widely accepted as a significant indicator of the viability and overall health of newborns.

When comparing APR-DRGs and APS-DRGs, APRs also stand out as having more granularity for specific services commonly paid for by a Medicaid program. For example,

- » For newborns, there are 112 APR-DRG codes for newborns (28 base DRGs, each with 4 levels of severity), and 27 APS-DRG codes (9 base DRGs each with 3 levels of severity)
- » For psychiatric care, there are 96 APR-DRGs (24 base DRGs each with 4 levels of severity), and 30 APS-DRG codes (10 base DRGs each with 3 levels of severity)

5.1.1.4 Long Term Viability

As mentioned previously, CMS-DRGs and AP-DRGs have already been discontinued and are not expected to be offered in an ICD-10 compliant version. APR-DRGs and MS-DRGs are heavily used, and widely accepted, so their viability is strong. Both are planned to be released with ICD-10 compliant versions and are expected to be updated as necessary to follow future changes in healthcare payment strategies in the United States for years to come. OptumInsight has confirmed they too plan to have an ICD-10 compliant version of APS-DRGs and plan to maintain the product for the foreseeable future. All of that is presumably true, but confidence in the long term viability of the APS-DRG product is a little lower simply because it appears to hold a much smaller share of the market – in fact there is no state Medicaid agency using APS-DRGs to pay for fee-for-service claims.

² CMS, “Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Final Rule,” *Federal Register* 72:162 (Aug. 22, 2007), p. 47,158.

5.1.1.5 Applicability to Quality Measures

Incorporating hospital quality measures into payment systems has become increasingly common and sophisticated over the past decade. States face increasing pressure to demonstrate that Medicaid payments support quality care – as evidenced by section 2702 of the Patient Protection and Affordable Care Act prohibiting federal Medicaid payments for services treating healthcare-acquired conditions (effective July 1, 2012).

To fairly measure hospital quality, the quality measure should be risk adjusted (also referred to as casemix adjusted). For example, performing direct comparisons of mortality rates or complication rates between a cancer institute and a small rural hospital would be unfair unless they are casemix adjusted. In a situation where a cancer institute has a complication rate of 7 percent, and a small rural hospital has a complication rate of 5 percent, at face value, the complication rate of the cancer institute appears higher. However, when taking into consideration patient acuity between the two facilities, the complication rate at the cancer institute might prove to be lower than the rate at the rural hospital. APR-DRGs are very commonly used for the purpose of casemix adjustment.

APR-DRGs are also used as a basis for two quality measurement tools becoming increasingly popular with Medicaid programs for measurement of hospital quality using medical claims data. Those tools are:

- » **3M™ Potentially Preventable Complications (PPC) Grouping Software** – identifies complications that may have been avoided. This software first identifies conditions not present on admission and then determines whether those conditions were potentially preventable given the patient’s reason for admission, procedures, and underlying medical conditions. It also flags Hospital Acquired Conditions monitored by CMS.
- » **3M™ Potentially Preventable Readmission (PPR) Grouping Software** – identifies readmissions clinically related to previous admissions which were potentially preventable.

Both of the above software applications have already been used by various payers – including Medicaid agencies – for reporting purposes, payment purposes, or both. The Maryland All Payer system, for example, uses PPCs to adjust inpatient hospital rates. In the first year of use, the system experienced a 12 percent reduction in PPCs (\$62.5 million in averted costs to state and providers) and an 8 percent reduction the following year (\$43 million in additional averted costs).³ Texas Medicaid reduced inpatient Medicaid spending by \$18 million using PPRs and PPCs and reduced premiums to managed care organizations (MCOs) by up to 5 percent by reducing a variety of preventable events.⁴

³ 3M Health Information Systems for the Navigant Healthcare Payer Strategy Group. *3M Payment and Performance Measurement Systems*. January 31, 2012.

⁴ 3M Health Information Systems for the Navigant Healthcare Payer Strategy Group. *3M Payment and Performance Measurement Systems*. January 31, 2012.

Because the 3M PPC and PPR quality measurements are built “using the language of APR-DRGs,” implementing APR-DRGs for payment can facilitate a move to PPC and PPR quality measures.

5.1.1.6 Prevalence in the Industry

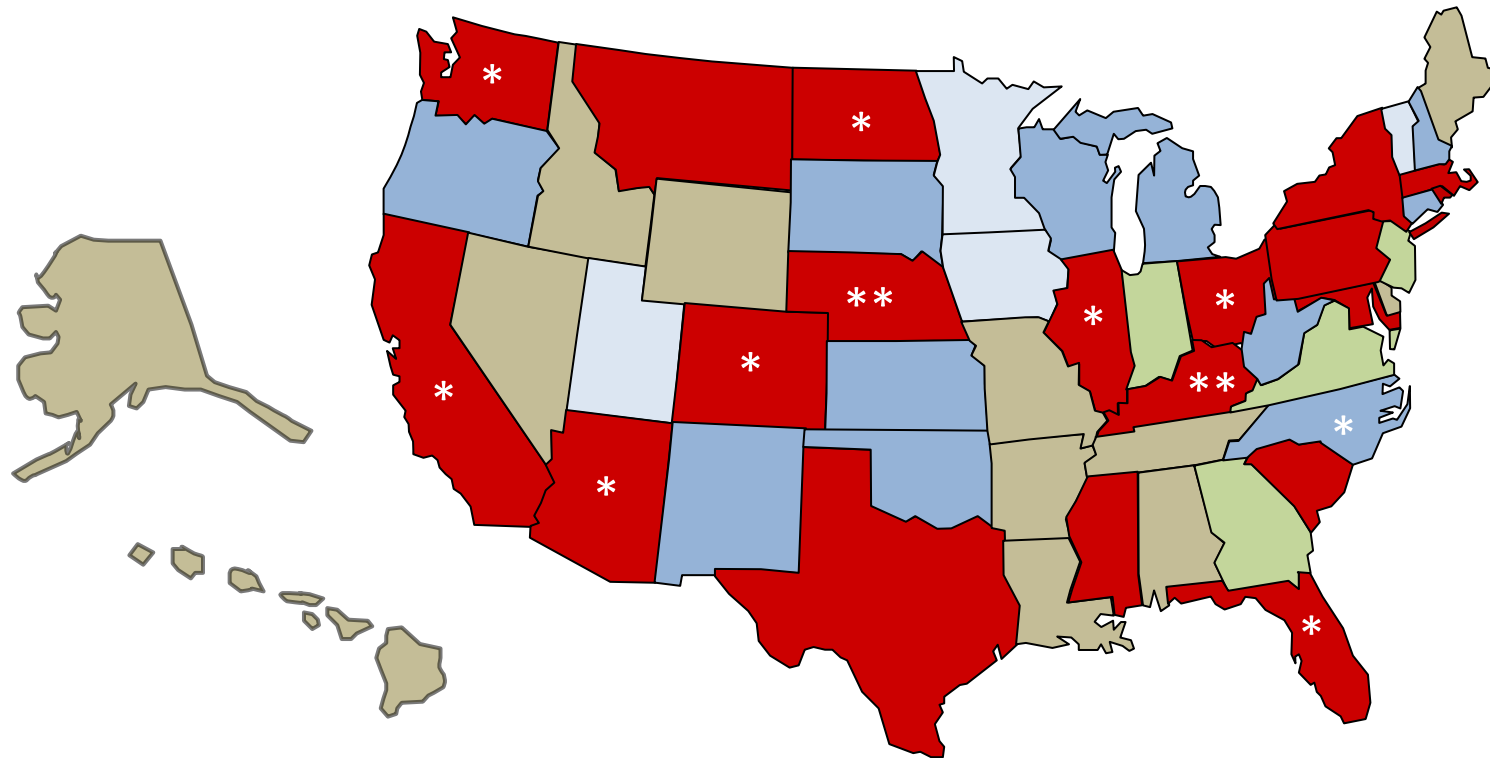
MS-DRGs are the DRG algorithm implemented for Medicare. In addition, a few state Medicaid agencies have chosen MS-DRGs. APR-DRGs are also used by several public and commercial payers. Figure 2 shows how states currently pay for inpatient care, including nine state agencies already using APR-DRGs (Massachusetts, Maryland, Mississippi, Montana, New York, Pennsylvania, Rhode Island, South Carolina, and Texas) and seven having announced plans to implement APR-DRGs in the near future (Arizona, California, Colorado, Illinois, North Dakota, Ohio, and Washington). APR-DRGs have also been used to adjust for casemix differences in performance measures in Florida, Hawaii, Maryland, Massachusetts, New York, Texas and Utah.⁵ Blue Cross Blue Shield of Massachusetts and Blue Cross Blue Shield of Tennessee have also implemented APR-DRGs.

APS-DRGs are not currently used by any state Medicaid agency for the purpose of determining reimbursement of inpatient acute care claims.

⁵ Prepared by ACS for the California Department of Health Care Services. *Medi-Cal DRG Project Draft Policy Design Document*. January 10, 2012. Page 24.

Figure 2: How states pay for inpatient acute care.

- APR-DRGs
- CMS-DRGs
- Per Stay/Per Diem/Cost Reimbursement/Other
- AP or Tricare DRGs
- * Indicates Moving Toward
- ** Indicates Under Consideration



5.1.2 DRG Grouping - Recommendation

For a Medicaid population, there is one DRG grouper that stands out as the best option for use in paying inpatient claims – APR-DRGs. Of the two other primary options, MS-DRGs are not well suited for a Medicaid population (at CMS’s own admission) and APS-DRGs have gained little traction in the market – in fact they are not used by any state Medicaid agency to pay fee-for-service claims. APR-DRGs, in contrast, have sufficient granularity to categorize hospital stays and associated cost of care for the full range of beneficiaries served by Medicaid agencies. In fact, APR-DRGs are particularly detailed for certain services in which Medicaid is a major payer, specifically sick newborns (neonates), obstetrics and pediatrics. APR-DRGs are currently used by several state Medicaid agencies for claims payment and are planned for implementation in numerous additional states. With its strong market share, APR-DRGs are expected to be updated for future changes impacting the U.S. medical insurance industry, including the planned migration to ICD-10. And finally, APR-DRGs are heavily used for risk adjustment and for hospital quality measures that are becoming more prevalent as a way to incent quality care.

Table 3 shows a comparison of APR-DRGs and MS-DRGs on three years of Florida Medicaid claims, including both fee-for-service and managed care claims. It shows that APR-DRGs are a better predictor of hospital cost than MS-DRGs overall and particularly better for neonates, obstetrics and pediatrics. With the R-squared measurement, an absolutely perfect predictor would have an R-squared value equal to 1.0. With the breakout by service line, a value of 1.0 could be achieved only if every single claim within the service line (from all the Florida hospitals providing those services) had exactly the same CCR cost. This is not realistic, no matter how minutely we define our service lines. So a value of 1.0 or even very close to 1.0 is not expected given the type of data we are analyzing. Even so, R-squared is a helpful measurement tool and higher values (values closer to 1.0) are an indication of a grouping method that better predicts cost. In nearly all categories, and certainly overall, APR-DRGs show higher R-squared values than MS-DRGs.

Table 3 DRG Cost Correlation Analysis					
Service Line	Discharges	CCR Cost	Coefficient of Determination (R ²)		
			MS-DRG	APR-DRG	Difference
Burns	1,189	\$ 23,110,651	0.36	0.40	0.04
Circulatory Adult	82,020	\$ 945,172,942	0.55	0.54	(0.01)
Gastroent Adult	92,838	\$ 922,920,435	0.36	0.39	0.03
HIV	9,806	\$ 148,013,653	0.25	0.24	(0.00)
Mental Health	44,311	\$ 138,770,930	0.04	0.10	0.06
Misc Adult	221,004	\$ 2,683,836,823	0.48	0.48	0.01
Misc Pediatric	111,384	\$ 937,396,061	0.27	0.33	0.06
Neonate	33,929	\$ 928,497,893	0.23	0.51	0.27
Obstetrics	351,914	\$ 1,282,741,557	0.18	0.26	0.08
Rehab	5,816	\$ 79,216,743	0.14	0.15	0.01
Resp Adult	61,673	\$ 599,158,745	0.31	0.32	0.01
Resp Pediatric	53,149	\$ 290,755,802	0.25	0.27	0.02
Substance Abuse	7,643	\$ 32,901,446	0.28	0.29	0.01
Transplant	449	\$ 49,814,896	0.27	0.31	0.04
Trauma	7,785	\$ 202,160,983	0.52	0.48	(0.05)
All	1,084,910	\$ 9,264,469,559	0.38	0.47	0.09
Notes:					
1) Normal Newborn claims were removed from this analysis, as a significant portion are not reported in current claims system.					
2) For this chart, Medicare (not AHCA) hospital-specific cost-to-charge ratios were used to determine CCR cost.					
3) Version 29 was used for both APR-DRGs and MS-DRGs.					

5.2 DRG Relative Weights

5.2.1 DRG Relative Weights - Discussion

States have three options when selecting a set of relative weights for the DRGs they will be using:

- a. Use national relative weights
- b. Develop state-specific weights
- c. Borrow state-specific weights developed by another payer or Medicaid program

National relative weights exist for APR-DRGs, MS-DRGs, and APS-DRGs. For APR-DRGs and APS-DRGs, national relative weights are updated yearly and are calculated using the two most recent year's data from the Nationwide Inpatient Sample maintained by the Agency for

Healthcare Research and Quality (AHRQ). This data includes claims from all types of payers including many Medicaid programs. MS-DRG relative weights are also updated each year, using only claims data from Medicare recipients.

National relative weights are relatively easy to use as they are calculated by external agencies. If using national relative weights, states can decide to use the values as they are distributed, or re-center the weights to the individual state's overall casemix. Re-centering the weights simply resets the average relative weight to 1.0 which makes the numbers very easy to understand – relative weights less than 1.0 are below average and relative weights above 1.0 are above average.

Instead of using national relative weights, states can choose to calculate their own weights. This option has the benefit of ensuring the weights accurately reflect costs of hospitals when treating patients that are unique to that state's Medicaid population. However calculating state-specific weights requires more effort from the Medicaid agency (more than simply downloading national values). In addition, it offers the challenge of deciding what values to use for DRGs with statistically low volume in the Medicaid program. Even California, the largest Medicaid program in the country, found there were 463 APR-DRGs with fewer than 30 stays in a single year (2009), including 46 APR-DRGs with zero volume.⁶ In cases with low volume, states can choose to use the national value, or prorate the weight from a similar DRG.

If choosing to use state-specific relative weights, decisions must also be made on how those weights will be calculated. The basis for weights can be charges or relative costs. Typically, relative weights come out similarly when using charges or costs, but using costs is far more defensible (see Chapter 4 for a discussion of options for estimating the costs of services). When using costs, another necessary decision is defining how costs will be determined for the relative weight calculation. Further, the process for recalculating the weights would have to be performed periodically, usually annually.

The final option a state can select is to copy the relative weights from another Medicaid program. This has the advantage of limiting the effort a state expends to determine relative weights while allowing the weights used to be specific to a Medicaid program. Pennsylvania selected this option, and uses the state-specific APR-DRG relative weights calculated by New York.

Once a DRG grouper is selected, a comparison can be made of national relative weights versus state-specific weights. Navigant has performed this type of comparison in the past and found the national weights and state-specific weights align very closely on the high volume and high cost DRGs. If similar analysis using Florida Medicaid generates the same results, it will be an argument for using the national weights.

⁶ Prepared by ACS for the California Department of Health Care Services. *Medi-Cal DRG Project Draft Policy Design Document*. January 10, 2012. Page 33.

Similar to relative weights, average length of stay must also be determined for each DRG. Average length of stay is used in transfer and partial eligibility payment adjustments. Average length of stay can also be used in outlier calculations if day outliers are implemented. If using national relative weights, national average lengths of stay would also be available for use. Similarly, if borrowing from another state, both the relative weights and average lengths of stay could be borrowed. If, on the other hand, Florida Medicaid state-specific relative weights are selected, then state-specific average lengths of stay would also need to be calculated, including the challenge of deciding what to do with DRGs having statistically low volumes of observations.

5.2.2 DRG Relative Weights - Recommendation

Studies with other state Medicaid data have shown that state-specific weights and national weights align very well for high volume DRGs. The same proved true with Florida-specific relative weights (Figure 3). Also, as mentioned in the discussion section, using national weights requires less administrative burden and requires little or no manual adjustment for low-volume DRGs. Given these facts, we recommend adopting national relative weights for use by the Medicaid program.

Figure 3: Comparison of re-centered national APR-DRG relative weights versus Florida Medicaid relative weights.

R ² for top 50:	0.917
R ² for all DRGs:	0.924 (Stays >= 20)
Top 50 DRGs account for 62% of all stays	

In addition, we recommend re-centering the national weights to 1.0 (by dividing each national relative weight by the Florida Medicaid overall average casemix). Re-centering the weights has the simple effect of making 1.0 the average relative weight, numbers below 1.0 less than the average, and numbers above 1.0 greater than the average. This provides a quick and easy interpretation of relative weight values.

If Florida state-specific weights are used, there are 212 APR-DRGs with volume below 20 stays in two years of fee-for-service data (using data from fiscal years 09/10 and 10/11). States typically use a minimum threshold between 10 and 30 stays as the minimum volume needed to calculate a state-specific relative weight. For this discussion, we have picked the midpoint of this range, or 20 stays. DRGs with less than 20 stays would need their relative weights determined using data “borrowed” from another source as a proxy. Also, as Florida Medicaid

shifts more recipients to managed care, the number of DRGs in the fee-for-service population that have a sample size of less than 20 stays will increase. Assuming the plan to migrate to a managed care model moves forward, state-specific weights would likely need to be calculated in the future using the Florida Health Finder all-payer inpatient data instead of the Medicaid fee-for-service data. Another option would be use of a combination of Medicaid fee-for-service and managed care claims to reach sufficient volume for relative weight calculations. For this option to work, the encounter data would need to be as high in quality as the fee-for-service data.

6 Provider Base Rates

Provider base rates are another significant contributor to the reimbursement amount on individual hospital stays and to Medicaid hospital inpatient reimbursement in aggregate. Thus selection of provider base rates is a critical step in ensuring fair reimbursement when implementing a DRG payment method. The simplest approach from the point of view of maintaining budget neutrality would be to assign each hospital its own base rate. However, this would defeat one of the basic goals of a DRG payment method – that is incenting and rewarding hospital efficiency. The opposite approach would be to develop a single base rate to be applied to all hospitals, with potential adjustments to that base rate for individual hospitals only to address reasonable differences in cost, and where those differences are actually measurable. Many states have found, however, that a solution somewhere between individual hospital base rates and a single state-wide base rate is a more appropriate answer.

6.1 Provider Base Rate Categories

6.1.1 *Provider Base Rate Categories - Discussion*

The combination of provider base rates adjusted by wage area, DRG relative weights, and policy adjustors (discussed in section 7.2) may be enough to ensure fair payment to providers. However, if those options leave open some areas of concern, another option available is adjustment of hospital base rates based on hospital categories or peer groups. Hospital peer groups can be used to protect access to care at specific facilities, such as rural hospitals, and/or to generate fair payment to hospitals that legitimately have higher cost structures (if the reason for higher cost is separate from wages in different geographic areas). To protect access to care, for example, the California Department of Health Care Services plans to have a separate set of base rates for remote rural hospitals. In addition, when looking at cost structures, separate base rates may be justifiable, for example, for trauma facilities, specialty children’s hospitals and/or teaching hospitals. For teaching hospitals, Medicare provides additional payment, separate from the base rate. However, that additional payment can just as easily be incorporated into the base rate.

A peer group can also be considered if there is a group of hospitals who treat very complicated, expensive cases and are expected to have an unusually high percentage of outlier payments. In most DRG implementations, outlier payments cover a lower percentage of hospital costs than standard DRG payments so high numbers of outlier stays become a burden to hospitals. One

way to solve that problem is to give these hospitals a higher base rate, which will serve to reduce their percentage of outlier stays.

If separate base rates are selected for some groups of providers, we recommend the criteria used to categorize hospitals within groups be very clear and maintainable. Understandably, hospitals will be motivated to be defined into the peer group offering the most attractive reimbursement. Having clearly defined criteria for each grouping will help maintain the integrity of the payment policy and lessen the administrative burden of categorizing all hospitals.

6.1.2 Provider Base Rate Categories - Recommendation

With input from AHCA, we are recommending a single common base rate (referred to as “standard base rate” by Medicare), which means using only one base rate category. This means all hospitals will be treated the same, in terms of base rate, each being assigned the same dollar amount. However, a few hospital categories will be given provider policy adjustors which are described in detail in section 7.2.

The provider base rate is a key factor in the calculation of DRG payment and will be funded from state general revenue and the Public Medical Assistance Trust Fund. Distribution of funds from Inter-Governmental Transfers (IGTs) will be made separately as per-claim supplemental payments and these funds will not contribute to the provider base rate. This topic is discussed in more detail in section 6.3.

6.2 Provider Base Rate Wage Area Adjustments

6.2.1 Provider Base Rate Wage Area Adjustments - Discussion

One factor employed by states (and by the Medicare program) to adjust hospital base rates is a geographic wage area index or factor. The wage areas and associated wage indices can be state-defined values or can be linked to the Medicare values. Adjustment by wage area allows for higher payment in geographic regions that have historically reported higher wage rates for hospital employees.

Wage area indices act as multipliers to common base rate(s) and can be applied either to the entire base rate or to a portion of the base rate. For example, Medicare applies the wage area index only to a percentage of the common base rate where the percentage is a standardized estimate of the percentage of hospital costs attributed to labor. In particular, Medicare applies the wage index to 62.0 percent of the common base rate for hospitals with a wage index less than 1 and applies the wage index to 68.8 percent of the common base rate for hospitals with wage index greater than or equal to 1. For example, the base rate for a hospital with a wage index greater than 1 is:

$$\begin{aligned} \text{Base rate} &= ([\text{Common base rate}] * [\text{hospital wage index}] * 0.688) \\ &+ ([\text{Common base rate}] * 0.312) \end{aligned}$$

Medicare also has a cost of living adjustment (COLA) applied to the non-labor portion, but that is only applied to hospitals in Alaska and Hawaii. In addition, Medicare has separate calculations for operating base payment and capital base payment, and sums the two to generate overall payment. The formulas for the two separate base payments are very similar.

Medicare wage indices for providers participating in Florida Medicaid (including a select few out of state providers) range from 0.7277 to 1.0163 and the average is 0.9287. The difference from the lowest wage index to the highest is 0.2886 which is over 30 percent of the average.

An alternative to adopting Medicare’s wage indices would be to develop Florida-specific wage indices. However, determination of wage areas can be very complicated and would likely require AHCA to take on a significant amount of additional effort. In addition, CMS is currently undergoing a major effort to redesign wage areas that will presumably result in a solution more widely accepted in the hospital community.

6.2.2 Provider Base Rate Wage Area Adjustments - Recommendation

Because of varying opinions on the fairness of Medicare wage areas and AHCA’s strong preference for a simplified payment method, we are recommending against having a wage area adjustment. Simulations were run both with and without wage area adjustments and the results in both cases were nearly identical when viewed across service lines and across provider categories. So we are recommending a single provider base rate that gets adjusted only for a few providers through provider-specific policy adjustors.

6.3 Funding for Provider Base Rates

6.3.1 Funding for Provider Base Rates - Discussion

Much of the funding for the Florida Medicaid program comes from general revenue and from a provider assessment. In addition, a significant portion of funding also comes from inter-governmental transfers (IGTs) which are received for rate buy-backs, exemptions, and other purposes. Some of this money is designated to be distributed to certain categories of hospitals, such as statutory teaching, hospitals with a high percentage of charity cases, and hospitals involved in the Community Hospital Education Program (CHEP). These are referred to as “automatic IGTs.” In addition, local governments can voluntarily contribute money to buy-back hospital Medicaid rate reductions. These funds are referred to as “self-funded IGTs.”

Many states use inter-governmental transfers (IGTs) to help fund their Medicaid program. However, Florida Medicaid is somewhat unique in that it distributes some of these IGT funds back out to hospitals on a claim-by-claim basis. Most states distribute IGT funds as supplemental payments distributed periodically, such as quarterly or yearly, much the way Florida Medicaid distributes Low Income Pool (LIP) payments. Automatic and self-funded IGTs are distributed per claim, with a contribution to each hospital’s per diem rate (in the current payment method). Separate sums of money are identified for each hospital each year to be funded by automatic and self-funded IGTs. These funds are then divided by the estimated

total days from Medicaid recipients at each hospital and the resulting per-day amount is added to the each hospital's per diem rate.

6.3.2 Funding for Provider Base Rates - Recommendation

After discussions with AHCA, Navigant is recommending the provider DRG base rate be determined using only general revenue and provider assessment funds. Automatic and self-funded IGTs which are distributed on a per claim basis will be kept outside the base rate and added on as per-claim supplemental payments. Keeping IGT payments separate from the provider base rate allows the automatic and self-funded IGTs to go to the hospitals for which they are designated without requiring a separate base rate for each hospital. In particular, we are recommending two per-claim supplemental payments, one for automatic IGTs and one for self-funded IGTs. A more detailed discussion of how per claim IGT payments fit into the DRG pricing calculation is given in section 7.4.

6.4 Per Diem Base Rates

6.4.1 Per Diem Base Rate - Discussion

As mentioned previously, some provider types and some types of services may be carved out of the DRG payment method because they are more appropriately paid via another method. If such a decision is made, the carved-out services will presumably be paid per diem as that is the current AHCA inpatient payment method, and per diem rates will need to be determined. The current method used to create per diem rates may be acceptable, in which case no changes need to be made. However, the current method may be unnecessarily cumbersome when applied to only a relatively small subset of inpatient stays, and, if so, AHCA may want to consider adjusting the per diem rate setting process.

Options for setting per diem base rates include setting rates based on average hospital cost per day and using a graduated scale based on length of stay as Medicare uses for paying psychiatric services. In addition, the availability of DRG grouping allows the option of calculating casemix adjusted per diems, similar to the way Medicare pays for some services. Furthermore, for a limited number of specialty services, a percent of charges (cost based) method could be considered in place of a per diem payment method.

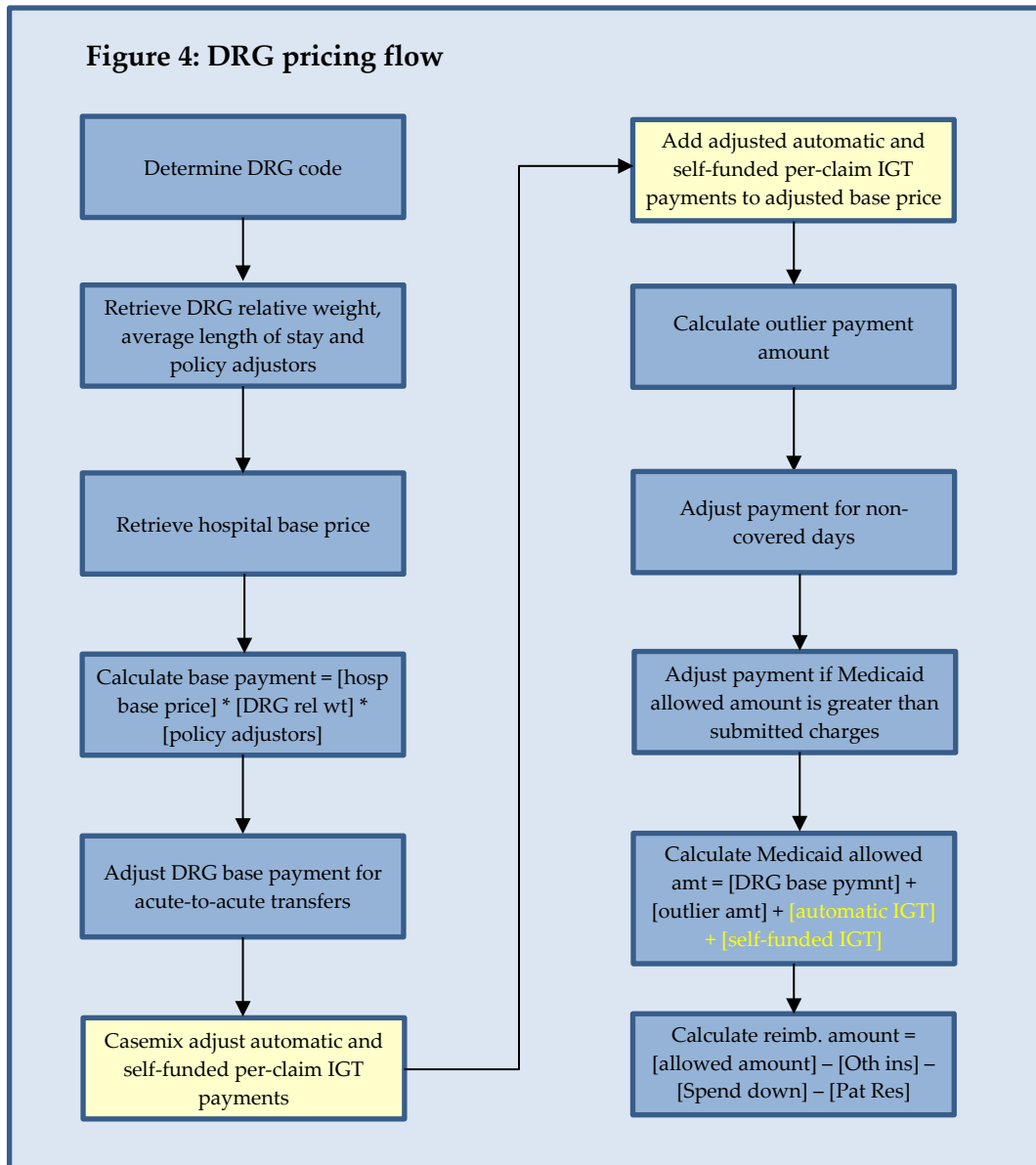
6.4.2 Per Diem Base Rate - Recommendation

The only inpatient care we are recommending for exclusion from the DRG payment method is care provided at the four state psychiatric hospitals. (Please see sections 3.1 and 3.2 for further discussion on provider types and services included in the DRG payment method.) AHCA will need to calculate per diems for these four facilities. Our recommendation is to continue the current cost-based process for determining per diems for the state psychiatric facilities.

7 Pricing Logic

7.1 Pricing Flow

Figure 5 shows the basic flow of DRG pricing logic. In this figure, items are included which are unique to the calculation we are recommending for Florida Medicaid, as compared to the generic DRG payment calculation described in Chapter 2. The boxes shaded with a yellow background and the text that is yellow in color are the portions of the DRG calculation which are unique to Florida Medicaid.



DRG codes, DRG relative weights, and hospital base prices were discussed previously in Chapters 5 and 6. The following sections of this chapter discuss the rest of the factors involved in calculating a DRG-based price.

7.2 Policy Adjustors

7.2.1 Policy Adjustors - Discussion

Policy adjustors are multipliers applied to specific claims for the purpose of increasing or decreasing payment. Generally, policy adjustors are applied for specific types of care, either for all recipients receiving that care or for subsets of recipients. Four types of policy adjustors are commonly used:

- Service adjustors
- Age/service adjustors
- Provider/service adjustors
- Provider adjustors

Policy adjustors are an optional feature that can be used to help protect access to care for specific services. Often these are used for services where Medicaid funding can have a significant impact on beneficiary access, such as obstetrics, newborn care, mental health and pediatrics. The adjustors are above and beyond DRG relative weights and represent an explicit decision to direct funds to a particular group of patients who are otherwise clinically similar. Also, assuming a goal of budget neutrality, use of policy adjustors cause hospital base rates to be reduced having the effect of shifting some money from one area to another. We generally recommend including policy adjustor functionality in a DRG implementation because it creates an ability to meet current and future Medicaid program goals by adjusting payments without requiring significant software changes within the MMIS. However, policy adjustors do not necessarily need to be a major contributor to overall program reimbursements. They can be used sparingly to meet specific needs.

The first type of policy adjustor, service adjustor, works particularly well if there is a desire to increase payment for specifically targeted services, such as obstetrical and neonatal care.

The age/service adjustor is better suited if AHCA desires to adjust payment for recipients within specific age categories, such as adjusting all pediatric services. Age/service adjustors provide a different payment for similar services when provided to a child versus an adult. For example, an age/service adjustor of 1.25 on APR-DRG 139-1 (pneumonia severity 1) would increase payment by 25 percent if the patient was a child. In contrast, an adult whose claim mapped to APR-DRG 139-1 (pneumonia severity 1) would receive the DRG base payment without any adjustment. In truth, age/service adjustors can be applied to any age range, but are typically used by Medicaid programs to promote access for pediatric beneficiaries.

Provider/service adjustors can be used to increase (or decrease) payment for specific services when offered by specific groups of providers. For example, a Medicaid agency might choose to

increase payment for neonatal care when offered at a specialty children’s hospital which might incur greater costs to support clinical expertise and equipment needed to treat very sick children. In such a scenario, a provider/service adjustor could be used to increase payment for neonatal care when provided at children’s hospitals without increasing payment for other types of care (such as normal deliveries) at the same hospitals.

Finally, provider adjustors can be used to increase (or decrease) payments for all services performed by specific individual providers or categories of providers. Provider adjustors differ from provider/service adjustors in that they apply for all stays at a particular hospital, not just stays for certain types of services.

Within DRG pricing calculations, the adjustors can affect the DRG base payment using the following formula:

$$\begin{aligned}
 \text{[DRG base payment]} &= \text{[Hospital base rate]} * \text{[DRG relative weight]} \\
 &* \text{[Service adjustor]} * \text{[Age/service adjustor]} \\
 &* \text{[Provider/service adjustor]} * \text{[Provider adjustor]}
 \end{aligned}$$

Or only the highest adjustor can be used, in which case the formula is,

$$\begin{aligned}
 \text{[DRG base payment]} &= \text{[Hospital base rate]} * \text{[DRG relative weight]} \\
 &* \text{Maximum of}(\text{[Service adjustor]}, \text{[Age/service adjustor]}, \\
 &\text{[Provider/service adjustor]}, \text{[Provider adjustor]})
 \end{aligned}$$

For any particular service, one, two, three, or all four of the adjustors can be, and very commonly are, set to 1.0, thus creating no adjustment.

The types or categories of service for which policy adjustors are applied are identified by DRG codes. Each DRG code is assigned a DRG relative weight and three adjustor values: service, age, and provider. In theory, a Medicaid program could simply make adjustments to DRG relative weights outside the MMIS and avoid putting separate adjustor fields into the MMIS. However, this would upset the integrity of the DRG relative weights and is something we strongly discourage. DRG relative weights are intended to indicate relative hospital resource expenditures and patient acuity, and can be used to measure hospital casemix. Those measurements would not be valid if the DRG relative weights were manipulated.

7.2.2 Policy Adjustors - Recommendation

The DRG payment simulations have shown the need for targeted policy adjustors. These are discussed in detail in the following subsections.

7.2.2.1 Service Adjustors

DRG payment simulations show all services critical to the Medicaid program, neonates, newborns, pediatrics, obstetrics and mental health, getting paid above the statewide average

pay-to-cost ratio. The statewide average pay-to-cost ratio is 91 percent and the pay-to-cost ratios of these Medicaid critical services are anticipated to be:

- » Neonates 101%
- » Normal newborns 122%
- » Pediatrics 100%
- » Obstetrics 92%
- » Mental health 122%

As a result, we are not recommending any service policy adjustors for these services. However, the pay-to-cost ratio for obstetric services is only slightly higher than the state-wide average. If this value dips below the state-wide average when the final rates for SFY 2013/2014 are generated, then we will likely add an adjustor for obstetric services.

We are however, recommending a service adjustor for rehabilitation services. Rehabilitation services are often carved out of a DRG payment method because the level of variation in hospital resources needed for rehabilitation diagnoses is so great that DRGs struggle to accurately predict relative hospital cost. And when early simulations were run payments for rehabilitation stays were shown to decrease quite significantly in the move from per diem payment to per-stay DRG payment. However, AHCA expressed interest in keeping the payment method as simple as possible and in putting as many inpatient services as possible within the DRG payment method. To meet AHCA’s interests and ensure fair payment for rehabilitation services, we are recommending a service policy adjustor be applied for rehabilitation services. In addition, we are recommending that the adjustor be set so that the pay-to-cost ratio of the free-standing rehabilitation hospitals (whose primary business is rehabilitation) reach 60 percent. This 60 percent figure is above their current pay-to-cost ratio, 54 percent, under the per diem method.

7.2.2.2 Age/Service Adjustors

Typically, age/service adjustors are used to increase payment for pediatric services. We believe a payment adjustment for pediatric services is unwarranted for Florida Medicaid because simulations show the pay-to-cost ratio for these services is predicted to be 100 percent, which is well above the state-wide average of 91 percent. As a result, we are not recommending any policy adjustors based on patient age.

7.2.2.3 Provider/Service Adjustors

We are not recommending use of provider/service adjustors which allow for payment increase for specific services only when provided at specific hospitals. In general, these adjustors are in conflict with the guiding principle of equity as they support different payment for the same service when provided at different hospitals.

7.2.2.4 Provider Adjustors - Introduction

We are recommending three provider policy adjustors. To offer relatively equitable payment to some types of providers while still maintaining AHCA’s expressed goal of having one standard base rate, we believe provider policy adjustors are warranted. Specifically, we are recommending policy adjustors for the following types of providers:

- Rural hospitals
- Long term acute care hospitals
- Hospitals with both high Medicaid utilization and high outlier payment percentage

These will be applied to all stays at the affected hospitals, not just stays for certain types of services. Our recommendation is to include provider policy adjustors that get these categories of providers to the following pay-to-cost ratios:

Hospital Category	Pay-to-Cost Goal
Rural hospitals	98%
Long term acute care hospitals	66%
Rehabilitation hospitals	60%
Hospitals with both high Medicaid utilization and high outlier payment percentage	95%

7.2.2.4.1 Provider Adjustors – Rural Hospitals

Rural hospitals are a category of hospitals that has historically been given special consideration by the Florida legislature. The legislature has exempted rural hospitals from many rate cuts and has ensured there is money set aside from general revenue (separate from the IGT program) to keep per diem rates for rural hospitals relatively high. In keeping with this general policy, we are recommending a provider policy adjustor for rural hospitals that will set their overall pay-to-cost ratio to 98 percent according to our simulation modeling. Without any policy adjustor for rural hospitals, their pay-to-cost ratio would drop from 98 percent to 60 percent. Such a significant drop in overall pay-to-cost for this category of hospitals might have the potential to reduce access to care for Medicaid beneficiaries in rural regions which would go against one of our overall project guiding principles. Therefore, adding a policy adjustor for rural hospitals is a relatively straight forward decision. Specifically, we are recommending a rural hospital target pay-to-cost ratio of 98 percent because it matches the pay-to-cost ratio for these hospitals under the legacy per diem system.

7.2.2.4.2 Provider Adjustors – Long Term Acute Care Hospitals

Long term acute care (LTAC) hospitals are often excluded from DRG payment because DRGs are not a great predictor of cost for the types of stays common at these facilities. However,

AHCA has expressed interest in moving as many providers as possible to the new DRG payment method. In addition, the volume of Medicaid stays at these hospitals is quite low (less than 100 LTAC stays in state fiscal year 2010/2011), making it difficult to justify the additional administrative cost of maintaining a separate payment method for this category of hospitals. However, in our simulations, DRG payment without any policy adjustor showed a significant reduction in reimbursement for these providers when compared to payments under the legacy per diem system (pay-to-cost going from 66 percent to 50 percent). Our recommended solution is to give this category of providers a policy adjustor that maintains its overall reimbursement compared with the legacy per diem method. Specifically, we are recommending a pay-to-cost goal of 66 percent for LTACs, which matches their historical reimbursement level.

7.2.2.4.3 Provider Adjustors – High Medicaid, High Outlier Hospitals

The final provider policy adjustor we are recommending is for hospitals that have a very high Medicaid utilization and a very high percentage of stays hitting an outlier status. Clearly, there is value in a Medicaid agency giving special consideration to hospitals whose business comes primarily from Medicaid recipients. In addition, stays hitting outlier status, by definition, result in financial losses to a hospital (the loss must be above a threshold amount to be defined as an outlier) and costs above the threshold are reimbursed at a percentage below the state-wide average (through use of the marginal cost factor). Overall in a DRG payment method, we expect the losses to be balanced by stays that are gains. However, a hospital that has a very high percentage of outliers may not have a sufficient number of gains to balance the losses. And the combination of high occurrences of outlier cases with high Medicaid utilization puts undue burden on specific hospitals. Thus, we are recommending a provider policy adjustor for any hospital with Medicaid utilization at or above 50 percent and a projected outlier payment percentage at or above 30 percent. Given these thresholds, only two providers qualify for this policy adjustor in our simulation modeling, All Children’s Hospital and Miami Children’s Hospital, however, in future periods, this adjustment would be available for any hospital that has a combination of Medicaid utilization and outlier payment percentages exceeding these thresholds. Our recommendation is to set the policy adjustor for these two hospitals to a value that ensures their payments are no less than they were under the current per diem payment method. The policy adjustor is being set for these two providers so that their pay-to-cost ratio reaches 95 percent.

7.3 Transfer Payment Adjustments

7.3.1 Transfer Payment Adjustments - Discussion

DRG payments are designed to be a single payment for a complete stay in a hospital. Given this design, full DRG payments can be unnecessarily high if a patient is transferred from one acute care facility to another resulting in an unusually short length of stay at the “transferring from” hospital. To handle this situation, most Medicaid DRG implementations have followed the Medicare model in which a payment amount is calculated using a per diem method and then compared to the DRG base payment. The per diem payment is referred to as a transfer-adjusted payment amount and, if less than the DRG base payment, is used in place of the DRG base payment. The formula used to calculate the transfer-adjusted base payment is:

$$\text{Transfer adjusted base pymt} = \{[\text{DRG base payment}] / [\text{DRG average length of stay}]\} \\ * \{[\text{length of stay}] + 1\}$$

Adding one to the length of stay takes into account the disproportionate amount of costs required in the first day of admission to complete the admission process and perform an initial diagnostic evaluation. Under this particular formula, the transfer adjusted base payment comes out less than the DRG base payment if the length of stay is less than the DRG's average length of stay minus 1. Otherwise, the "transferring from" hospital receives full DRG payment.

For average length of stay data, AHCA can use arithmetic or geometric averages derived from untrimmed or trimmed data. In addition, statewide averages can be used, or national averages calculated using data from the Nationwide Inpatient Sample.

Transfer payment adjustments only apply to the transferring hospitals. Receiving hospitals are paid the full DRG amount.

The transfer payment adjustment process is used when a patient is transferred from one acute care setting to another. Transfers are identified in claims data through the discharge status and AHCA's DRG payment policy will need to specify which discharge status codes apply to the transfer payment adjustment process. Possible status codes to include are:

- 02 – discharged/transferred to a short-term general hospital for inpatient care
- 05 – discharged/transferred to a designated cancer center or children's hospital
- 07 – left against medical advice (Medicare uses this value if the patient is admitted to another acute care hospital on the same day)
- 43 – discharged/transferred to a federal facility
- 62 – discharged/transferred to an inpatient rehabilitation facility or distinct part unit
- 63 – discharged/transferred to a long term care hospital
- 65 – discharged/transferred to a psychiatric hospital or distinct part unit
- 66 – discharged/transferred to a critical access hospital

AHCA may also consider a "post-acute care transfer policy" similar to that used by Medicare. This policy reduces payment to hospitals for a specified list of DRGs (currently 275 MS-DRGs) when the patient is transferred to a particular type of hospital. The need for this policy arose from the disparate payment incentives facing acute care providers (paid per stay) and post-acute care providers (paid per day). For patients requiring both acute and post-acute care (as identified by the list of 275 MS-DRGs, for example, hip replacement), Medicare reduces payment to the hospital if a stay is particularly short and the patient is discharged to a post-acute setting. Patient discharge status codes that Medicare includes in its post-acute care transfer policy are:

- 03 – discharged/transferred to a skilled nursing facility
- 05 – discharged/transferred to a cancer or children’s hospital
- 06 – discharged/transferred to a care of a home health agency
- 62 – discharged/transferred to a rehabilitation facility or distinct part unit
- 63 – discharged/transferred to a long-term care hospital
- 65 – discharged/transferred to a psychiatric hospital or distinct part unit⁷

Medicare has a large enough percentage of their population fitting this scenario to justify incurring the extra administrative complexity of this post-acute transfer policy. Medicaid programs have a significantly lower percentage of their populations fitting this scenario, so the added complexity of this policy may be unwarranted.

**7.3.2 Transfer Payment Adjustments - Recommendation*

7.3.2.1 Acute Care Transfers

We recommend including an acute care transfer policy that reduces payment for short than average lengths of stay resulting from transfer of a patient from one acute care hospital to another. Also, we recommend using the Medicare model for calculating the transfer payment amount and deciding when it applies. As mentioned in the previous discussion section, the transfer payment is calculated as

$$\text{Transfer adjusted base pymt} = \{[\text{DRG base payment}] / [\text{DRG average length of stay}]\} \\ * \{[\text{length of stay}] + 1\}$$

This formula calculates a per diem amount using the DRG base payment and average length of stay. The “plus 1” added to the length of stay takes into account the disproportionate amount of costs required in the first day of admission to complete the admission process and perform an initial diagnostic evaluation. The formula effectively pays double for the first day of care.

For DRG average length of stay, we recommend using national average lengths of stay. This is consistent with our recommendation to use national APR-DRG relative weights.

When a patient is transferred to another acute care facility, payment equals the lower of the transfer adjusted base payment and the DRG base payment. The effect is to reduce payment on transfer cases only when the length of stay is less than the [average-length-of-stay minus 1]. Also, this calculation applies only to the transferring hospital. The receiving hospital is paid a full DRG reimbursement.

Acute care transfers are determined through discharge statuses reported on the UB-04 and 837I forms. Payers must identify which discharge statuses will qualify as acute care transfers. We recommend the following statuses as an indication of an acute care transfer as opposed to a post-acute care transfer:

⁷ Medicare Claims Processing Manual - Chapter 3 - Inpatient Hospital Billing; Rev. 2388, 01-20-12, 40.2.4-C p. 123

- 02 – discharged/transferred to a short-term general hospital for inpatient care
- 05 – discharged/transferred to a designated cancer center or children’s hospital
- 65 – discharged/transferred to a psychiatric hospital or distinct part unit
- 66 – discharged/transferred to a critical access hospital

The above list does not include discharge status 07 (left against medical advice). Medicare does include this as an acute transfer status if the patient is admitted to another Medicare DRG hospital on the same day. In practice, we expect this occurs very rarely and the logic required to implement this policy is difficult to install in an MMIS and is dependent on the order in which claims are received. As a result, we do not feel it is worthwhile to include in the acute transfer policy stays with discharge status 07 followed by an admission at another hospital on the same day.

The above list also does not include discharge status 43 (discharged/transferred to a federal facility) because this includes discharges to both acute care providers (i.e., a VA hospital) and post-acute care providers (i.e., a VA nursing facility). We suggest following Medicare’s example in not defining this status as an acute care transfer.

The above list does include discharge statuses 05, 65, and 66 which are not included in Medicare’s acute transfer policy. Instead, Medicare chooses to include these in its post-acute transfer policy because none of the receiving hospitals are paid via DRG under Medicare’s Inpatient Prospective Payment System. We prefer to think of the transfer policy as applying to any acute care facility independent of the receiving facility’s method of reimbursement. Thus, even if psychiatric care is carved out of Florida Medicaid’s DRG payment method, we recommend leaving discharge status 65 in the acute transfer policy.

Given this list, the percentage of stays expected to be considered for transfer adjustments is less than 2 percent, as shown in Table 5.

Table 5
Discharge Statuses - Fee-for-Service, SFY 10/11

Discharge Status	Description	Stays	Days	Charges	Estimated Cost	Baseline Payment	Reimbursement Amount	APR-DRG Casemix (National Relative Weights)	APR-DRG Casemix (Re-centered Relative Weights)
01	Discharged home	376,925	1,538,196	\$ 9,316,796,473	\$ 2,264,253,593	\$ 2,216,232,506	\$ 2,187,456,400	0.64	0.85
02	Discharged to another short term general hospital	3,674	24,158	\$ 206,827,361	\$ 49,557,199	\$ 37,095,541	\$ 36,556,506	1.48	1.94
03	Discharged to SNF	6,626	73,514	\$ 648,300,939	\$ 150,870,028	\$ 118,933,130	\$ 117,960,838	2.00	2.63
04	Discharged to an Intermediate Care Facility (ICF)	1,595	10,673	\$ 68,822,017	\$ 15,764,531	\$ 15,875,837	\$ 15,753,695	1.01	1.33
05	Discharged to a cancer center or children's hospital	667	6,509	\$ 45,218,958	\$ 12,758,308	\$ 12,380,642	\$ 12,329,746	1.57	2.06
06	Discharged to care of a home health organization	10,496	103,528	\$ 935,232,832	\$ 228,847,402	\$ 176,734,569	\$ 175,149,180	1.86	2.44
07	Left against medical advice	6,118	18,278	\$ 170,561,497	\$ 37,260,070	\$ 28,634,369	\$ 28,423,466	0.75	0.99
09	Admitted as an inpatient to this hospital	8	44	\$ 289,876	\$ 66,189	\$ 49,116	\$ 46,333	0.89	1.17
10	Invalid	3	6	\$ 21,193	\$ 4,960	\$ 7,442	\$ 3,613	0.42	0.55
20	Expired	3,233	40,602	\$ 595,022,886	\$ 145,448,087	\$ 70,478,547	\$ 69,840,260	4.25	5.58
21	Discharged to law enforcement / prison	193	1,067	\$ 6,988,953	\$ 1,574,126	\$ 1,615,286	\$ 1,609,603	0.94	1.24
40	Expired at home	11	24	\$ 161,664	\$ 34,131	\$ 35,319	\$ 15,321	0.47	0.62
41	Expired in a medical facility	5	21	\$ 250,443	\$ 56,321	\$ 29,878	\$ 29,878	2.12	2.78
43	Discharged to a federal health care facility	27	370	\$ 3,113,873	\$ 727,331	\$ 565,755	\$ 565,752	2.28	2.99
50	Discharged to hospice - home	1,442	12,304	\$ 99,759,029	\$ 24,389,771	\$ 20,888,322	\$ 20,779,117	1.61	2.11
51	Discharged to hospice - medical facility	1,827	19,258	\$ 195,860,527	\$ 43,595,518	\$ 30,640,782	\$ 30,498,619	2.32	3.04
61	Discharged to SNF within same institution	13	111	\$ 923,907	\$ 264,443	\$ 246,047	\$ 246,044	1.90	2.49
62	Discharged to inpatient rehab facility / unit of hospital	1,896	24,573	\$ 283,788,634	\$ 74,637,441	\$ 45,796,404	\$ 45,350,684	3.17	4.17
63	Discharged to long term care hospital	208	3,361	\$ 35,887,047	\$ 7,700,044	\$ 5,024,499	\$ 4,944,284	3.75	4.93
64	Discharged to a Medicaid nursing facility	182	2,005	\$ 20,302,583	\$ 3,673,953	\$ 2,485,473	\$ 2,485,473	1.89	2.49
65	Discharged to a psych hospital or distinct part unit	2,460	10,712	\$ 72,303,694	\$ 16,163,837	\$ 15,950,878	\$ 15,844,969	0.72	0.94
66	Discharged to a critical access hospital	17	275	\$ 2,357,600	\$ 619,070	\$ 396,968	\$ 396,968	2.76	3.63
70	Discharged to another type of health care institution	380	3,002	\$ 21,174,133	\$ 5,124,272	\$ 5,134,039	\$ 5,114,377	1.23	1.62
71	Invalid	1	6	\$ 84,212	\$ 15,233	\$ 4,317	\$ 4,317	1.42	1.86
Total		418,007	1,892,597	\$ 12,730,050,330	\$ 3,083,405,860	\$ 2,805,235,667	\$ 2,771,405,441	0.76	1.00

7.3.2.2 Post-Acute Care Transfers

Paying rehabilitation stays via a per diem while paying other acute care stays via a DRG method creates an opportunity for hospitals (particularly those who own a rehab center) to maximize reimbursement by shifting patients as quickly as possible from an acute care setting to a rehab setting. Medicare limits this opportunity through its post-acute transfer adjustment policy. This policy reduces payment for stays with specific DRGs that have a discharge status indicating the patient has moved to a post-acute setting and has a length of stay less than the DRG's average length of stay. We do not recommend adopting a post-acute care transfer policy for Florida Medicaid.

We recommend against this policy because it adversely affects one of the basic concepts of a DRG payment method – that being the idea that DRGs pay based on average service resource needs, while individual cases may be higher or lower than average in terms of hospital resources used. A post-acute care transfer policy may take away from the basic integrity of a DRG payment method. In addition, the policy would add some complexity to the overall payment method and would require regular updates of the list of applicable DRGs. We do, however, recommend monitoring the frequency of short stays followed by discharges to rehabilitation units within the same hospital.

7.4 Payment of IGT Funds Distributed on a Claim-by-Claim Basis

7.4.1 *Payment of IGT Funds Distributed on a Claim-by-Claim Basis - Discussion*

Funds from inter-governmental transfers (IGTs) make up a significant portion of the total reimbursements paid out through the Florida Medicaid program. In addition, unlike most other states, Florida's Medicaid program distributes much of the IGT funds through claim payments, as opposed to lump sum supplemental payments made quarterly or yearly. Two specific amounts of money, one for automatic IGT funds and another for self-funded IGT funds, are budgeted for each hospital each year. Under the current payment method these budgeted dollar amounts contribute to the per diem rates for each qualifying hospital. Because each hospital is given its own per diem amount, including hospital-specific IGT distributions within per diems is a practical option. However, under the new DRG payment method, we are planning on a single state-wide hospital base rate, so consideration has to be made for how IGT funds can be distributed with DRG payments.

7.4.2 *Payment of IGT Funds Distributed on a Claim-by-Claim Basis - Recommendation*

We are recommending per-claim payments of IGT funds be made as supplemental add-on payments separate from the DRG payment. This is necessary to ensure the correct amount of IGT funds goes to each hospital qualifying for the IGT program without giving each hospital its own base rate. Also, because there is a clear distinction between automatic IGTs and self-funded IGTs, we are recommending two supplemental add-on payments per claim – one for automatic IGTs and one for self-funded IGTs.

Specifically, we recommend calculating average per discharge IGT supplemental payments (one for automatic and one for self-funded IGT funds) and casemix adjusting these averages to get the supplemental payment amounts for an individual claim. The average per-claim automatic IGT payment amount will be set to the total annual automatic IGT distribution designated for a hospital divided by the number of anticipated discharges at that hospital. A similar calculation will also be made to determine the average per-claim self-funded IGT payment. These calculations are very much like the calculations performed under the current payment method, with the only difference being the use of the number of discharges instead of the number of days as the divisor.

To determine the IGT supplemental payments for a particular claim, the per-discharge average IGT payments will be casemix adjusted. Casemix adjustment allows for higher total claim payment for cases with higher acuity and lower total claim payment for cases with lower acuity. Given the significant portion of claim payments made through IGT funds, the casemix adjustment has an advantage of reducing the number of outlier cases. In addition, it has the advantage of tying total claim payment to acuity and, thus, to hospital cost. Without casemix adjustment of IGT payments, services with low acuity are reimbursed at unusually high levels. For example, simulation 1, in which each claim for a provider received the same (the average) per claim IGT payment, showed a pay-to-cost ratio of 350 percent for newborn claims. That is, the IGT payments skewed payments so much that the average payment for a newborn claim

was three and a half times the hospital’s cost. Casemix adjusting distribution of IGT funds removed this incongruity in Medicaid payments by service line.

Casemix adjustment of IGT payments is performed using values unique to each provider. The amount of IGT funds, both automatic and self-funded, designated for hospital inpatient payments is different for each provider. In addition, the overall average casemix is different for each provider. To ensure the correct amount of IGT funds reach an individual hospital over the course of a year, casemix adjustment is performed using that hospital’s average IGT payment per discharge and that hospital’s casemix (average DRG relative weight). Two examples of the casemix adjustment are shown in Figure 5. In this figure only one supplemental payment is shown, however, on each claim there will, in fact, be two similar calculations, one for automatic IGTs and one for self-funded IGTs.

Figure 5 Example Casemix Adjustment of Per Claim IGT Fund Distribution	
<p>A hypothetical example provider has the following characteristics:</p> <ul style="list-style-type: none"> • \$5 million in IGT funds designated to be paid out over the course of a fiscal year • Overall casemix (average DRG relative weight) in the previous year equal to 0.6 • 2,500 Medicaid discharges in the previous year • Average per-discharge IGT payment = $\\$5M / 2,500 = \\$2,000$ 	
<p>For a claim with casemix equal to 0.75,</p> <p>Per-claim IGT Pymt = $\\$2,000 * (0.75 / 0.6)$ = \$2,500</p>	<p>For a claim with casemix equal to 0.3,</p> <p>Per-claim IGT Pymt = $\\$2,000 * (0.3 / 0.6)$ = \$1,000</p>

Lastly, we recommend adding the supplemental payments from IGT funds to the DRG base payment before calculation of outliers. This allows a better representation of the potential loss on individual outlier claims, as supplemental IGT payments often make up a substantial portion of total claim payment. The result of this approach also provides for a significant reduction in overall percentage of outlier payments, as discussed in more detail in section 7.5.2.

7.5 Outlier Payments

7.5.1 Outlier Payments - Discussion

DRG payment methods typically include outlier provisions to adjust payment for stays that are unpredictably expensive and sometimes for stays that are unpredictably inexpensive. The DRG grouper is designed to predict hospital resource use so that the relative weight and therefore the DRG base payment may be set accordingly. However, the DRG grouper is limited to using only

the information on medical insurance claims including principal diagnosis, procedures, age, complications and comorbidities (identified through secondary diagnosis codes), and discharge status. Given the tremendously wide range of cases seen in an inpatient setting, DRG grouping does not always accurately predict hospital resource use. In those cases, where the prediction differs significantly from reality, outlier payments are used to generate a more reasonable reimbursement.

Most outlier cases are stays where the costs to the hospital far outweigh the payment, but the opposite also occurs – where payment far exceeds hospital cost (this occurs most often with patients who expire). Payers typically provide outlier payment increases to mitigate extreme losses to hospitals, thus promoting access to inpatient care for seriously ill patients. Making outlier payment reductions for cases of extreme hospital gain is less common, but is worthy of consideration. Having a policy to reduce payments in cases of high hospital profit is prudent particularly if a charge cap is not in place. In addition, it has the benefit of shifting money, albeit a relatively small amount of money, from highly profitable stays into other stays.

Medicare and many Medicaid agencies utilize a cost-based stop-loss model that applies outlier payments if the estimated loss to a hospital exceeds a dollar amount threshold. When the threshold is exceeded, remaining costs are reimbursed at some percentage. This percentage is referred to as a “marginal cost factor” because it is intended to cover only the marginal costs of the additional care. These costs include only variable costs such as staffing and supplies, not fixed costs such as buildings and equipment. Medicare’s marginal cost factor is 80 percent (90 percent for burns) and states’ values range from 50 percent to 80 percent.⁸

A variety of strategies are used to set the estimated loss threshold. Medicare uses a single threshold. California Medicaid has selected two thresholds, with one marginal cost percentage (60 percent) used for losses between threshold 1 and threshold 2 and a second marginal cost percentage (80 percent) applied for losses above threshold 2. Other states base the outlier threshold on the DRG relative weight, for example, Ohio and Washington, DC, while other states, for example Pennsylvania, set the outlier threshold to some percentage of the DRG base payment, such as 150 percent.

Under the cost-based stop-loss outlier payment model, a method has to be selected for determining cost-to-charge ratios (CCRs) for purposes of estimating hospital cost. A single state-wide CCR can be used, separate CCRs for each hospital can be determined – one per hospital, or separate CCRs can be determined for each standard cost center for each hospital. The lower level of granularity in CCRs offers greater accuracy in estimating costs, but has the trade-off of requiring additional effort to periodically recalculate the values.

Less commonly, outlier cases are identified by length of stay being above a threshold number of days. For days above the threshold a per diem amount can be paid to help alleviate hospital

⁸ Prepared by ACS for the California Department of Health Care Services. *Medi-Cal DRG Project Draft Policy Design Document*. January 10, 2012. Page 57.

losses. Rhode Island, for example, uses a length of stay outlier threshold for mental health stays. However some states, as well as Medicare, have discarded the day outlier option because virtually all day outliers are also cost outliers – so a day outlier policy adds complexity to the payment method without having a significant effect on overall reimbursements.

Setting outlier threshold(s) and marginal cost percentage(s) are a policy decision. Generally the values are set so that outlier payments are within a pre-determined range of total payments. For example, Medicare generally aims for an outlier payment percentage between 5 and 6 percent. Medicaid programs tend to have a slightly higher percentage of high-cost cases and generally aim for an outlier payment percentage between 5 and 10 percent. The percentage of payments made through outliers can be adjusted by increasing or decreasing the outlier threshold and/or increasing or decreasing the marginal cost percentage. As previously described in Chapter 2, a common formula used to calculate the outlier payment on a claim is:

$$[\text{Outlier pymt adjstmnt}] = \{[\text{Hospital cost}] - [\text{DRG payment}] - [\text{Outlier threshold}]\} \\ * [\text{Marginal cost \%}]$$

and outlier payments are only made if $\{[\text{Hospital cost}] - [\text{DRG payment}]\}$ is greater than the outlier threshold. Payment simulations can be made in which the outlier threshold and the marginal cost percentage are adjusted until the desired outlier payment percentage is reached. Provider base rates and policy adjustors can also be manipulated resulting in an increase or decrease of outlier payments.

From a policy perspective outlier payments are important to ensure access to care for very high cost cases. Providers need to know they will be compensated if they treat very sick individuals. However, paying too much out in the form of outliers removes provider incentives to contain costs as outlier payments are cost based – increasing when costs increase. In addition, in a budget neutral system, an increase in reimbursements paid out as outliers generates a reduction in provider base rates. These trade-offs are typically balanced in Medicaid programs by setting a target outlier payment in the range of 5 to 10 percent, and outlier threshold and marginal cost percentage are set to hit that target.

A completely different strategy for dealing with outlier cases is to shift them out of the DRG payment method and pay them with some other method, such as percentage of cost or per diem. These methods may be more amenable to hospitals, however, they remove some of the incentives to control costs provided by a DRG payment method. They also complicate the overall Medicaid inpatient payment method because individual providers are reimbursed using more than one process.

7.5.2 *Outlier Payments - Recommendation*

For significant hospital losses on individual stays, we recommend following the Medicare stop-loss outlier model. In this model, the payer must set two numeric values, the stop-loss threshold and a marginal cost percentage. We are recommending those values to be \$27,425

and 80 percent, respectively. The goal when setting these values is to get the overall Florida Medicaid percentage of payments made in the form of outlier payments to fall within a range of 5 to 10 percent.

In the calculation of hospital loss, we recommend including per-claim supplemental payments which we anticipate will be the payments from automatic and self-funded IGTs. Thus, the formula for estimating hospital loss will be:

$$\begin{aligned}
 \text{[Hospital loss]} &= (\text{[Billed Charges]} * \text{[Cost to Charge Ratio]}) \\
 &\quad - (\text{[DRG payment]} + \text{[Automatic IGT Supplement]}) \\
 &\quad + \text{[Self-funded IGT Supplement]}
 \end{aligned}$$

The inclusion of supplemental payments prior to the outlier calculation is recommended because a relatively high portion of hospitals’ reimbursements come from IGT funding. Without inclusion of the add-ons prior to calculating outliers, losses on individual outlier claims are overstated, and as a result, the number of outliers has been shown to be unacceptably high. For example, the overall percentage of payments from outliers was 15 percent in Simulation 1, in which supplemental IGT payments were made *after* the calculation of outliers. By moving the inclusion of supplemental IGT payments prior to the calculation of outliers in Simulation 2, the percentage of payments from outliers reduced to 10 percent.

Our proposed flow for the DRG pricing calculation, including supplemental IGT payments added in prior to calculation of outliers, is depicted in Figure 4, which was shown previously in section 7.1.

We also considered a “low-side” or provider gain outlier policy in which payments are reduced slightly in cases where a hospital is making a large profit. However, for reasons of payment simplicity, we are recommending against a provider gain outlier policy, and instead suggesting AHCA use a charge cap policy. A charge cap policy pays the lesser of Medicaid allowed amount and the submitted charges on the claim.

7.6 Non-Covered Days Adjustments

7.6.1 Non-Covered Days Adjustments - Discussion

As mentioned in an earlier section related to transfer claims, a DRG payment is designed to be a single payment for a complete hospital stay. This kind of payment will be inappropriate if the recipient did not have Medicaid fee-for-service eligibility and benefit coverage for the entire stay. If some of the days of a stay are not covered then a reduction should be applied to the full DRG payment. Having eligibility for only part of a hospital stay is relatively rare in a Medicaid program, but can happen at times either because a recipient lost or gained Medicaid eligibility during the hospital stay or shifted from fee-for-service to managed care during the stay. In addition, some recipients have benefit coverage only for emergency services. If these recipients are deemed to be in an emergency medical condition for part, but not all of an inpatient stay, then the Medicaid payment should cover only part of the hospital stay. Thus, this scenario is

very similar to a partial eligibility scenario. Recipients who are eligible only for emergency services include undocumented non-citizens and adults who have reached their 45 day annual benefit limit.

One option for reducing payment in this scenario is to perform calculations very much the same as those used with transfer claims. A per diem type of payment, referred to as the non-covered-day adjusted base payment, can be calculated and compared against the full DRG base payment. If the eligibility-adjusted base payment is less, it can be used in place of the full DRG base payment.

Another option would be to prorate the full DRG payment based on the number of covered days. For example, if a recipient is Medicaid fee-for-service eligible for 6 days out of a 10 day hospital stay, payment could be reduced to 60 percent of the full DRG payment. Similarly, if the recipient was covered only for emergency services and the recipient was deemed to be in an emergency medical condition for only 6 days of a 10 day stay, then payment could be reduced to 60 percent of the full DRG payment.

In the Florida Medicaid program recipients may have limited benefit coverage for one of two reasons:

- 1) The recipient has reached his/her 45 day benefit limit
- 2) The recipient is an undocumented non-citizen

In both cases, the recipient is eligible only for emergency services.

The 45-day limit is an existing statutory requirement that limits Medicaid benefits to adults to 45 days in an inpatient setting each state fiscal year. After an adult reaches the limit, Florida Medicaid only reimburses emergency care. Inpatient days due to an emergency admission may be eligible for payment beyond the 45-day cap if the emergency criteria in the federal Balanced Budget Act of 1997 (BBA) are met. This benefit day limit does not apply to recipients under the age of 21.

For undocumented non-citizens, CMS regulation authorizes AHCA to pay only for the emergency portion of a hospital stay. Limiting payment to only the emergency portion is handled in the current payment method through use of prior authorization of a specific number of days.

7.6.2 Non-Covered Days Adjustments - Recommendation

Independent of the reason for non-covered days, we recommend prorating the payment based on the number of covered days as compared to the total length of stay. Under this recommendation, the pricing logic will calculate a full DRG payment first, including outliers, and then adjust that payment downward because of the fact there were non-covered days on the claim. For example, if the length of a hospital stay was 10 days and 4 days were not covered

(leaving 6 days covered) then payment would be reduced to 60 percent (6 / 10) of the full DRG payment.

We expect identification of non-covered days due to partial eligibility (Medicaid fee-for-service eligibility for only part of a hospital stay) will be identified within the MMIS based on eligibility information.

In contrast, non-covered days in the 45-day benefit limit and the undocumented non-citizen scenarios will be identified through the prior authorization process, consistent with the way they are identified today. These are the only two scenarios where AHCA (or its designated contractor) will need to continue authorizing all the days of a hospital stay even though the payment method is transitioning to DRGs. The number of days authorized will be the number of days for which the recipient was receiving care for an emergency situation, and, thus, are reimbursable by Medicaid.

For recipients whose coverage is limited based on the 45-day benefit, we recommend applying the non-covered day adjustment only if the recipient reached their limit prior to admission. If the recipient reaches the 45 day benefit limit while in the hospital we recommend paying for the full hospital stay. In addition, if the recipient is admitted near the end of a state fiscal year, has reached his/her benefit limit at the time of admission, then gains a new 45 days of coverage at the start of a new fiscal year, we recommend paying for the full hospital stay. In other words, if the recipient has benefit coverage for at least one day of a hospital stay then pay it under normal DRG processing. This recommendation is made with the idea of simplicity in mind. Under current procedures, two claims and two authorizations are needed in the scenario where part of a stay is paid within the 45-day benefit limit and another part is paid as authorized emergency care outside of the 45-day benefit limit. Two claims for a single hospital stay are not acceptable under a DRG payment method. Paying in full for the stay removes the need for two hospital claims and two authorizations.

7.7 Per Claim Add-On Payments

7.7.1 Per Claim Add-On Payments - Discussion

In addition to varying provider base rates to ensure fair payment, some DRG installations include per-claim add-on payments, which can be applied for a variety of reasons. For example, Medicare offers per-claim add-on payments for direct graduate medical education costs. (Medicare also provides payment adjustments for indirect medical education costs, capital, and disproportionate share hospitals, but these adjustments are made to the common base rates.⁹) Montana Medicaid provides separate add-on payments for medical education, capital, and disproportionate share payments. Similarly, Washington DC Medicaid provides per-claim add-on payments for medical education and capital. Other supplemental payments

⁹ Medicare Learning Network (MLN), *Acute Care Hospital Inpatient Prospective Payment System – Payment System Fact Sheet*, ICN 006815, February 2012.

can also be distributed through add-on payments if distribution of the funds makes sense to be made on a per claim basis.

7.7.2 Per Claim Add-On Payments - Recommendation

After discussions with AHCA, we are recommending per-claim payment of automatic and self-funded IGT funds be incorporated as add-on payments and kept separate from provider DRG base rates. This helps distinguish payments made from each source of funding. It also takes away the need to have separate base rates for statutory teaching, children's, CHEP, rehabilitation and high charity hospitals, each of which are allotted specific percentages of the automatic IGT funds.

No other add-on payments are recommended.

7.8 Transitional Period

7.8.1 Transitional Period - Discussion

Making a change in payment method from per diem to DRGs has potential to result in significant redistribution of funds. Even if implemented with budget neutrality, we expect some hospitals will receive higher payments under the new DRG method (when compared to legacy system payments) and some hospitals will receive lower payments. Such changes in payments are common in these types of transitions.

Some payers have established transitional policies to mitigate the impacts of such payment changes in the years immediately following implementation of a new DRG model. For example, when Medicare implemented DRGs for the first time, it provided a phase-in period of four years for the operating component of the new payment rates, and a 10-year period for the transition of the capital-related component of the rate. Some Medicaid programs, New York, Nebraska and California for example, have either used or are planning to use transition periods. On the other hand, other Medicaid programs, including those in Pennsylvania, Washington and Kentucky, have not provided for phase-ins or transitional periods. Similarly, when Medicare transitioned from the legacy CMS-DRG model to its new severity-based MS-DRG model, it did not use a transition period.

There are some advantages to utilizing transitional strategies. Phase-in or transitional periods provide time for providers to internally respond to anticipated changes in Medicaid funding. A transitional period allows time for providers to take the steps necessary to improve documentation and coding practices, and potentially implement improvements to operating performance relative to efficient delivery of services. In addition, a transition period gives hospitals time to make modifications to the complement of service lines offered in future periods – to the extent that Medicaid payments affect such decisions.

On the other hand, there are disadvantages to utilizing transitional strategies. From a payer perspective, transitional periods tend to increase the program administrative complexity of both policy implementation and system implementation. It also requires payers to either maintain

two payment systems simultaneously (which would be required to blend payments between a per diem and DRG model), or alternatively, to determine hospital-specific base rates that would effectively “build in” the transition to such rates. From the providers’ perspective, hospitals that stand to see increased payments under the new payment model will not realize the full benefit of the change in payment model until after the transition period has run its course.

7.8.2 *Transitional Period - Recommendation*

We recommend that AHCA not utilize a transition period. Based on discussions with the Governance Committee, there is a desire from a program administration perspective to avoid the administrative complexity associated with a transition. Further, it is believed that delaying full implementation will simply delay the inevitable, and effectively bring any inequities currently embedded in the legacy payment model into the new model. A transitional approach would be inconsistent with the guiding principle of Equity, resulting in different payments to hospitals for similar services. It would also be inconsistent with the guiding principles of Efficiency, Transparency and Simplicity.

7.9 **Documentation and Coding Adjustment**

7.9.1 *Documentation and Coding Adjustment - Discussion*

Under a DRG payment method, overall casemix has a significant impact on overall Medicaid payments. This can be seen when looking at the DRG base payment formula:

$$[\text{DRG Base Payment}] = [\text{Hospital base rate}] * [\text{DRG relative weight}] * [\text{Policy adjustor(s)}]$$

While payments under a DRG payment method are also affected by policy adjustors, outlier payments, and transfer and non-covered days adjustments, these additional factors all have a relatively small impact on overall spending when compared with the impact resulting from changes in casemix. The significance of potential changes in casemix relative to overall Medicaid spending for inpatient hospital services punctuate the need to accurately estimate these values and to monitor them through the first few years of a DRG payment implementation. If casemix is significantly understated during the design process, resulting Medicaid spending will likely be well above estimates.

When considering the increases in casemix that will occur after implementation of the APR-DRG model, there are generally two components. One component is attributable to actual changes in the patients’ health status, where hospitals are required to expend more resources because patients they are treating are actually sicker – this component is commonly referred to as a “real” increase in acuity. And there is an expectation that casemix will increase slightly from year to year, all other things remaining equal. As an example, before Medicare’s implementation of MS-DRGs in 2008, annual casemix increases ranged from -0.8 percent to 1.0 percent, and on average reflected 0.1 percent year-to-year change.¹⁰ This slight increase may be

¹⁰ Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy* (March, 2011), p. 49.

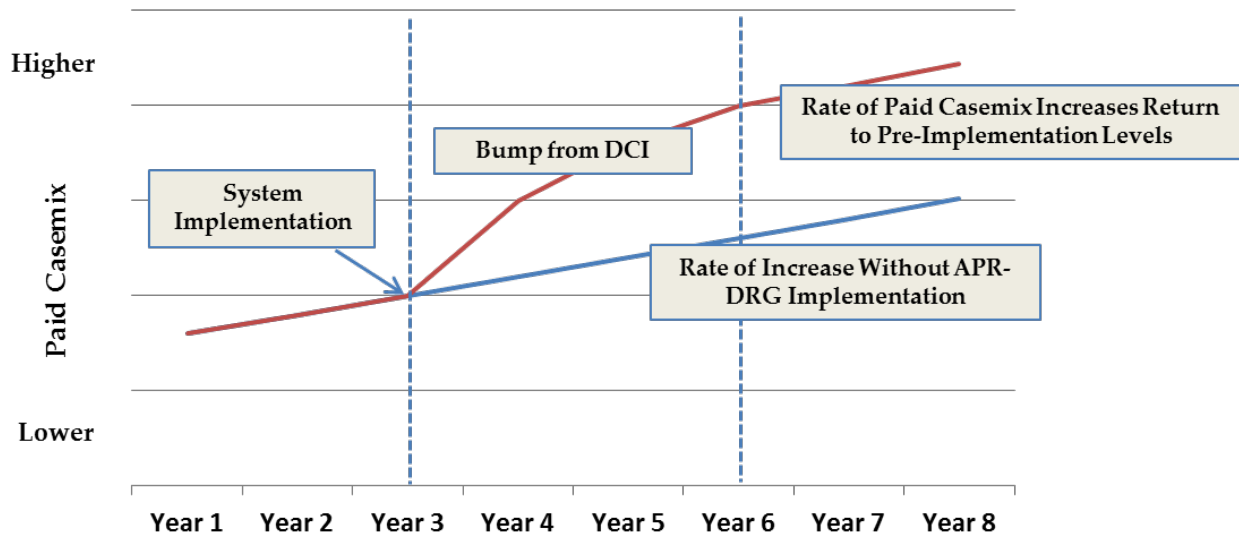
the result of a number of factors, including the trend of providing more and more services efficiently and effectively in outpatient settings, leaving only sicker patients in the inpatient hospital setting. Increases can also be attributable to advances in medical technology that allow hospitals to be more effective in caring for the sickest of patients. A DRG system is generally designed to “self-adjust” for this type of casemix increase – as patients get sicker, they are classified into DRGs with higher relative weights, and as a result, payments for services increase. Payers must set rates appropriately, considering these small increases in casemix over time.

The other component of the increase in casemix can generally be attributable to documentation and coding improvements (DCI). During AHCA’s transitions from the legacy per diem payment model to a new APR-DRG per discharge payment model, there is an expectation that DCI will result in the rate of increase in reported casemix being higher than it would have been if AHCA had decided to maintain the current legacy per diem model. This increase in casemix can be attributed to improvements in medical record documentation and improvements in claim coding as Medicaid claim payment becomes dependent on the diagnosis and procedure codes on claims. These documentation and coding improvements are an appropriate and necessary response by providers to AHCA’s implementation of the APR-DRG payment model.¹¹ However, the underlying cause of this component increase is very different. It is due to better reporting, not to actual changes in types of patients treated. Also, the increase in casemix from DCI is expected to be much more significant than “real” casemix change, when comparing the first year of DRG implementation to the simulation dataset containing claims from SFY 2010/2011. There is a risk that the casemix values reflected in the simulation data significantly understate the actual acuity of the patients served. This understatement is primarily the result of coding and documentation practices that were intended to support payment under the legacy per diem model, and not intended to support payment under an APR-DRG model. The coding practices that are necessary to generate accurate payments under the two models are significantly different, with the standard under an APR-DRG model being much higher.

The potential impact of this DCI on casemix is illustrated in the figure below, using hypothetical values. As shown in the following illustration, it is our expectation that there will be an immediate “bump” in aggregate paid casemix in the first year following implementation of the new system, with smaller increases in following years, and with paid casemix increases trending back to pre-implementation levels once providers successfully improve their coding and documentation processes.

¹¹ Expected increases in casemix resulting from DCI should not be confused with casemix increases attributable to the term “DRG creep”, which may be the result of inappropriate billing practices. Such inappropriate billing practices are intended to generate higher payment by billing for services using a DRG code that provides for a higher payment rate than the DRG code that accurately reflects the condition and treatment of the patient, oftentimes accomplished through miscoding or inappropriate re-sequencing.

Figure 6: Illustration of Potential Impacts to Paid Casemix from Coding and Documentation Improvement



Clearly, a potential financial risk to both the State and to the providers exists as a result of this situation. Understanding that the DRG payment rates that will be implemented will be based on payment simulation models that reflect a potentially understated casemix, the State will be at risk of overspending its budget in the event that actual casemix exceeds expected levels after the system’s effective date. On the other hand, the providers are at risk if the opposite is true – that the simulation models used to set DRG payment rates overstate actual casemix, although this scenario is less likely. In addition, providers are at risk if the State over compensates for anticipated changes in casemix. The challenge related to this issue is to implement a strategy that effectively mitigates the potential risk of overpayment (or underpayment) to both the State and to the providers.

Other government payers have experienced significant increases in paid casemix following system changes, as did the Medicare program when it transitioned to the Medicare Severity DRG (MS-DRG) payment model. In its March 2011 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC¹²) reported that the “implementation of Medicare’s MS-DRG model gave hospitals a financial incentive to improve medical record documentation and diagnosis coding to more fully account for each patient’s severity of illness. While documentation and coding improvements (DCI) appropriately improve measurement of patient

¹² MedPAC is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission’s statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

severity, they also can increase reported case mix under MS-DRGs even if patients' levels of illness and resource need are not different from prior years. The result was strong growth in payments per case in 2008 and 2009. Analysis by CMS found (and [MedPAC's] analysis concurred) that payments increased by a total of 5.8 percent over the two years due to coding improvements."¹³ MedPAC's report characterized this increase as extraordinary since it "followed a decade in which the case-mix index declined in 5 of the 10 years and never grew by more than 1 percent in any year."¹⁴

At the state payer level, Pennsylvania Medicaid's experience provides another recent example of the potential impact on paid casemix resulting from a transition to APR-DRGs. The Pennsylvania Medicaid program implemented an APR-DRG payment system effective for acute care inpatient hospital discharges on July 1, 2010. The State Plan for the APR-DRG payment system specified that the anticipated statewide average case mix would be between 1.02 and 1.04 during the first fiscal year of the new system. This case mix range was determined by developing relative weights which yielded a modeled casemix of 1.00 for claims from FYE 2008 and the assumption that real case mix would increase at one percentage point per year. A plus or minus one percentage point band was also established around the expected 1.03 case mix value for FYE 2011 yielding the 1.02 to 1.04 range.

The actual casemix for the first six months of claims from FYE 2011 was 1.067. The actual casemix for the full twelve months of FYE 2011 claims was 1.121. Since the actual case mix of 1.121 exceeded the maximum agreed-upon case mix of 1.04 a reduction to the APR-DRG relative weights was put into effect for claims related to discharges on or after July 1, 2011. The relative weights were adjusted by a factor of 0.9277 (equal to 1.04/1.121). The impact of the revised relative weights was implemented by a mass-adjustment in the summer of 2012 to all claims that had been filed for discharges on or after July 1, 2011.

It is important to note that the adjusted relative weights were applied to discharges beginning July 1, 2011. The payments for the first full year of the APR-DRG system (July 1, 2010 to June 30, 2011) were not adjusted even though the casemix for that year was outside the expected range. The change was applied on a go-forward basis to bring the casemix back to the agreed-upon range. It should also be noted that other states have incorporated policies to mitigate the risk of payment increases attributable to DCI, including New York, Maryland, and Virginia, however, Pennsylvania stands out as a state where increases were significant.

There are several options available to AHCA as strategies to mitigate potential over or underpayment of services as a result of DCI. These options are:

- Option 1: Prospectively reduce either base rates or relative weights to reduce future payments to offset anticipated increases in payments resulting from DCI. This is

¹³ MedPAC Report to Congress (March 2011), pages 39-40, *emphasis added*

¹⁴ MedPAC Report to Congress (March 2011), page 49

generally the approach that was taken by CMS when it implemented the MS-DRG payment system for Medicare services. The key challenge with this option is accurately estimating in advance what the increases related to DCI will be in future periods.

- Option 2: Retroactively adjust either base rates or relative weights to offset actual increases in payments resulting from DCI. To implement this option, it would be necessary to first estimate what expected, or “real” casemix increases should be, based on historical trends. To the extent that actual casemix increases exceed the established casemix increase trend line, adjustments can be made. Adjustments could be made in the form of retroactive adjustments of historical claims (e.g., through mass adjustments to claims) or through reductions to future payments.
- Option 3: Establish a hybrid strategy that establishes a prospective adjustment with a corridor (for example, the expected casemix in future periods based on historical trends, plus or minus a fixed percentage). Using this corridor, monitor actual paid casemix on a regular basis, and if it remains within the established corridor, make no adjustment going forward. If it falls outside of the established corridor, make an adjustment, either prospectively or retrospectively, to bring payments to where they would have been had the actual paid casemix not exceeded the upper bound of the corridor (or the lower bound of the corridor in the instance of a measured casemix reduction).

There are a number of variations that can be applied to each of these options.

7.9.2 Documentation and Coding Adjustment – Recommendation

Based on significant discussion with (and consideration by) the Governance Committee, we recommend that AHCA implement a prospective approach to mitigating the risks associated with DCI. Under this approach, we recommend that AHCA reduce the relative weights implemented under the new APR-DRG system by 6 percent for DCI, to allow for increases in paid casemix up to that amount to occur in the first year of implementation without increasing financial risk to the State.

It is our understanding that AHCA may not have the legislative authority to adjust payments in subsequent periods, either prospectively or retrospectively, to mitigate potential underpayments or overpayments in the event that actual casemix values differ significantly from expectation in the first year of implementation. Also understanding that the experiences of other payers have varied significantly (for example, Medicare’s experience of 5.6 percent in the first two years of MS-DRGs, and Pennsylvania Medicaid’s increase exceeding 12 percent in the first year), we believe it is prudent to make a fairly conservative recommendation in this case. As such, we believe a 6 percent reduction provides for sufficient cushion to mitigate the described risk to the State.

The 6 percent reduction for anticipated casemix increase from improved documentation and coding will be coupled with a 1.5% increase for real casemix change between our simulation dataset, from SFY 2010/2011, and the first year of DRG implementation, SFY 2013/2014. The

1.5% increase for real casemix comes from an estimate of 0.5% real casemix increase per year. So the total adjustment for anticipated change in casemix between the SFY 2010/2011 simulation dataset and the first year of DRG implementation is recommended to be 7.5%.

We also recommend that AHCA explore options for future periods relative to making adjustments to the relative weights in subsequent periods, including:

- Making additional adjustments (higher or lower) to relative weights in future periods in the event that the actual casemix increases after implementation are significantly different from the 6 percent adjustment made prospectively in year one, and
- Recalibrating relative weights each year in the early periods following implementation of the system to maintain weights that are “re-centered” to a system wide casemix of 1.0, or possibly to reflect slight increases in actual increases in acuity (i.e., “real” casemix increases, not related to DCI).

7.10 Interim Claims and Late Charges

7.10.1 *Interim Claims and Late Charges – Discussion*

DRG payments are designed to be single payments for complete hospital stays. Thus, a final DRG payment cannot be made until the patient is discharged. For most hospital stays, that is perfectly acceptable to both the provider and the Medicaid agency. However, for very long stays, waiting until discharge for payment from Medicaid can cause cash flow challenges for hospitals. This can be solved by allowing interim billing and payment. Unfortunately, generating final payment for a hospital stay after interim payments have been made is an extremely challenging task to implement in an MMIS. As a result, decisions related to interim claim payments are an important part of a DRG payment policy despite the fact that they affect a relatively small percentage of overall stays.

One option is to disallow all interim claims and put the onus on hospitals to manage their cash flow. If instead, AHCA decides to allow interim payments, then a series of design decisions must be made. First, the threshold minimum number of days per interim claim must be decided – most states have selected 30 days when interim claims are accepted. Next the method of payment for interim claims must be determined. Per diem payment is the most common option, and if per diem is used then a per diem amount needs to be selected. The amount should be set low enough so that interim claim payment is rarely, if ever greater than the full DRG payment. If the interim payment(s) are greater than the full DRG payment, then hospitals will have no incentive to submit a final bill when the patient is discharged. Finally the payment policy must include a method for making final payment. When the final claim is submitted, many states have chosen to void all interim claims, thus taking back the money paid out on the interim claims, followed by full DRG payment for the final claim. With this solution, decisions must be made either to give hospitals the responsibility to submit voids for all the interim claims, systematically void all the interim claims, or suspend the final claim and require manual void of all interim claims. Once all the interim claims are voided, the final claim can be paid. Another option is to adjust reimbursement on the final claim down by the amount already paid

out on interim claims. However, there is risk that the interim payment(s) turn out to be more than the final DRG payment, which would be extremely problematic under this option because the payment amount on the final claim would be negative.

Late charges (claims with bill type 115) are also problematic in a DRG payment method. To accurately calculate DRG payment, including outlier payments, all charges for the hospital stay need to be submitted on a single claim. For this reason, late charges are typically not accepted by Medicaid agencies paying via DRGs.

7.10.2 Interim Claims and Late Charges – Recommendation

After discussions with AHCA, we are recommending no interim claims for inpatient care receive payment. The number of very long hospital stays is relatively low (about 300 annually with length of stay greater than four months across the entire Medicaid program). And these very long stays are spread across about 30 hospitals. In addition, processing of interim claims requires either very significant software changes to the Florida Medicaid Management Information System or creation of a labor-intensive manual process for monitoring these claims. As a result, we are recommending interim claims be disallowed and payments made only when patients are discharged.

In addition, we also recommend against accepting claims for late charges. The decision on late charges is independent of the decision on interim claims, and we believe late charges should be disallowed even if the final policy design includes acceptance of some interim claims.

7.11 Charge Cap

7.11.1 Charge Cap – Discussion

Medicaid programs, like most payers traditionally have a charge cap in place which ensures payment on individual claims equals the lesser of the Medicaid allowable payment and the provider's submitted charges. AHCA will need to decide if a charge cap should be put in place for claims priced via the new DRG method. Because DRGs are a prospective payment based off of averages of hospital resource usage (recorded in the form of DRG relative weights), the actual payment for an individual stay may be above or below hospital costs and could possibly even be above hospital charges. The general strategy with DRG payments is that payments will over time average out to hit Medicaid's desired pay-to-cost ratio even though payments on individual claims may be above or below this ratio. Applying a charge cap can get in the way of this basic strategy, so it is worthwhile to consider excluding the charge cap logic from claims paid via DRGs. In addition, instituting a charge cap on DRG claims has potential to negatively impact providers who are doing a good job of aligning charges with costs. Charge caps have the effect of rewarding hospitals who inflate charges well above costs, which is not necessarily a behavior worthy of reward.

However, charge caps are straight forward, easy to implement, and have the advantage of being familiar to payers and providers.

If AHCA decides to exclude charge caps on DRG priced claims, then we more strongly recommend instituting a hospital gain outlier policy. If on the other hand, AHCA decides to apply a charge cap to DRG priced claims, then the need for a hospital gain outlier policy is diminished. One way or the other, we recommend AHCA have a policy that avoids gross overpayments of individual stays.

7.11.2 Charge Cap – Recommendation

For simplicity of the payment method, we are recommending a charge cap policy be put in place instead of using a provider gain outlier policy. As discussed above, the charge cap policy pays the lesser of the Medicaid allowed amount and the submitted charges on the claim. A charge cap policy is less complicated than a provider gain outlier policy and is familiar to all stakeholders because it is commonly used in payment of outpatient and professional claims.

In practice, Medicaid allowed amount is rarely less than the submitted charges, but this scenario does occur on occasion. In the simulation dataset, it occurred on 11,623 stays and shifted \$33 million from these claims into the pool of money used to determine the hospital base rate.

7.12 Medicare Crossover Comparison Pricing

7.12.1 Medicare Crossover Comparison Pricing – Discussion

Many Medicaid programs have implemented Medicare crossover comparison pricing logic. This logic is applied specifically to Medicare crossover claims and compares the Medicare allowed amount to the Medicaid allowed amount. It then sets Medicaid reimbursement amount so that the total provider reimbursement, combining Medicare and Medicaid payments, reaches the lower of the two allowed amounts. If AHCA uses this kind of pricing logic, then Medicare crossover claims will need to be processed through the new DRG pricing method so that a DRG-based Medicaid allowed amount can be determined.

7.12.2 Medicare Crossover Comparison Pricing – Recommendation

We recommend including Medicare/Medicaid comparison logic, ensuring total payment is the lesser of the Medicare allowed amount and the Medicaid allowed amount. For this to occur, DRG pricing should be performed on Part A crossover claims to determine the Medicaid allowed amount.

7.13 45-Day Benefit Limit

Please see section 7.6 “Non-Covered Days Adjustments” for discussion of this topic.

7.14 Reimbursement for Undocumented Non-Citizens

Please see section 7.6 “Non-Covered Days Adjustments” for discussion of this topic.

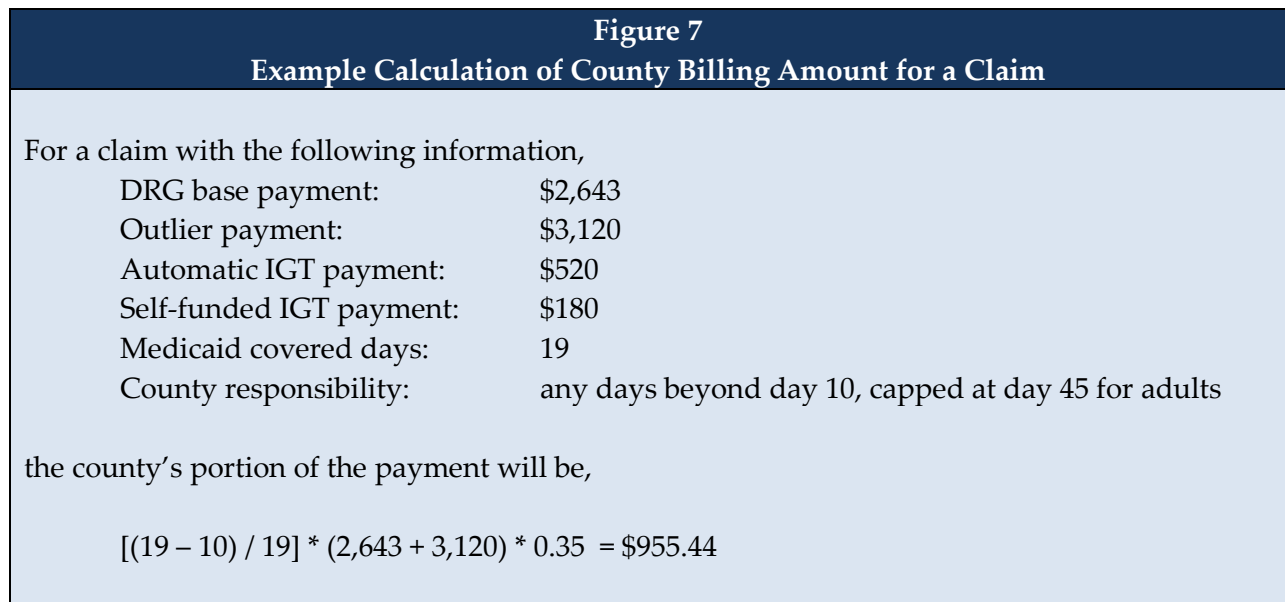
7.15 County Billing Rate

7.15.1 County Billing Rate - Discussion

Under s. 409.915, F.S., the Agency currently relies on contributions from the counties for a portion of the funding for hospital inpatient stays in excess of 10 days. The amount paid by the counties is 35% of the State’s share of cost of inpatient hospitalization in excess of 10 days. Under the new DRG per discharge payment model, a new method will need to be identified for determining the counties’ obligation under this program.

7.15.2 County Billing Rate - Recommendation

We recommend the portion of payment defined as the responsibility of the county be calculated on a claim-by-claim basis. The county’s portion can be calculated by dividing the number of days for which the county is responsible (any days after day 10, capped at day 45 for adults) by the total covered days on the claim and multiplying that percentage times the claim DRG payment (payment including outliers and excluding supplemental add-on payments from IGT funds), and multiplying this result by 35%. The IGT portion of total claim payment is excluded because counties are not responsible for funding those payments (or in some cases already provided the funds for those payments). The county billing rate only relates to the county’s portion of claim payment from general revenue and PMATF funds. An example of our recommended calculation of a county’s responsibility for an individual claim is shown in the following figure.



8 Specifics for Florida Medicaid

8.1 Budget Neutrality

The implementation of DRG pricing is intended to be budget neutral across the entire Medicaid program. That is, the total Medicaid expenditures in the first year of DRG payment are intended to equal the total expenditures from the previous year, except for standard adjustments made for inflation and fee for service eligibility changes. Reaching budget neutrality at the program level will not ensure neutrality for individual hospitals. Some hospitals will see overall Medicaid revenue increase with DRG payments while others will see revenues decrease.

DRG payment simulations have been performed using historical Florida Medicaid fee-for-service inpatient claims from state fiscal year 2010/2011. Base rates, policy adjustors, outlier parameters and so forth have been determined to reach the same total Medicaid reimbursement via DRGs as was actually paid on these claims using the current payment method. This will allow predictions of how the DRG payments will reimburse individual hospitals, categories of hospitals, and categories of care in the future. Final base rates, adjustors, etc., to be used in production when DRG pricing first goes live will be recalculated based on actual budget numbers planned for state fiscal year 2013/ 2014 (the first year DRG pricing is expected to be live).

Because of the need to maintain budget neutrality, any policy adjustors selected for the new payment method will help out specific hospitals or types of services at the expense of all hospitals and services untouched by the adjustors. For this reason, policy adjustors will be used only where AHCA and Navigant feel they are needed to meet the guiding principles of an effective Medicaid payment method.

8.2 Interaction of DRG Payment and IGT Funding

It is our understanding that the only way in which the DRG payment method may affect IGT funding is related to the limits on amounts providers and local governments can contribute. CMS will only provide federal matching funds up to certain limits. The limits are related to total reimbursements to hospitals. If individual hospitals receive more money through DRG payments than through historical per diem payments, then the amount they can receive from IGT funds (which will be eligible for federal matching dollars) will go down, thus their contributions to IGTs will go down. Of course, the opposite is also true. Individual hospitals that receive less money through DRG payments than historical payments will be able to receive more from IGT funds and will have the option to contribute more in the form of IGTs.

CMS limits on federal matching funds are referred to as upper payment limits (UPL) and are only measured for broad categories of hospitals. For the UPL, three categories are defined: state owned, non-state government owned, and private. The following table shows how payment levels for these three categories are anticipated to change with DRG pricing.

UPL Designation	Stays	Covered Days	Charges	Estimated Cost	Baseline Payment	DRG Simulation Payment
Non-State Govt Owned	90,582	431,590	\$ 2,534,799,112	\$ 754,265,607	\$ 757,194,831	\$ 706,399,252
Private	327,413	1,459,296	\$ 10,193,937,442	\$ 2,327,826,477	\$ 2,046,669,618	\$ 2,083,311,934
State Owned	12	1,711	\$ 1,313,775	\$ 1,313,775	\$ 1,371,218	\$ 957,675

8.3 Per Claim Distribution of IGT Funds

The current plan is to determine DRG base rates using only funds from general revenue and the PMATF. Payments from funds originating from IGTs that are paid out on individual claims will be included as add-on payments, separate from the DRG base payment. We recommend, however, that the add-on payments be included before calculation of DRG outlier payments, otherwise an unusually high percentage of claims will reach outlier status. The steps involved in the DRG pricing calculation including addition of IGT payments prior to outlier calculations are shown in section 7.1.

8.4 Recipient Out of Pocket Expenses

Policies related to recipient out of pocket expenses will be unaffected by the transition to DRG pricing for inpatient fee-for-service stays.

8.5 Effect of Transition to Managed Care

The new DRG pricing method has been designed under the assumption that Florida Medicaid will have similar levels of fee-for-service in SFY 2013/2014 as they had in SFY 2010/2011. Simulations of the new DRG pricing method have been performed using only fee-for-service claims from SFY 2010/2011. Thus, the planned move of Florida Medicaid recipients to managed care has had relatively little effect on the DRG payment method design. However, this may change in subsequent years. As the percentage of Florida Medicaid recipients in managed care increases, AHCA will need to consider including encounter claims (from managed care plans) in the calculation of rates and outlier parameters used in DRG pricing. This will be particularly true if the fee-for-service payment method is used to help determine capitation rates for the managed care plans.

Also, managed care plans may choose to adopt Medicaid’s fee-for-service DRG payment process. In general, we believe DRG payment is the best method currently available for reimbursing most inpatient acute care stays. In addition, there is in some cases a policy or expectation that managed care plans pay hospitals at a level similar to what Medicaid fee-for-service would pay. As such, we would expect that managed care plans would consider DRG reimbursement. Navigant has and will continue to work with AHCA to document the new DRG payment method as clearly as possible so that managed care plans can understand and adopt the method if they choose.

Appendices

Appendix A – Summary DRG Payment Method Options

The following table summarizes the payment method options described in this document.

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
3.1. Affected Providers		
Stand-alone facilities <ul style="list-style-type: none"> • General acute care • Physical rehabilitation • Long term acute care • Mental health and substance abuse facilities • Critical access / rural hospitals • Children’s hospitals • Cancer hospitals • Federally Qualified Health Centers • Rural Health Clinics • In-state / out-of-state / border hospitals • Native American Indian hospitals • Public hospitals 	Include or exclude in DRG payment	Include in the DRG payment method all facilities except the four state-owned psychiatric facilities. Thus, the only inpatient facilities excluded from DRG payment will be: <ul style="list-style-type: none"> • Florida State Hospital • Northeast Florida State Hospital • South Florida State Hospital • West Florida Community Care
Distinct part units <ul style="list-style-type: none"> • Physical rehabilitation • Long term acute care • Mental health and substance abuse 	Include or exclude in DRG payment	Include all inpatient distinct part units in the DRG payment method.
3.2. Affected Services		
<ul style="list-style-type: none"> • Physical rehabilitation • Mental health and substance abuse 	Include or exclude in DRG payment	Include in the DRG payment method all inpatient services. No services will be excluded

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
<ul style="list-style-type: none"> Unpredictable and expensive services and supplies such as blood factors and organ search and acquisition New technologies 		and no services will be separately payable except for newborn hearing screening. Newborn hearing screening will be paid above and beyond the DRG payment.
3.3. Affected Beneficiaries / Medicaid Programs		
<ul style="list-style-type: none"> Fee-for-service Primary care case management Managed care CHIP Waiver programs Dual eligible (Medicare and Medicaid) 	Include or exclude in DRG payment	<p>Inpatient care for all recipients in the fee-for-service program will be reimbursed through the new DRG payment method.</p> <p>Undocumented non-citizens and recipients who have exhausted their 45-day benefit limit prior to admission will continue to require prior authorization for both admission and length of stay because they are eligible only for emergency services. The authorized length of stay will be used to identify the emergency portion of a hospital stay, and a pricing calculation like that used for partial eligibility will be used to prorate payment based on the number of covered days.</p>
3.4. Prior authorizations		
<ul style="list-style-type: none"> Authorize length of stay Change concurrent review Change focus of post-payment review 	<ul style="list-style-type: none"> Yes/no/sometimes Currently based on length of stay 	<ul style="list-style-type: none"> For most inpatient stays, only authorization of the admission will be needed. For undocumented non-citizens and recipients who have exhausted their 45-day benefit limit prior to admission, authorization of both admission and length of stay will continue to be needed. Both of these types of recipients are eligible only for emergency services and the length of stay portion of the prior authorization will be used to determine the emergency portion of

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
		the hospital stay.
4. Cost Estimation		
<ul style="list-style-type: none"> Aggregate CCR methodology Detailed line-level methodology 	Select costing methodology. Note that both options provide reasonable estimates.	Use one CCR per hospital calculated using Medicaid charges and cost determined by AHCA using hospitals' cost reports. Whenever available, use the hospital cost reports that apply for the dates of service of the claims in the DRG simulation dataset – 7/1/2010 through 6/30/2011.
5. DRG Grouping		
DRG Grouper <ul style="list-style-type: none"> APR (all patient refined) MS (medical severity) APS (all-payer severity-adjusted) 	Select a grouping algorithm	APR
Source of DRG relative weights and average length of stay	Options are, <ul style="list-style-type: none"> National all-payer values State Medicaid-specific values Values borrowed from another state 	National all-payer values, re-centered to 1.0 using overall Florida Medicaid casemix.
6.1. Provider Base Rates Categories		
Number of common (a.k.a. standard) base rates	Generally one or very few common base rates are used. If more than one is used, the different values are typically used for different categories of providers.	One standardized base rate.
6.2. Provider Base Rate Wage Area Adjustments		
Geographic base rate adjustments	Apply or forego geographic base rate adjustments	Do not adjust the standardized base rate with wage indices.
If geographic base rate adjustments are applied, define geographic regions	Options are, <ul style="list-style-type: none"> Medicare wage areas State counties Any other state designator of geographic regions 	N/A

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
If geographic base rate adjustments are applied, define the adjustment factor per region	Wage indices are available with Medicare wage areas. If some other method is used to define geographic regions, then adjustment factors must be assigned to each region.	N/A
If geographic base rate adjustments are applied, define the percentage of the base rate to which the adjustor applies	The adjustment factors can be applied to all or some portion of the common base rate. For example, Medicare wage indices are only applied to the labor portion of hospital costs, which is defined as 62% for wage areas less than 1.0 and 68.8% for wage areas greater than 1.0.	N/A
6.3. Funding for Provider Base Rates		
Should all or part of the following types of funding contribute to provider base rates: <ul style="list-style-type: none"> - General revenue - Provider assessment - Automatic IGTs - Self-funded IGTs 	Funds contributing to base rates are spread across all hospitals when a single base rate is used. If targeting funds to a category of hospitals and including those funds in a base rate, then the targeted category of hospitals must be given their own base rate.	Funds from general revenue and the provider assessment will be used to determine the single standardized hospital base rate. Funds from automatic and self-funded IGTs will be disbursed as two separate add-on payments on each claim, where a “claim” is synonymous with a hospital discharge. Both IGT supplemental payments will be added in to the DRG base payment prior to calculating the outlier amount (if any).
6.4. Per Diem Base Rates		
How will per diems be calculated for any services or hospitals excluded from DRG payment.	The existing processes used to calculate per diems, may be acceptable, or AHCA may want to consider other methods.	Use the existing per diem calculation method for the few hospitals carved out of the DRG payment method – the state-owned psychiatric facilities.
7.2. Policy Adjustors		
Service adjustors - should service adjustors be included in the DRG payment method? If yes, what services should get an adjustment and what	If included, payment for services for which Medicaid is a major payer, such as obstetrics and neonatal care, are typically assigned an adjustor.	Service adjustor rehabilitation. No other service adjustors.

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
should the adjustment factor(s) be?		
Age/service adjustors - should age/service adjustors be included in the DRG payment method? If yes, what age ranges and for what services should an adjustment be applied, and what should the adjustment factor(s) be?	Can be used to adjust payment for services to any age grouping, but is typically used by Medicaid payers to adjust payment for pediatric care.	No age/service adjustors
Provider/service adjustors - should provider/service adjustors be included in the DRG payment method? If yes, what providers (or provider categories) and for what services should an adjustment be applied, and what should the adjustment factor(s) be?	This adjustor is the least commonly used of the three, but can be used to adjust payments for specific services if provided at specific types of services – for example neonatal care at a hospital with a level III neonatal intensive care unit.	None
Provider adjustors	These are policy adjustors applied to all hospital stays for a category of providers.	Include provider adjustors for the following categories of providers: <ul style="list-style-type: none"> • Rural hospitals • Long term acute care hospitals • Hospitals with both high Medicaid utilization and high outlier payment percentage
Application of policy adjustors	If multiple policy adjustors are implemented, the adjustors can either be cumulative (multiple adjustors applied to the same claim, when appropriate), or hierarchical in which case only one adjustor (possibly the largest one) gets applied to a claim.	Select the maximum service adjustor applicable for the claim and use on that adjustor in the pricing calculation.
7.3. Transfer Payment Adjustments		
What patient discharge statuses should be used for acute-to-acute hospital transfers	Options are: 02 – discharged/transferred to a short-term general hospital for inpatient care 05 – discharged/transferred to a designated	02, 05, 65, 66

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
	<p>cancer center or children’s hospital</p> <p>07 – left against medical advice (Medicare uses this value if the patient is admitted to another acute care hospital on the same day)</p> <p>43 – discharged/transferred to a federal facility</p> <p>62 – discharged/transferred to an inpatient rehabilitation facility or distinct part unit</p> <p>63 – discharged/transferred to a long term care hospital</p> <p>65 – discharged/transferred to a psychiatric hospital or distinct part unit</p> <p>66 – discharged/transferred to a critical access hospital</p>	
Should there be an acute-to-post-acute care transfer payment adjustment? If yes, for which patient discharge statuses should the adjustment apply?	<p>If a post-acute care transfer policy is implemented, options for applicable patient discharge statuses are:</p> <p>03 – skilled nursing facility</p> <p>05 – cancer/children</p> <p>06 – home health</p> <p>43 – federal facility</p> <p>62 – rehabilitation</p> <p>63 – long-term care hospital</p> <p>65 – psychiatric</p>	No post-acute transfer policy. But if one is implemented, use statuses 03, 06, 43, 62, and 63
What should the transfer claim payment adjustment formula be?	<p>Medicare and several states use the following formula:</p> $\text{Transfer-adjusted base payment} = \{[\text{DRG base payment}] / [\text{DRG average length of stay}]\} * \{[\text{length of stay}] + 1\}$	Medicare formula
7.4. Payment of IGT Funds Distributed on a Claim-by-Claim Basis		

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
Should IGT funds be included in the DRG base rate or paid separately as supplemental, add-on payments. If paid separately, how many different add-on payments should there be.	<p>Funds contributing to base rates are spread across all hospitals when a single base rate is used. If targeting funds to a category of hospitals and including those funds in a base rate, then the targeted category of hospitals must be given their own base rate.</p> <p>Automatic IGTs are targeted for categories of hospitals. Self-funded IGTs are targeted to specific hospitals.</p>	<ul style="list-style-type: none"> - Keep IGT funds separate from the DRG base rate and distribute them as supplemental, per-claim add-on payments. - Include two add-on payments per claim, one for automatic IGT funds, and another for self-funded IGT funds. - Casemix adjust the add-on payments based on the provider's overall casemix and the DRG relative on the claim. This will tie the amount of IGT payment to complexity and cost of the case. - Include IGT payments in the overall claim payment <i>before</i> determining outlier payments.
7.5. Outliers		
How to pay outlier claims	DRG with outlier (stop loss model) or another method such as percentage of charges	Stop loss model with a single threshold
Loss and/or gain	Pay outliers only for cases of extreme hospital loss or for both cases of loss and gain	Outlier policy only for both hospital losses. Use charge cap policy for provider gains.
Size of outlier pool	<p>Set targeted percentage of payments made via outliers</p> <p>Medicaid agencies generally have an outlier pools between 5 and 10 percent. In FY 2012, Medicare is aiming for an outlier pool of 5.1 percent of total IPPS payments.¹⁵</p>	Between 5 and 10 percent
Basis of threshold	Cost, days, or both - depending on the service	Cost only
Number of thresholds	One or two pre-set thresholds, thresholds based on DRG relative weight or thresholds set as a multiple of DRG base payment.	One

¹⁵ Medicare Learning Network (MLN), *Acute Care Hospital Inpatient Prospective Payment System – Payment System Fact Sheet*, ICN 006815, February 2012.

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
Amount of threshold	One pre-set threshold, one per DRG, or a multiple of DRG base payment. Generally this value and marginal cost percentage are adjusted to ensure the outlier payment amount hits a particular target percentage.	A single pre-set threshold of \$27,425. This is the value Medicare is using in federal fiscal year 2013.
Marginal cost percentage	Typically, one cost percentage is used, but more than one can be used if more than one threshold is implemented. Generally this value and the threshold value are adjusted to ensure the outlier payment amount hits a particular target percentage.	A single percentage equal to 80%.
Granularity of cost-to-charge ratio	One for the entire state; one per hospital; one per standard cost center within each hospital	One per hospital
IGT supplemental payments	Include before or after calculation of outlier amount	Include IGT payments in total claim payment <i>before</i> determination of any outlier payments.
7.6. Non-Covered Days Adjustments		
Do partial eligibility scenarios occur enough to justify a partial eligibility payment adjustment?	Include or forego a partial eligibility payment adjustment calculation.	Include a partial eligibility payment adjustment
If a partial eligibility payment adjustment is included, what should the formula be?	A formula similar to the transfer payment adjustment formula or a proration based on the number of covered days.	Proration based on the number of covered days.
7.7. Per Claim Add-On Payments		
Will there be any supplemental payments made on a per-claim basis.	Any type of supplemental payment can, in theory, be made on a per-claim basis, including DSH, graduate medical education, and capital. Reimbursement levels for supplemental payments made this way depend on hospital claim volume.	No per claim supplemental payments beyond those made to distribute IGT funds.
7.8. Transitional Period		
Should there be a period of transition into the new DRG pricing methodology?	Yes or no.	No

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
If a transition period is offered, how many years will it entail?	Typically the length of transition periods is between 1 and 4 years.	N/A
If a transition period is offered, which providers will be affected?	All providers or only those with project payment changes above a certain percentage. In addition, each hospital's Medicaid market share could be used as a determining factor.	N/A
If a transition period is offered, how the transition be applied?	Through adjustments to base rates performed outside the MMIS, or through adjustment multipliers in the MMIS, or through merger of payments calculated using the Legacy method and the new DRG method.	N/A
If a transition period is offered, what will the phase in percentages be each year?	One option (used by Medicare), is to phase in by 25% each year, ending up at full transition (100%) in year 4. Another option is to transition slowly in the first year or two, limiting hospital reimbursement shifts, then making the final jump to full DRG reimbursement in the final year of the transition.	N/A
7.9. Documentation and Coding Adjustment		
How much adjustment should be estimated for real casemix changes between the dataset used for pricing simulations and the first year of DRG payment in production?	Typically this value is estimated between 0.5 and 1 percent.	0.5 percent per year, totaling 1.5 percent between the simulation dataset (from 2010/2011) and the first year of implementation (2013/2014).
How much adjustment should be estimated for improvements in coding by providers?	Typically, this value is estimated between 2 and 5 percent, but can be greater.	6 percent in the first year followed by a re-evaluation every subsequent year.
What kind of strategy should be used to cover risk of inaccurate estimate for both the Medicaid program and the hospital community?	Lump sum payments or hospital credits can be applied, or retroactive payment adjustments can be made by adjusting previously paid claims.	Any payment adjustment will require legislative approval.
7.10. Interim Claims and Late Charges		
Should interim claims be accepted?	Yes or no	No

Appendix A Summary of DRG Payment Method Options		
Decision Point	Options / Comments	Recommendation
If interim claims are accepted, what will be the minimum length of stay on each interim claim?	Typically 30 days.	N/A
If interim claims are accepted, how should they be paid?	Typically they are paid a per diem with a relatively low per diem rate so that there is little risk of the payment made on interim claims being greater than the final DRG payment.	N/A
If interim claims are accepted, how will final payment be calculated when the final claim is received?	Typically, the final claim is paid the full DRG payment amount, but only after all interim claims are voided. Under this method, a process must be defined to identify the interim claims and submit a void for each one.	N/A
Should claims for late charges (type of bill 0115) be paid?	Typically the answer is no. Instead, if a provider identifies additional charges, it must submit a void for the original claim and then submit a new claim.	No
7.11. Charge Cap		
Should a charge cap be applied to claims paid via a DRG method?	Yes, or no. If no, then a provider gain outlier function is highly recommended.	Yes, implement charge cap logic
7.12. Medicare Crossover Comparison Pricing		
Will comparison pricing (Medicare versus Medicaid) be applied to Medicare crossover claims?	Yes or no.	Yes
7.13. 45-Day Benefit Limit		
How, if at all, should the 45-day benefit limit be changed with the move from per diem to DRG pricing?	Keep as is, or change. If changed, how should it be changed?	Apply the 45-day benefit limit only for stays in which the recipient has reached his/her limit prior to admission. In this scenario, prorate payment based on the number of covered days. If a recipient has at least one day covered within the 45-day benefit limit, then pay full DRG amount.

Appendix A
Summary of DRG Payment Method Options

Decision Point	Options / Comments	Recommendation
7.14. Reimbursement for Undocumented Non-Citizens		
Should undocumented non-citizens be included in the DRG payment method? If yes, will there be anything unique about DRG payment for these recipients?	Undocumented non-citizens are eligible only for emergency services and AHCA’s Medicaid Services Division commonly deems part of a hospital stay as emergency and part as non-emergency, thus limiting payment to only part of a hospital stay for these recipients.	Include undocumented non-citizens in DRG payment and used logic very similar to that used for partial eligibility. That is prorate payment based on the number of days the recipient was deemed to be in an emergency health status as compared to the total length of stay. This will require prior authorizations to include a number of authorized days for undocumented non-citizens.
7.15. County Billing Rate		
How should county billing rates be determined when DRG payment is implemented?	County billing rates are per diems today, and are used for the county’s share of claim reimbursement, which is for days after the 10 th day of a hospital stay.	Continue to use a per diem method, however, calculate the per diem separately on each claim using the following formula: $\text{Per diem} = \frac{([\text{DRG base pymt}] + [\text{Outlier pymt}])}{[\text{number of covered days}]}$ Claim payments from IGT funds are currently and will continue to be separate from county billing rates.

Appendix B - Sample State Medicaid DRG Implementations

Category	California	New York	Texas	Virginia	Pennsylvania	Illinois
Scope						
Included provider types	All acute care hospitals not in the exclusion list, including, children’s hospitals, specialty cancer hospitals, critical access hospitals, teaching hospitals, and tertiary hospitals	General acute Specialty hospitals (long-term acute, cancer, and Blythedale Children’s Hospital) Chemical dependency rehab Critical access hospitals	All acute care hospitals not in the exclusion list	General acute hospitals Children’s hospitals	All acute care hospitals not in the exclusion list, including, children’s hospitals, specialty cancer hospitals, critical access hospitals, teaching hospitals, and tertiary hospitals and trauma centers	General acute hospital Freestanding Children’s Hospitals Long term acute care providers
Excluded provider types	Psychiatric hospitals Hospice providers Designated public hospitals Rehabilitation hospitals (including alcohol and drug rehabilitation) Rehabilitation units at general hospitals	Psychiatric hospitals Medical rehabilitation	Children’s hospitals Rural hospitals, including critical access hospitals State-owned teaching hospitals Freestanding psychiatric facilities FQHCs have the option of payment via DRGs or payment at 100% of reasonable cost Rural health clinics	Freestanding Psychiatric facilities Rehabilitation hospitals Rehabilitation units at general hospitals Hospitals operated by the Department of Behavioral Health and Developmental Services	Psychiatric hospitals and distinct part units Hospice providers Designated public hospitals Rehabilitation hospitals (including alcohol and drug rehabilitation) and distinct part units	Psychiatric freestanding and distinct part units Rehabilitation freestanding and distinct part units
Included services	General acute care Transplants Neonatal care Trauma	General acute care Transplants Neonatal care Trauma	General acute care Transplants Neonatal care	General acute care Neonatal care Transplants Inpatient acute psychiatric (with service authorization)	General acute care Neonatal Trauma	General acute care Neonatal care Long-term acute care Transplants
Excluded services	Rehabilitation Most psychiatric care Sub-acute Administrative days Blood factors Donor search	Chemical dependency detoxification		Behavior modification Remedial education Psychological testing Alcoholism and drug abuse therapy	Transplants, including acq. (negotiated) Psych, rehab, D&A in freestanding or DPUs Psych partial hospitalization Observation	Psych and rehab in freestanding or DPRs
Included Medicaid	Fee for service	Fee-for-service	Fee for service	Fee for service	Fee-for-service	Fee for service and CHIP

Category	California	New York	Texas	Virginia	Pennsylvania	Illinois
programs	California Children's Services (CCS) Genetically Handicapped Persons Program (GHPP)	Managed care Workers comp No fault	Primary care case management			
Excluded Medicaid programs	Managed care	None listed	Managed care	None listed	Managed care, but required to pay out-of-network using predecessor AP-DRG model	Managed care
DRG Grouping						
Groupers	APR (planned for implementation 7/1/2013)	APR	APR (effective 9/1/2012)	AP	APR	APR
Relative weights	National weights adjusted (re-centered) for CA casemix	New York specific	Texas specific	National	Adopted New York weights, adjusted (re-centered) for PA casemix	National weights adjusted (re-centered) for Illinois case mix
Provider Base Rates						
Provider groupings with separate standard base rates	Remote rural All other	Single common base rate	Single common base rate	Single common base rate, but separate rate for State Teaching Hospitals	Single statewide operating rate (excludes capital and medical education)	Long-term acute care hospitals All other hospitals
Base rate adjustments	Medicare wage indices	Hospital's labor costs wage equalization factor (WEF) and each hospital's GME costs using updated cost basis and formula	Geographic wage adjustment Medical education Trauma designation	Medicare wage indices Rural hospitals - Medicare wage index of the nearest metropolitan wage area or the effective Medicare wage index, whichever is higher Adjustment for medical education	Adopted Medicare wage index adjustment if hospital's Medicare index exceeded 1.0. If below 1.0, no adjustment.	Geographic wage adjustments using Medicare values and method Adjustments for critical access and specialty providers are maintained through legacy supplemental payments outside of DRG model – but will be phased out over time.
Pricing Rules						
Policy adjustors	1.25 for pediatrics 1.25 for most neonates 1.75 for neonates at a facility operating a	None	None	None	Provider-specific teaching hospital adjustments of either 5% (Teaching) or 10%	Yes – for critical access hospitals only – value TBD. No other policy

Category	California	New York	Texas	Virginia	Pennsylvania	Illinois
	certified NICU surgery unit				(Advanced Teaching). Designations based on Medicare resident of bed ratio – Advanced Teaching above average ratio, Teaching below average ratio. Provider-specific adjustments based on Medicaid utilization ranging from 0% to 20%.	adjustors, but enhanced funding for specialty services (children’s, neonatal, pediatric, etc.) are accommodated through legacy supplemental payments made outside of the DRG model. Supplemental funding will be gradually incorporated into DRG model over time, and may be replaced with additional policy adjustors.
Transfer payments	<p>Calculation for acute-to-acute transfers:</p> <p>Lesser of [DRG base payment] and $\{([DRG \text{ base pymt}] / [DRG \text{ ALOS}]) * (LOS + 1)\}$</p> <p>No acute-to-post-acute transfer payment reductions</p>	<p>Calculation for acute-to-acute transfers:</p> <p>Lesser of [DRG base payment] and $\{([DRG \text{ base pymt}] / [DRG \text{ ALOS}]) * LOS\}$</p> <p>No acute-to-post-acute transfer payment reductions</p>	<p>Calculation for acute-to-acute transfers:</p> <p>$\{[DRG \text{ base pymt}] / [DRG \text{ ALOS}]\}$ times the lesser of $\{[DRG \text{ ALOS}], [\text{claim LOS}], \text{and } [30 \text{ days}]\}$</p> <p>No acute-to-post-acute transfer payment reductions</p>	<p>Calculation for acute-to-acute transfers:</p> <p>Lesser of [DRG base payment] and $\{([DRG \text{ base pymt}] / [DRG \text{ ALOS}]) * LOS\}$</p> <p>No acute-to-post-acute transfer payment reductions</p>	<p>Calculation for acute-to-acute transfers:</p> <p>Lesser of [DRG base payment] and $\{([DRG \text{ base pymt}] / [DRG \text{ ALOS}]) * LOS\}$</p> <p>No acute-to-post-acute transfer payment reductions</p>	<p>Calculation for acute-to-acute transfers:</p> <p>Lesser of [DRG base payment] and $\{([DRG \text{ base pymt}] / [DRG \text{ ALOS}]) * (LOS + 1)\}$</p> <p>No acute-to-post-acute transfer payment reductions</p>
Provider loss outliers?	Yes, cost based	Yes, cost based	Yes for recipients under age 21 only, and based on either cost or length of stay. If both apply on a single claim, the higher outlier amount is paid.	Yes, cost based	Yes, cost based	Yes – cost based
Provider loss outlier threshold(s)	Two thresholds: tier 1 threshold \$30,000, tier	By DRG and adjusted by provider wage	Variable – greater of [1.5 times DRG base	\$26,000, adjusted in the base year so as to	\$30,000	\$22,385

Category	California	New York	Texas	Virginia	Pennsylvania	Illinois
	2 threshold \$100,000	equalization factor	payment] and [11.14 times hospital base price]	result in expenditures for outliers operating payments equal to 5.1% of total operating payments for DRG cases.		
Provider loss outlier marginal cost percentage(s)	60% for losses between tier 1 and tier 2 thresholds; 80% for losses above tier 2 threshold	100%	60%	80%	100% for neonatal and burn cases; 80% for all other services	80 % marginal cost factor
Provider gain outliers?	Yes, cost based	No	No	No	Yes, cost based	Under consideration
Provider gain outlier threshold(s)	\$30,000	n/a	n/a	n/a	\$30,000	
Provider gain outlier marginal cost percentage(s)	60%	n/a	n/a	n/a	80%	
Interim claims	Paid via per diem if length of stay is > 30 days		Yes, but only one accepted per hospital stay.	Yes	No	Yet to be determined
Charge cap	Currently undecided				Yes	Currently undecided
Medicare/Medicaid dual eligible pricing comparison logic	Yes	Yes	Yes	No	Yes – lesser of payment difference or deductible/copay amount	Proposed but not in effect
Implementation Items						
Transition strategy	Limit gain and loss to 5% per year for first 3 years (maximum is 15% in third year). Full implementation in year 4.		None (Moving from MS-DRG to APR-DRG)		No transition period	Considering a transition similar to California
Documentation and coding adjustment	0.5% real casemix increase yearly between simulation dataset and implementation 2.5% anticipated casemix change from improved				1% real casemix increase yearly between simulation dataset and implementation No prospective adjustment in anticipation of documentation and	0.8% real casemix increase yearly between simulation dataset and implementation 5% anticipated casemix change from improved

Category	California	New York	Texas	Virginia	Pennsylvania	Illinois
	documentation and coding				coding with plan. Documentation and coding improvement proved to be significant in the first year of implementation.	documentation and coding with plan to redistribute money to hospitals if documentation and coding improvement is over estimated.

Appendix C – DRG Simulation Dataset

The simulation dataset started out as an extract of three years of paid inpatient claims. For a few analyses such as the comparison of APR-DRGs versus Medicare MS-DRGs, all three years of data were used. But for all pricing simulations, the dataset was reduced down to one year of fee-for-service inpatient claims that were deemed valid for simulating DRG pricing. The specific year used for the DRG pricing simulations was state fiscal year 2010/2011 which ran from 7/1/2010 through 6/30/2011. Also as part of the dataset creation process, healthy newborn claims were created for concurrent newborn stays because mothers and newborns must be billed on separate claims for DRG pricing. A summary of this creation and exclusion of claims from the dataset is shown in the following table. The end result is a dataset that includes most, but not every single claim that was paid in SFY 2010/2011. This dataset is worthwhile for simulating DRG payments and setting rates, but is not intended as an indication of the full inpatient budget for SFY 2010/2011 or any other year.

Claim Reconciliation											
Description	Claims	Excluding Newborn Hearing Test					Newborn Hearing Test				
		Covered Days	Charges	Baseline Payment	Reimbursement Amount	Other Insurance Amount	Covered Days	Charges	Baseline Payment	Reimbursement Amount	Other Insurance Amount
Original Dataset from AHCA	1,302,035	6,010,515	\$ 43,040,116,420	\$ 8,786,717,429	\$ 7,842,925,422	\$ 118,741,355	5	\$ 27,015,753	\$ 1,573,563	\$ 1,509,167	\$ -
Claim Data Exclusions:											
Invalid date of admission	368	174,415	\$ 6,968,195	\$ 66,009,525	\$ 3,421,396	\$ 24,099	-	\$ 243	\$ -	\$ -	\$ -
Non-hospital provider type	138,841	592,352	\$ 1,037,376,625	\$ 151,543,115	\$ 151,273,562	\$ 108,891	-	\$ 49,392	\$ -	\$ -	\$ -
Non-hospital bill type	11	57	\$ 208,920	\$ 3,101	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -
Interim Claim	29,886	-	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -
Claim for newborn hearing test only	262	-	\$ -	\$ -	\$ -	\$ -	-	\$ 68,088	\$ 6,762	\$ 5,565	\$ -
Allowed amount is zero	10,608	26,926	\$ 248,542,477	\$ -	\$ -	\$ 27,697,974	-	\$ 370,984	\$ 27,005	\$ 24,014	\$ -
Incomplete stay - patient status is 30	10,308	244,403	\$ 2,213,963,092	\$ 484,128,344	\$ 468,101,069	\$ 3,405,158	-	\$ 430,955	\$ 7,427	\$ 7,427	\$ -
Ungroupable	784	6,414	\$ 42,206,071	\$ 9,651,173	\$ 7,078,313	\$ 56,126	-	\$ 26,878	\$ 1,091	\$ 1,010	\$ -
Claim Additions:											
Newborn build	252,037	834,589	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ -
Sub-Total	1,363,004	5,800,537	\$ 39,390,851,040	\$ 8,075,382,171	\$ 7,213,051,082	\$ 87,449,106	5	\$ 26,069,213	\$ 1,531,279	\$ 1,471,151	\$ -
Claim Simulation Exclusions:											
Outside SFY 2010/2011	867,666	3,648,490	\$ 24,540,408,787	\$ 4,889,816,036	\$ 4,419,557,689	\$ 43,954,478	3	\$ 17,109,394	\$ 1,106,711	\$ 1,091,866	\$ -
Managed care encounter claim	76,269	252,767	\$ 2,070,456,119	\$ 365,350,096	\$ 7,167,757	\$ 1,226,916	-	\$ 365,546	\$ 45,457	\$ 566	\$ -
Out-of-state, non-participating hospital	1,062	6,683	\$ 49,935,804	\$ 14,980,371	\$ 14,920,194	\$ 28,345	-	\$ 3,652	\$ -	\$ -	\$ -
Simulation Dataset	418,007	1,892,597	\$ 12,730,050,330	\$ 2,805,235,667	\$ 2,771,405,441	\$ 42,239,366	2	\$ 8,590,620	\$ 379,111	\$ 378,719	\$ -
<i>Notes:</i>											
1) Original data included about three years of inpatient claims.											

Appendix D – Summary of DRG Pricing Simulation Results

The tables in this section summarize the results of the final DRG pricing simulation performed using state fiscal year (SFY) 2010/2011 data. These tables will be updated with information from a new simulation once the SFY 2010/2011 data has been adjusted to more closely reflect the funds anticipated in the first year of DRG implementation, SFY 2013/2014.

D.1 Budget Calculations

The table in this section shows the budget or total payment goals for the DRG pricing simulation. The payment goals were set in order to reach budget neutrality – that is the total payment under the DRG pricing simulations is intended to be as close as possible to the total historical payment for the claims in the dataset.

	A	B	C	D	E	F	G	H	I	J
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Baseline Payment From Automatic IGTs	Baseline Payment From Self-Funded IGTs	Estimated Cost	Historical Pay-to-Cost	Percentage of Cost Goal	Total Budget Goal with IGTs	DRG Reimbursement from GR and PMATF
1	Rural	11,140	\$ 45,610,156	\$ -	\$ -	\$ 46,496,367	98%	98%	\$ 45,566,440	\$ 45,566,440
2	LTAC	86	\$ 1,517,291	\$ 36,065	\$ 87,713	\$ 2,494,916	66%	66%	\$ 1,646,645	\$ 1,522,867
3	High Medicaid & High Outlier	9,229	\$ 119,252,071	\$ 43,757,522	\$ 8,863,176	\$ 177,012,181	97%	95%	\$ 168,161,572	\$ 115,540,874
4	All Other	397,552	\$ 1,572,452,882	\$ 837,192,259	\$ 176,466,531	\$ 2,857,402,396	91%		\$ 2,589,861,011	\$ 1,576,202,220
5										
6	Totals:	418,007	\$ 1,738,832,401	\$ 880,985,847	\$ 185,417,420					
7										
8		Overall Total Historical Baseline Payment:			\$ 2,805,235,667					
Notes:										
1) For rural, LTAC, and high-Medicaid-high-outlier hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals a percentage of estimated cost minus any per-claim payments being made via IGTs. For example, J1 = [I1 - (D1 + E1)].										
2) For "All Other" hospitals, DRG reimbursement from general revenue and provider assessment (PMATF) equals the total historical allowed amount from GR and assessment minus the total planned DRG reimbursement from GR and assessment for rural, LTAC, and high-Medicaid-high-outlier hospitals. J4 = [C6 - (J1 + J2 + J3)].										

D.2 Payment Parameters and Summary Results

The table in this section shows the historical payments and simulated payments by the categories of hospitals for which provider policy adjustor were included. As mentioned previously, these numbers are from SFY 2010/2011 data and will be updated to more closely reflect SFY 2013/2014 funds. So the final base rate and policy adjustors used during the first year of DRG implementation may differ slightly from what is shown in this table.

DRG Payment Simulation 14					
Simulation Parameters	Value - Overall	Value - All Other Hospitals	Value - Rural Hospitals	Value - LTAC Hospitals	Value - High Medicaid High Outlier Hospitals
Baseline payment, total	\$2,805,235,667	\$2,586,111,673	\$45,610,156	\$1,641,069	\$171,872,769
Baseline payment, general revenue and PMATF	\$1,738,832,401	\$1,572,452,882	\$45,610,156	\$1,517,291	\$119,252,071
Baseline payment, automatic IGTs	\$880,985,847	\$837,192,259	\$0	\$36,065	\$43,757,522
Baseline payment, self-funded IGTs	\$185,417,420	\$176,466,531	\$0	\$87,713	\$8,863,176
Simulation payment goal	\$2,805,235,667	\$2,589,861,011	\$45,566,440	\$1,646,645	\$168,161,572
Simulation payment, result	\$2,791,004,718	\$2,576,981,135	\$45,577,806	\$1,646,795	\$166,798,982
Difference	-\$14,230,949	-\$12,879,876	\$11,367	\$150	-\$1,362,590
Simulation payment, general revenue and PMATF	\$1,738,866,358	\$1,576,203,319	\$45,577,806	\$1,523,017	\$115,562,216
Simulation payment, automatic IGTs	\$869,461,525	\$826,757,091	\$0	\$36,065	\$42,668,369
Simulation payment, self-funded IGTs	\$182,676,835	\$174,020,725	\$0	\$87,713	\$8,568,397
DRG base price	\$3,607.10	\$3,607.10	\$3,607.10	\$3,607.10	\$3,607.10
Cost outlier pool (percentage of total payments)		7%	1%	7%	20%
Wage index adjustment of base price	None				
Policy adjustor - Provider	n/a	None	1.757	1.636	1.419
Policy adjustor - DRG (service)	Rehabilitation - 1.35				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	APR v.30 national re-centered to 1.0 for FL Medicaid				
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost (MC) percentage	\$27,425 80%				
Low side (provider gain) threshold and marginal cost (MC) percentage	None				
Charge Cap	Yes				
Undocumented non-citizen non-covered day adjustment	Yes				

D.3 Summary by Service Line

The table in this section shows a summary of the DRG pricing simulation broken out by a high-level list of service lines.

Simulation 14 Summary of Simulation by Service Line											
Service Line	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,745	1.70	\$ 973,696,869	\$ 723,688,401	\$ 823,079,884	\$ 99,391,482	14%	74%	85%	\$ 69,481,680	8%
Obstetrics	111,700	0.57	\$ 429,991,911	\$ 447,708,629	\$ 397,768,036	\$ (49,940,593)	-11%	104%	93%	\$ 2,547,145	1%
Neonate	11,641	4.10	\$ 355,356,941	\$ 446,142,293	\$ 358,287,196	\$ (87,855,096)	-20%	126%	101%	\$ 52,417,722	15%
Pediatric	46,320	1.11	\$ 389,232,185	\$ 381,580,487	\$ 388,387,859	\$ 6,807,372	2%	98%	100%	\$ 43,790,138	11%
Gastroent Adult	27,910	1.34	\$ 292,298,322	\$ 218,235,942	\$ 235,189,092	\$ 16,953,150	8%	75%	80%	\$ 11,770,449	5%
Circulatory Adult	24,525	1.69	\$ 299,764,304	\$ 170,486,175	\$ 259,348,747	\$ 88,862,573	52%	57%	87%	\$ 12,937,043	5%
Resp Adult	18,092	1.31	\$ 184,602,807	\$ 156,705,564	\$ 148,800,193	\$ (7,905,371)	-5%	85%	81%	\$ 8,751,942	6%
Normal newborn	90,713	0.16	\$ 74,862,289	\$ 111,028,700	\$ 91,755,068	\$ (19,273,632)	-17%	148%	123%	\$ 1,122,024	1%
Mental Health	12,442	0.68	\$ 40,411,740	\$ 100,628,645	\$ 48,878,987	\$ (51,749,658)	-51%	249%	121%	\$ 254,719	1%
Rehab	1,787	1.92	\$ 25,783,035	\$ 39,097,427	\$ 24,000,106	\$ (15,097,322)	-39%	152%	93%	\$ 669,962	3%
Transplant Pediatric	51	14.60	\$ 10,580,108	\$ 6,245,353	\$ 9,504,321	\$ 3,258,968	52%	59%	90%	\$ 3,806,638	40%
Transplant Adult	81	10.49	\$ 6,825,349	\$ 3,688,051	\$ 6,005,229	\$ 2,317,178	63%	54%	88%	\$ 921,557	15%
Total	418,007	1.00	\$ 3,083,405,860	\$ 2,805,235,667	\$ 2,791,004,718	\$ (14,230,949)	-1%	91%	91%	\$ 208,471,019	7%

Notes:

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

D.4 Summary by Provider Category

The table in this section shows a summary of the DRG pricing simulation broken out by the set of provider categories recognized by AHCA. In this chart the “LIP” category includes any provider who qualifies to receive supplemental payments through the LIP program. Also in this chart, providers can be included in more than one category.

Simulation 14 Summary of Simulation by Provider Category											
Provider Category	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,620	0.99	\$ 2,980,430,760	\$ 2,741,413,441	\$ 2,716,180,573	\$ (25,232,867)	-1%	92%	91%	\$ 203,004,125	7%
Trauma	167,942	1.19	\$ 1,595,763,765	\$ 1,579,657,176	\$ 1,487,715,642	\$ (91,941,533)	-6%	99%	93%	\$ 145,654,169	10%
Statutory Teaching	98,530	1.19	\$ 1,011,414,746	\$ 1,010,532,422	\$ 924,324,126	\$ (86,208,296)	-9%	100%	91%	\$ 88,191,012	10%
High Charity	112,464	0.91	\$ 731,618,588	\$ 680,768,661	\$ 695,959,333	\$ 15,190,672	2%	93%	95%	\$ 39,640,789	6%
CHEP	75,786	1.01	\$ 532,603,382	\$ 509,827,242	\$ 521,883,286	\$ 12,056,043	2%	96%	98%	\$ 29,403,676	6%
Public	76,884	0.96	\$ 515,531,094	\$ 508,160,115	\$ 495,107,598	\$ (13,052,517)	-3%	99%	96%	\$ 33,305,484	7%
General Acute	123,619	0.88	\$ 688,279,631	\$ 505,461,403	\$ 555,563,050	\$ 50,101,647	10%	73%	81%	\$ 27,397,083	5%
Children	9,263	1.79	\$ 177,764,206	\$ 172,011,952	\$ 166,987,383	\$ (5,024,569)	-3%	97%	94%	\$ 33,475,366	20%
Rural	11,140	0.66	\$ 46,496,367	\$ 45,610,156	\$ 45,577,806	\$ (32,350)	0%	98%	98%	\$ 387,446	1%
Rehabilitation	525	1.85	\$ 7,821,288	\$ 4,184,588	\$ 4,631,064	\$ 446,476	11%	54%	59%	\$ 185,106	4%
Long Term Acute Care	86	2.87	\$ 2,494,916	\$ 1,641,069	\$ 1,646,795	\$ 5,725	0%	66%	66%	\$ 122,830	7%
Out of state	412	1.22	\$ 2,591,606	\$ 1,064,107	\$ 1,819,099	\$ 754,992	71%	41%	70%	\$ 23,205	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.

Appendix E – Summary of DRG Pricing Simulation Results – Excluding IGT Payments

The DRG legislation specifically asked for a description of what payments would look like with DRGs if IGT funds were excluded from the hospital inpatient reimbursement program.

E.1 Budget Calculations

The table in this section shows the budget or total payment goals for the DRG pricing simulation. The payment goals were set in order to reach budget neutrality – that is the total payment under the DRG pricing simulations is intended to be as close as possible to the total historical payment for the claims in the dataset. In this section, the historical payment was assumed to be the payment only from general revenue and the Provider Medical Assistance Trust Fund (PMATF). IGT funds were not included.

	A	B	C	D	E	F	G
	Provider Classification	Stays	Baseline Payment From GR and PMATF	Estimated Cost	Historical Pay-to-Cost	Percentage of Cost Goal	Total Budget Goal
1	Rural	11,140	\$ 45,610,156	\$ 46,496,367	98%	98%	\$ 45,566,440
2	LTAC	86	\$ 1,517,291	\$ 2,494,916	61%	61%	\$ 1,521,899
3	High Medicaid & High Outlier	9,229	\$ 119,252,071	\$ 177,012,181	67%	67%	\$ 118,598,161
4	All Other	397,552	\$ 1,572,452,882	\$ 2,857,402,396	55%		\$1,573,145,902
5							
6	Totals:	418,007	\$ 1,738,832,401				
<p>Notes:</p> <p>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. For example, G1 = D1 * F1.</p> <p>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.</p> <p>G4 = [C6 - (G1 + G2 + G3)].</p>							

E.2 Payment Parameters and Summary Results

The table in this section shows the historical payments and simulated payments by the categories of hospitals for which provider policy adjustor were included. As mentioned previously, these numbers are from SFY 2010/2011 data and will be updated to more closely reflect SFY 2013/2014 funds. So the final base rate and policy adjustors used during the first year of DRG implementation may differ slightly from what is shown in this table.

DRG Payment Simulation 15					
Simulation Parameters	Value - Overall	Value - All Other Hospitals	Value - Rural Hospitals	Value - LTAC Hospitals	Value - High Medicaid High Outlier Hospitals
Baseline payment, total	\$1,738,832,401	\$1,572,452,882	\$45,610,156	\$1,517,291	\$119,252,071
Baseline payment, general revenue and PMATF	\$1,738,832,401	\$1,572,452,882	\$45,610,156	\$1,517,291	\$119,252,071
Simulation payment goal	\$1,738,832,401	\$1,573,145,902	\$45,566,440	\$1,521,899	\$118,598,161
Simulation payment, result	\$1,738,840,835	\$1,573,146,578	\$45,563,206	\$1,522,218	\$118,608,833
Difference	\$8,434	\$676	-\$3,233	\$319	\$10,672
DRG base price	\$3,453.70	\$3,453.70	\$3,453.70	\$3,453.70	\$3,453.70
Cost outlier pool (percentage of total payments)	12.5%	12%	1%	4%	26%
Wage index adjustment of base price	None				
Policy adjustor - Provider	n/a	None	1.841	1.787	1.571
Policy adjustor - DRG (service)	Obstetrics - 1.15 Rehabilitation - 1.48				
Policy adjustor - Age	None				
Documentation & coding adjustment	None				
Relative weights	APR v.30 national re-centered to 1.0 for FL Medicaid				
Transfer discharge statuses	02, 05, 65, 66				
High side (provider loss) threshold and marginal cost (MC) percentage	\$35,000 65%				
Low side (provider gain) threshold and marginal cost (MC) percentage	None				
Charge Cap	Yes				
Undocumented non-citizen non-covered day adjustment	Yes				

E.3 Summary by Service Line

The table in this section shows a summary of the DRG pricing simulation broken out by a high-level list of service lines.

Simulation 15 Summary of Simulation by Service Line											
Service Line	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
Misc Adult	72,745	1.70	\$ 973,696,869	\$ 723,688,401	\$ 506,482,644	\$ (217,205,757)	-30%	74%	52%	\$ 75,443,217	15%
Obstetrics	111,700	0.57	\$ 429,991,911	\$ 447,708,629	\$ 260,430,404	\$ (187,278,225)	-42%	104%	61%	\$ 1,883,095	1%
Neonate	11,641	4.10	\$ 355,356,941	\$ 446,142,293	\$ 231,691,092	\$ (214,451,201)	-48%	126%	65%	\$ 61,029,768	26%
Pediatric	46,320	1.11	\$ 389,232,185	\$ 381,580,487	\$ 237,237,211	\$ (144,343,276)	-38%	98%	61%	\$ 39,914,017	17%
Gastroent Adult	27,910	1.34	\$ 292,298,322	\$ 218,235,942	\$ 143,043,980	\$ (75,191,962)	-34%	75%	49%	\$ 10,962,456	8%
Circulatory Adult	24,525	1.69	\$ 299,764,304	\$ 170,486,175	\$ 158,110,149	\$ (12,376,026)	-7%	57%	53%	\$ 14,231,509	9%
Resp Adult	18,092	1.31	\$ 184,602,807	\$ 156,705,564	\$ 92,045,547	\$ (64,660,018)	-41%	85%	50%	\$ 7,993,927	9%
Normal newborn	90,713	0.16	\$ 74,862,289	\$ 111,028,700	\$ 53,033,262	\$ (57,995,438)	-52%	148%	71%	\$ 782,529	1%
Mental Health	12,442	0.68	\$ 40,411,740	\$ 100,628,645	\$ 28,653,878	\$ (71,974,767)	-72%	249%	71%	\$ 138,622	0%
Rehab	1,787	1.92	\$ 25,783,035	\$ 39,097,427	\$ 17,244,714	\$ (21,852,713)	-56%	152%	67%	\$ 513,883	3%
Transplant Pediatric	51	14.60	\$ 10,580,108	\$ 6,245,353	\$ 6,858,476	\$ 613,124	10%	59%	65%	\$ 3,990,192	58%
Transplant Adult	81	10.49	\$ 6,825,349	\$ 3,688,051	\$ 4,009,478	\$ 321,427	9%	54%	59%	\$ 1,077,852	27%
Total	418,007	1.00	\$3,083,405,860	\$2,805,235,667	\$1,738,840,835	\$(1,066,394,832)	-38%	91%	56%	\$217,961,067	13%

Notes:

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

E.4 Summary by Provider Category

The table in this section shows a summary of the DRG pricing simulation broken out by the set of provider categories recognized by AHCA. In this chart the “LIP” category includes any provider who qualifies to receive supplemental payments through the LIP program. Also in this chart, providers can be included in more than one category.

Simulation 15											
Summary of Simulation by Provider Category											
Provider Category	Stays	Casemix Recentered	Estimated Cost	Baseline Payment	Simulated Payment	Change	Percent Change	Baseline Pay / Cost	Simulated Pay / Cost	Simulated Outlier Payment	Sim Outlier % of Pymt
LIP	404,620	0.99	\$2,980,430,760	\$2,741,413,441	\$1,678,223,105	\$(1,063,190,336)	-39%	92%	56%	\$213,555,690	13%
Trauma	167,942	1.19	\$1,595,763,765	\$1,579,657,176	\$888,994,427	\$(690,662,749)	-44%	99%	56%	\$159,245,975	18%
Statutory Teaching	98,530	1.19	\$1,011,414,746	\$1,010,532,422	\$515,607,423	\$(494,924,999)	-49%	100%	51%	\$102,237,253	20%
High Charity	112,464	0.91	\$731,618,588	\$680,768,661	\$405,834,561	\$(274,934,100)	-40%	93%	55%	\$43,046,275	11%
CHEP	75,786	1.01	\$532,603,382	\$509,827,242	\$299,490,633	\$(210,336,609)	-41%	96%	56%	\$31,013,151	10%
Public	76,884	0.96	\$515,531,094	\$508,160,115	\$296,490,219	\$(211,669,896)	-42%	99%	58%	\$35,597,053	12%
General Acute	123,619	0.88	\$688,279,631	\$505,461,403	\$402,196,304	\$(103,265,099)	-20%	73%	58%	\$21,915,572	5%
Children	9,263	1.79	\$177,764,206	\$172,011,952	\$118,774,818	\$(53,237,134)	-31%	97%	67%	\$30,539,333	26%
Rural	11,140	0.66	\$46,496,367	\$45,610,156	\$45,563,206	\$(46,950)	0%	98%	98%	\$233,668	1%
Rehabilitation	525	1.85	\$7,821,288	\$4,184,588	\$4,738,581	\$553,993	13%	54%	61%	\$86,490	2%
Long Term Acute Care	86	2.87	\$2,494,916	\$1,641,069	\$1,522,218	\$(118,851)	-7%	66%	61%	\$59,761	4%
Out of state	412	1.22	\$2,591,606	\$1,064,107	\$1,744,993	\$680,886	64%	41%	67%	\$13,605	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.

Appendix F – Provider Specific Payment Estimates from DRG Pricing Simulations

The table in this section shows historical and simulated inpatient payments for each hospital participating in the Florida Medicaid program. Both historical (baseline) and simulated payments in this table include distribution of State general revenue, PMATF, automatic IGT and self-funded IGT funds. As mentioned previously, the numbers presented in this table are from SFY 2010/2011 data and will be updated to more closely reflect SFY 2013/2014 funds. So the final DRG payment estimates for each hospital during the first year of DRG implementation may differ slightly from what is shown in this table.

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
A.G. Holley State Hospital	1.11	12	1,711	\$1,313,775	\$1,313,775	\$1,371,218	\$957,826	-\$413,392	-30%	1.04	0.73	36%
All Children's Hospital	2.13	4,356	37,658	\$342,778,631	\$94,718,843	\$93,820,661	\$92,503,980	-\$1,316,682	-1%	0.99	0.98	18%
Anne Bates Leach Eye Hospital	0.87	3	13	\$44,672	\$91,274	\$104,981	\$44,672	-\$60,309	-57%	1.15	0.49	34%
Archbold Memorial Hospital	1.40	4	26	\$120,428	\$42,073	\$15,217	\$20,264	\$5,047	33%	0.36	0.48	0%
Atmore Community Hospital	1.03	20	89	\$474,092	\$123,620	\$54,457	\$74,179	\$19,722	36%	0.44	0.60	0%
Aventura Hospital & Medical Center	1.23	1,514	7,788	\$83,120,795	\$11,749,249	\$5,199,123	\$7,329,908	\$2,130,785	41%	0.44	0.62	9%
Baptist Hospital (Pensacola)	1.05	3,470	16,413	\$87,315,019	\$25,402,582	\$20,865,245	\$23,392,316	\$2,527,071	12%	0.82	0.92	6%
Baptist Hospital of Beaches	0.51	1,031	2,973	\$13,441,273	\$3,858,990	\$1,712,278	\$1,940,676	\$228,398	13%	0.44	0.50	3%
Baptist Medical Center	1.18	5,840	29,453	\$165,530,538	\$46,062,674	\$35,897,478	\$40,793,149	\$4,895,670	14%	0.78	0.89	9%
Baptist Medical Center - Nassau	0.49	605	1,383	\$5,431,378	\$2,376,917	\$2,458,774	\$1,819,348	-\$639,426	-26%	1.03	0.77	0%
Baptist of Miami	0.98	6,378	28,757	\$262,043,960	\$65,331,838	\$56,312,484	\$57,740,196	\$1,427,712	3%	0.86	0.88	8%
Bartow Memorial Hospital	1.24	382	1,588	\$13,941,088	\$2,058,709	\$1,600,597	\$1,973,731	\$373,134	23%	0.78	0.96	1%
Bay Medical Center	1.45	2,142	9,348	\$56,188,750	\$15,322,493	\$12,690,583	\$16,221,009	\$3,530,426	28%	0.83	1.06	3%
BayCare Alliant Hospital	3.93	23	517	\$3,570,460	\$1,000,428	\$603,727	\$712,702	\$108,975	18%	0.60	0.71	8%
Bayfront Medical Center	0.89	4,951	19,388	\$129,759,405	\$25,560,378	\$24,263,794	\$26,732,381	\$2,468,586	10%	0.95	1.05	4%
Bayonet Point/Hudso	1.53	757	4,184	\$49,362,544	\$6,316,309	\$3,347,575	\$4,239,342	\$891,767	27%	0.53	0.67	2%
Bert Fish Memorial Hospital	1.73	192	1,016	\$5,606,618	\$1,856,784	\$991,529	\$1,250,507	\$258,978	26%	0.53	0.67	6%
Bethesda Mem. Hosp.	0.70	6,042	25,992	\$134,266,399	\$29,683,775	\$29,295,929	\$26,114,668	-\$3,181,260	-11%	0.99	0.88	2%
Boca Raton Community Hospital	1.08	574	2,704	\$17,029,192	\$4,406,117	\$2,037,940	\$2,454,602	\$416,663	20%	0.46	0.56	10%
Brandon Regional Medical Center	0.77	4,055	14,793	\$115,547,522	\$19,726,184	\$17,678,152	\$19,203,617	\$1,525,465	9%	0.90	0.97	3%
Brooksville Regional Hospital	0.75	2,703	10,189	\$84,263,686	\$11,359,681	\$9,284,626	\$10,189,416	\$904,790	10%	0.82	0.90	0%
Broward General Hospital	1.16	9,863	56,234	\$323,439,772	\$89,502,622	\$89,655,919	\$85,495,729	-\$4,160,191	-5%	1.00	0.96	11%
Calhoun Liberty Hospital	0.93	39	176	\$538,572	\$213,177	\$260,979	\$216,925	-\$44,054	-17%	1.22	1.02	0%
Campbellton-Graceville Hospital	0.96	7	29	\$93,187	\$41,115	\$66,116	\$40,303	-\$25,813	-39%	1.61	0.98	0%
Cape Canaveral Hospital	0.77	702	2,735	\$12,804,394	\$4,414,166	\$2,024,516	\$2,091,484	\$66,969	3%	0.46	0.47	9%
Cape Coral Hospital	0.70	2,171	7,697	\$34,815,738	\$10,731,862	\$10,023,720	\$9,533,931	-\$489,789	-5%	0.93	0.89	2%
Capital Regional Medical Center	0.82	2,101	8,144	\$56,396,418	\$10,860,628	\$6,215,164	\$6,661,466	\$446,302	7%	0.57	0.61	7%
Cedars Medical Center, Inc.	1.59	2,038	13,674	\$144,098,128	\$26,070,391	\$20,816,726	\$21,577,307	\$760,581	4%	0.80	0.83	6%
Central Florida Regional Hospital	1.01	1,197	4,328	\$30,649,599	\$6,749,221	\$3,239,585	\$4,463,473	\$1,223,888	38%	0.48	0.66	4%

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
Charlotte Regional Medical Center	1.54	468	2,434	\$25,214,503	\$4,429,204	\$2,063,147	\$2,842,341	\$779,194	38%	0.47	0.64	10%
Charlton Memorial Hospital	0.86	2	4	\$19,018	\$15,061	\$4,114	\$5,190	\$1,077	26%	0.27	0.34	0%
Citrus Memorial Hospital	0.78	1,394	4,213	\$22,444,434	\$5,571,078	\$8,335,317	\$8,391,688	\$56,370	1%	1.50	1.51	0%
Cleveland Clinic FL Hospital - Naples	0.96	1,026	3,760	\$33,252,615	\$6,769,307	\$3,337,137	\$3,641,695	\$304,558	9%	0.49	0.54	3%
Cleveland Clinic Hospital	1.91	151	704	\$6,174,527	\$1,660,976	\$638,676	\$1,079,323	\$440,647	69%	0.38	0.65	4%
Columbia Englewood Community Hospital	1.42	126	519	\$6,350,435	\$1,115,184	\$454,155	\$630,588	\$176,433	39%	0.41	0.57	3%
Columbia Hospital	0.84	1,071	4,736	\$35,764,970	\$5,846,693	\$5,175,543	\$5,529,013	\$353,470	7%	0.89	0.95	2%
Columbia JFK Medical Center	1.55	2,386	12,691	\$168,420,979	\$22,636,750	\$20,744,297	\$23,611,252	\$2,866,955	14%	0.92	1.04	3%
Columbia Kendall Medical Center	0.85	3,725	14,257	\$123,380,883	\$23,061,748	\$18,669,170	\$20,134,551	\$1,465,381	8%	0.81	0.87	4%
Columbia Medical Center-Osceola	0.71	3,768	12,537	\$100,857,418	\$17,100,753	\$13,594,415	\$15,592,373	\$1,997,958	15%	0.79	0.91	3%
Columbia New Port Richey Hospital	0.74	1,518	5,023	\$43,656,111	\$6,993,927	\$5,402,512	\$4,128,551	-\$1,273,960	-24%	0.77	0.59	2%
Columbia Palms West Hospital	0.78	2,982	11,177	\$87,806,924	\$15,144,832	\$16,607,684	\$15,639,805	-\$967,879	-6%	1.10	1.03	1%
Columbia Plantation General Hospital	0.79	4,612	21,142	\$145,109,202	\$25,427,660	\$23,124,257	\$22,614,060	-\$510,197	-2%	0.91	0.89	6%
Columbia Twin Cities Hospital	1.29	142	519	\$8,145,819	\$1,151,682	\$513,514	\$645,565	\$132,050	26%	0.45	0.56	1%
Coral Gables Hospital	0.98	546	2,082	\$26,085,578	\$3,565,460	\$2,908,857	\$3,307,491	\$398,634	14%	0.82	0.93	2%
Coral Springs Medical Center	0.66	3,802	13,008	\$53,952,069	\$16,336,020	\$17,217,376	\$16,442,247	-\$775,130	-5%	1.05	1.01	1%
D.W.McMillan Memorial	0.40	15	41	\$75,578	\$35,156	\$13,481	\$21,194	\$7,714	57%	0.38	0.60	0%
Delray Comm. Hospital	1.94	553	3,806	\$49,448,835	\$6,847,082	\$3,285,881	\$4,715,024	\$1,429,142	43%	0.48	0.69	8%
Desoto Memorial Hospital	0.50	1,152	2,973	\$9,364,270	\$4,190,814	\$3,774,306	\$3,550,895	-\$223,410	-6%	0.90	0.85	0%
Doctors Hospital	1.36	370	2,262	\$25,715,097	\$5,658,457	\$2,399,094	\$2,583,986	\$184,891	8%	0.42	0.46	30%
Doctors Hospital of Sarasota	1.54	150	751	\$7,299,994	\$1,170,615	\$678,191	\$842,203	\$164,012	24%	0.58	0.72	2%
Doctors Memorial Hospital	0.80	247	747	\$2,315,792	\$1,046,274	\$1,026,113	\$1,120,324	\$94,211	9%	0.98	1.07	0%
Doctor's Memorial Hospital	0.81	247	629	\$2,051,630	\$934,183	\$899,487	\$1,136,641	\$237,154	26%	0.96	1.22	0%
Edward White Hospital	1.95	190	1,066	\$12,405,507	\$2,132,389	\$1,139,279	\$1,546,186	\$406,908	36%	0.53	0.73	2%
Fawcett Memorial Hospital	1.53	496	1,905	\$28,469,429	\$3,334,367	\$1,297,846	\$2,749,652	\$1,451,806	112%	0.39	0.82	1%
Fishermen's Hospital	1.03	36	91	\$906,743	\$387,154	\$313,008	\$215,500	-\$97,508	-31%	0.81	0.56	4%
Flagler Hospital	0.66	2,153	7,191	\$35,569,343	\$7,963,031	\$5,826,082	\$5,683,910	-\$142,172	-2%	0.73	0.71	2%
Florida Hospital	1.01	18,130	84,910	\$668,523,983	\$156,476,143	\$145,688,533	\$144,350,370	-\$1,338,163	-1%	0.93	0.92	8%
Florida Hospital - Flagler	1.28	362	1,471	\$9,352,568	\$2,181,483	\$2,324,796	\$2,881,838	\$557,042	24%	1.07	1.32	0%
Florida Hospital Heartland Medical Center	0.72	2,165	6,573	\$33,765,629	\$8,402,395	\$4,373,434	\$5,802,819	\$1,429,385	33%	0.52	0.69	4%
Florida Hospital Waterman	0.77	2,031	6,949	\$32,097,339	\$9,620,843	\$11,030,618	\$10,720,540	-\$310,078	-3%	1.15	1.11	1%
Florida Hospital Wauchula	1.03	11	36	\$172,130	\$26,546	\$170,872	\$59,283	-\$111,589	-65%	6.44	2.23	0%
Florida Hospital Zephyrhills	0.77	1,302	4,389	\$30,663,673	\$6,092,082	\$2,870,950	\$3,666,056	\$795,106	28%	0.47	0.60	3%
Flowers Hospital	1.00	84	321	\$2,449,555	\$400,459	\$173,716	\$299,440	\$125,724	72%	0.43	0.75	0%
Ft. Walton Beach Medical Center	0.93	2,390	9,880	\$101,586,997	\$12,463,091	\$5,601,701	\$8,358,088	\$2,756,387	49%	0.45	0.67	5%
Genesis Rehabilitation Hospital	2.08	145	2,503	\$6,928,990	\$2,887,278	\$1,682,970	\$1,570,591	-\$112,379	-7%	0.58	0.54	10%
George E. Weems Memorial Hospital	0.70	13	31	\$137,639	\$125,481	\$88,552	\$57,110	-\$31,442	-36%	0.71	0.46	0%
Glades General Hospital	0.63	1,634	4,761	\$22,054,121	\$6,935,538	\$7,428,902	\$6,439,715	-\$989,187	-13%	1.07	0.93	1%
Good Samaritan Hospital	0.85	1,194	4,497	\$31,575,994	\$6,502,729	\$3,881,700	\$5,668,863	\$1,787,164	46%	0.60	0.87	1%

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
Gulf Coast Community Hospital	0.68	4,075	13,236	\$92,690,813	\$14,530,276	\$12,631,089	\$16,244,915	\$3,613,825	29%	0.87	1.12	2%
H L Moffitt Cancer Center	2.68	787	5,189	\$42,829,966	\$16,181,434	\$12,633,973	\$11,591,225	-\$1,042,748	-8%	0.78	0.72	18%
H.H. Raulerson	1.04	472	1,688	\$16,205,467	\$2,869,246	\$2,627,547	\$3,069,079	\$441,532	17%	0.92	1.07	0%
Halifax Medical Center	0.95	4,151	18,179	\$81,341,163	\$26,981,819	\$26,402,540	\$22,646,260	-\$3,756,281	-14%	0.98	0.84	7%
Health Central	0.72	2,173	7,184	\$31,505,977	\$8,619,036	\$8,976,473	\$9,188,235	\$211,762	2%	1.04	1.07	3%
Healthmark Regional Medical Center	0.82	212	554	\$2,260,992	\$881,499	\$734,981	\$1,023,315	\$288,335	39%	0.83	1.16	0%
Healthsouth Emerald Coast Hospital	1.74	57	665	\$1,252,840	\$602,912	\$303,667	\$429,964	\$126,297	42%	0.50	0.71	0%
Healthsouth Hospital of Spring Hill	1.81	5	126	\$207,669	\$108,534	\$68,531	\$44,186	-\$24,346	-36%	0.63	0.41	0%
Healthsouth Larkin Hospital-Miami	1.18	532	2,490	\$17,036,477	\$4,396,481	\$2,683,166	\$3,549,386	\$866,220	32%	0.61	0.81	1%
HealthSouth Rehabilitation Hospital Sarasota	2.41	16	216	\$362,986	\$184,641	\$90,785	\$183,792	\$93,007	102%	0.49	1.00	0%
HealthSouth Rehabilitation Hospital-Sea Pines	2.00	12	137	\$260,642	\$123,461	\$62,621	\$112,163	\$49,541	79%	0.51	0.91	0%
HealthSouth Rehabilitation Hospital-Sunrise	2.08	8	149	\$343,817	\$180,093	\$72,021	\$90,741	\$18,719	26%	0.40	0.50	11%
HealthSouth Rehabilitation Hospital-Tallahassee	2.07	9	114	\$231,062	\$134,863	\$55,103	\$74,149	\$19,046	35%	0.41	0.55	0%
HealthSouth Rehabilitation Hospital - Miami	1.80	32	317	\$571,163	\$339,959	\$137,446	\$263,045	\$125,599	91%	0.40	0.77	0%
HealthSouth Rehabilitation Hospital-Largo	2.25	45	724	\$1,119,824	\$698,167	\$348,861	\$460,475	\$111,614	32%	0.50	0.66	3%
HealthSouth Rehabilitation Hospital-Treasure Coast	2.21	20	271	\$573,968	\$311,359	\$127,282	\$198,211	\$70,929	56%	0.41	0.64	0%
Healthsouth Ridgelake Hospital	3.15	8	173	\$464,939	\$247,435	\$145,783	\$164,251	\$18,468	13%	0.59	0.66	9%
Heart of Florida Hospital	0.68	2,255	7,231	\$61,538,640	\$8,520,838	\$10,506,196	\$11,456,482	\$950,286	9%	1.23	1.34	1%
Helen Ellis Memorial Hospital	0.53	1,014	2,683	\$11,752,366	\$3,909,389	\$1,830,703	\$2,272,658	\$441,955	24%	0.47	0.58	3%
Hendry Regional Medical Center	0.99	114	309	\$1,589,463	\$683,593	\$571,381	\$678,294	\$106,913	19%	0.84	0.99	0%
Hialeah Hospital	0.74	3,661	13,424	\$123,521,189	\$20,864,654	\$16,663,336	\$18,126,547	\$1,463,212	9%	0.80	0.87	3%
Highlands Regional Medical Center	0.56	1,018	3,169	\$17,414,809	\$3,823,163	\$1,493,438	\$2,100,322	\$606,884	41%	0.39	0.55	4%
Holmes Regional Medical Center	0.99	3,717	16,931	\$97,567,538	\$28,561,493	\$25,374,599	\$25,344,397	-\$30,203	0%	0.89	0.89	5%
Holy Cross Hospital, Inc.	1.00	1,178	5,079	\$37,447,416	\$10,462,884	\$3,666,961	\$5,685,256	\$2,018,295	55%	0.35	0.54	25%
Homestead Hospital	0.68	3,227	11,373	\$83,889,592	\$29,208,261	\$22,381,136	\$21,987,806	-\$393,330	-2%	0.77	0.75	8%
Imperial Point Hospital	1.15	916	4,259	\$23,866,145	\$6,840,522	\$5,753,377	\$6,389,897	\$636,520	11%	0.84	0.93	6%
Indian River Memorial Hospital	0.81	2,304	7,559	\$26,701,747	\$11,130,185	\$10,199,965	\$10,914,458	\$714,493	7%	0.92	0.98	2%
Jackson Hospital	0.50	1,276	3,712	\$7,875,647	\$5,054,743	\$5,577,763	\$4,094,815	-\$1,482,948	-27%	1.10	0.81	5%
Jackson Memorial Hospital	1.24	23,066	135,083	\$802,593,679	\$299,186,358	\$309,928,124	\$270,125,446	39,802,678	-13%	1.04	0.90	11%
Jay Hospital	0.85	102	419	\$1,725,799	\$570,317	\$421,619	\$511,790	\$90,171	21%	0.74	0.90	0%
Jupiter Hospital	0.77	714	2,551	\$13,652,425	\$2,243,870	\$2,275,187	\$2,328,935	\$53,748	2%	1.01	1.04	0%
Kindred Hospital - Ft.Lauderdale	4.81	1	19	\$96,368	\$22,345	\$14,680	\$28,381	\$13,701	93%	0.66	1.27	0%
Kindred Hospital - Palm Beaches	4.76	4	57	\$376,347	\$99,292	\$57,378	\$112,274	\$54,896	96%	0.58	1.13	0%
Kindred Hospital (Tampa)	1.33	1	12	\$47,745	\$9,617	\$8,134	\$7,853	-\$281	-3%	0.85	0.82	0%
Kindred Hospital Central Tampa	1.68	2	38	\$134,881	\$38,015	\$30,678	\$19,784	-\$10,894	-36%	0.81	0.52	0%
Kindred Hospital Ocala	1.20	3	15	\$166,488	\$40,844	\$12,421	\$16,095	\$3,675	30%	0.30	0.39	0%

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
Kindred Hospital-Hollywood	2.22	6	86	\$630,363	\$141,519	\$56,829	\$98,739	\$41,911	74%	0.40	0.70	21%
Kindred Hospital-Melbourne	1.71	1	27	\$66,970	\$24,234	\$37,891	\$10,103	-\$27,788	-73%	1.56	0.42	0%
Kindred Hospital-St. Petersburg	1.54	1	32	\$140,458	\$27,254	\$21,434	\$9,088	-\$12,345	-58%	0.79	0.33	0%
L.W. Blake Memorial Hospital	1.43	313	1,563	\$16,028,267	\$2,495,511	\$1,178,764	\$1,674,068	\$495,305	42%	0.47	0.67	5%
Lake Butler Hospital	0.96	7	10	\$61,842	\$32,309	\$29,568	\$41,900	\$12,332	42%	0.92	1.30	0%
Lake City Medical Center	1.10	391	1,551	\$12,135,866	\$2,326,524	\$967,529	\$1,528,707	\$561,178	58%	0.42	0.66	0%
Lake Wales Hospital Association	1.03	431	1,375	\$15,481,662	\$2,279,706	\$1,995,064	\$1,697,806	-\$297,258	-15%	0.88	0.74	0%
Lakeland Regional Medical Center	0.88	5,393	21,154	\$126,384,282	\$21,342,269	\$28,518,496	\$29,594,520	\$1,076,024	4%	1.34	1.39	2%
Lakewood Ranch Medical Center	0.90	254	880	\$5,806,743	\$1,702,113	\$836,049	\$900,318	\$64,269	8%	0.49	0.53	9%
Largo Medical Center	1.49	754	4,223	\$42,381,209	\$6,079,991	\$5,980,426	\$6,163,527	\$183,100	3%	0.98	1.01	1%
Lawnwood Regional Medical Center	0.94	3,848	15,919	\$158,341,799	\$18,429,314	\$18,511,858	\$20,242,610	\$1,730,753	9%	1.00	1.10	3%
Lee Memorial Hospital	1.07	7,040	35,664	\$188,780,124	\$56,358,758	\$50,553,466	\$49,821,050	-\$732,417	-1%	0.90	0.88	9%
Leesburg Regional Medical Center	0.76	2,526	8,601	\$37,605,649	\$11,927,045	\$14,634,206	\$14,015,025	-\$619,181	-4%	1.23	1.18	1%
Lehigh Regional Medical Center	1.04	442	1,624	\$15,116,979	\$2,507,642	\$1,497,667	\$1,631,950	\$134,283	9%	0.60	0.65	0%
Lower Florida Keys Hospital	0.67	1,110	3,952	\$24,315,519	\$6,526,143	\$4,872,467	\$5,359,517	\$487,050	10%	0.75	0.82	5%
Madison County Memorial Hospital	0.73	15	54	\$118,621	\$42,993	\$57,024	\$63,817	\$6,793	12%	1.33	1.48	0%
Manatee Memorial Hospital	0.79	4,112	14,548	\$72,827,400	\$21,679,432	\$18,272,900	\$19,689,753	\$1,416,852	8%	0.84	0.91	5%
Mariners Hospital	1.02	34	141	\$1,605,656	\$799,864	\$535,224	\$297,805	-\$237,419	-44%	0.67	0.37	27%
Martin Memorial Hospital	0.75	2,240	8,053	\$51,930,467	\$11,945,861	\$10,273,890	\$10,583,815	\$309,926	3%	0.86	0.89	2%
Mayo Clinic Florida	3.81	125	1,069	\$11,551,276	\$3,953,309	\$2,983,778	\$3,752,734	\$768,956	26%	0.75	0.95	14%
Mease Hospital Clinic	1.78	349	1,965	\$14,741,111	\$3,216,366	\$3,214,561	\$3,461,968	\$247,407	8%	1.00	1.08	0%
Mease Hospital Countryside	0.82	1,939	8,741	\$39,625,553	\$11,986,277	\$14,567,005	\$12,719,763	-\$1,847,242	-13%	1.22	1.06	1%
Memorial Hospital	1.23	8,020	44,533	\$374,953,008	\$77,747,421	\$78,623,039	\$77,872,628	-\$750,411	-1%	1.01	1.00	10%
Memorial Hospital	0.94	3,885	17,504	\$75,798,135	\$21,332,867	\$23,677,115	\$24,875,518	\$1,198,403	5%	1.11	1.17	2%
Memorial Hospital - West	0.75	4,107	15,614	\$113,750,977	\$22,309,900	\$20,937,569	\$20,730,530	-\$207,038	-1%	0.94	0.93	6%
Memorial Hospital - West Volusia	0.62	1,823	5,242	\$23,912,931	\$7,264,536	\$7,172,144	\$7,202,907	\$30,763	0%	0.99	0.99	0%
Memorial Hospital Miramar	0.60	2,566	8,696	\$52,353,805	\$12,459,731	\$12,814,022	\$11,031,003	-\$1,783,019	-14%	1.03	0.89	4%
Memorial Hospital of Tampa	0.89	232	1,099	\$5,300,949	\$1,102,620	\$805,339	\$834,821	\$29,482	4%	0.73	0.76	12%
Memorial Medical Center	0.94	2,927	13,190	\$112,744,161	\$17,989,854	\$8,948,894	\$10,445,232	\$1,496,338	17%	0.50	0.58	6%
Mercy Hospital, Inc.	0.88	1,411	5,350	\$40,613,797	\$8,357,315	\$4,097,605	\$4,752,789	\$655,184	16%	0.49	0.57	5%
Metropolitan Hospital Miami	1.05	636	2,459	\$16,832,702	\$3,534,293	\$2,051,532	\$2,446,618	\$395,086	19%	0.58	0.69	2%
Miami Childrens Hospital	1.49	4,873	29,003	\$315,151,692	\$82,293,338	\$78,052,108	\$74,295,002	-\$3,757,105	-5%	0.95	0.90	22%
Mizell Memorial Hospital	0.82	3	21	\$31,899	\$17,795	\$11,429	\$8,879	-\$2,551	-22%	0.64	0.50	0%
Morton F. Plant Hospital	0.78	3,445	13,698	\$63,001,220	\$18,565,045	\$23,609,079	\$23,393,696	-\$215,383	-1%	1.27	1.26	1%
Mt. Sinai Medical Center	0.93	3,270	14,395	\$99,699,575	\$24,447,801	\$20,282,650	\$20,213,820	-\$68,830	0%	0.83	0.83	6%
Munroe Regional Medical Center	0.68	4,506	14,738	\$78,074,947	\$18,884,935	\$18,389,369	\$18,932,646	\$543,277	3%	0.97	1.00	1%
Naples Community Hospital	0.65	5,547	20,688	\$82,375,375	\$19,671,124	\$23,585,849	\$22,441,550	-\$1,144,299	-5%	1.20	1.14	3%
North Bay Medical Center	1.08	676	3,035	\$15,313,374	\$4,138,978	\$5,100,744	\$4,727,014	-\$373,730	-7%	1.23	1.14	1%
North Broward Medical Center	1.54	1,445	9,003	\$56,073,251	\$16,378,359	\$14,907,186	\$15,001,251	\$94,065	1%	0.91	0.92	6%

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
North Florida Regional Hospital	0.84	3,649	12,804	\$120,722,373	\$15,757,455	\$8,074,995	\$11,364,951	\$3,289,956	41%	0.51	0.72	4%
North Okaloosa Medical Center	0.71	1,245	3,505	\$36,757,859	\$3,989,486	\$2,487,362	\$3,159,606	\$672,244	27%	0.62	0.79	0%
Northshore Medical Center	0.95	4,721	22,666	\$168,697,329	\$30,799,869	\$26,095,006	\$28,997,744	\$2,902,739	11%	0.85	0.94	4%
Northside Hospital	1.81	584	3,382	\$48,732,891	\$6,687,612	\$5,898,643	\$7,344,215	\$1,445,572	25%	0.88	1.10	4%
Northwest Community Hospital	1.04	54	159	\$910,404	\$452,415	\$258,296	\$322,130	\$63,835	25%	0.57	0.71	0%
Northwest Regional Hospital	0.72	1,973	6,715	\$56,176,196	\$9,587,835	\$4,360,726	\$5,492,016	\$1,131,290	26%	0.45	0.57	7%
Oak Hill Community Hospital	1.39	514	2,359	\$33,507,395	\$3,585,938	\$1,471,719	\$2,654,173	\$1,182,454	80%	0.41	0.74	4%
Ocala Regional Medical Center	1.52	1,121	4,655	\$54,862,996	\$7,944,579	\$3,394,010	\$6,141,917	\$2,747,907	81%	0.43	0.77	1%
Orange Park Medical Center	0.68	3,346	11,370	\$93,165,872	\$13,515,620	\$6,868,944	\$8,357,555	\$1,488,612	22%	0.51	0.62	3%
Orlando Regional Medical Center	1.07	18,611	97,689	\$640,183,327	\$161,270,610	\$163,047,204	\$148,457,265	\$14,589,939	-9%	1.01	0.92	9%
Ormond Beach Memorial Hospital	0.73	1,992	7,270	\$29,790,426	\$9,644,277	\$5,236,148	\$5,753,828	\$517,680	10%	0.54	0.60	8%
Palm Bay Hospital	0.98	30	149	\$1,023,613	\$238,478	\$171,183	\$112,630	-\$58,553	-34%	0.72	0.47	6%
Palm Beach Gardens Medical Center	1.96	251	1,615	\$19,081,696	\$3,318,980	\$1,762,292	\$2,302,258	\$539,966	31%	0.53	0.69	11%
Palm Springs General Hospital	1.06	537	1,997	\$10,122,926	\$2,623,974	\$1,297,097	\$2,109,260	\$812,163	63%	0.49	0.80	3%
Palmetto General Hospital	0.90	5,081	21,191	\$202,196,534	\$30,946,224	\$26,858,376	\$30,973,399	\$4,115,023	15%	0.87	1.00	3%
Palms of Pasadena Hospital	1.68	142	902	\$7,345,889	\$1,575,487	\$872,856	\$1,211,827	\$338,970	39%	0.55	0.77	17%
Parrish Medical Center	0.72	1,102	3,788	\$14,574,868	\$6,090,169	\$5,764,275	\$5,435,622	-\$328,653	-6%	0.95	0.89	2%
Pasco Community Hospital	0.67	626	1,763	\$15,530,634	\$2,207,079	\$1,015,181	\$1,541,594	\$526,413	52%	0.46	0.70	2%
Peace River Regional Medical Center	0.62	2,430	7,893	\$42,084,272	\$8,920,660	\$4,748,437	\$5,404,523	\$656,086	14%	0.53	0.61	1%
Pembroke Pines Hospital	1.22	680	3,013	\$32,137,906	\$6,269,881	\$6,511,134	\$4,980,770	-\$1,530,364	-24%	1.04	0.79	6%
Putnam Community Hospital	0.75	1,116	3,667	\$17,242,260	\$4,329,070	\$2,837,539	\$5,278,272	\$2,440,733	86%	0.66	1.22	1%
Sacred Heart Hosp. - Gulf	0.75	100	219	\$875,630	\$297,976	\$707,996	\$431,998	-\$275,998	-39%	2.38	1.45	0%
Sacred Heart Hospital	1.15	8,055	37,847	\$152,409,039	\$47,460,427	\$51,464,424	\$53,788,841	\$2,324,418	5%	1.08	1.13	2%
Sacred Heart Hospital on the Emerald Coast	0.60	1,026	2,692	\$14,323,993	\$3,766,759	\$5,627,747	\$3,846,300	-\$1,781,447	-32%	1.49	1.02	0%
Santa Rosa Hospital	0.70	995	2,764	\$16,742,966	\$3,970,237	\$2,016,537	\$2,511,169	\$494,632	25%	0.51	0.63	1%
Sebastian Hospital	1.19	255	946	\$10,662,051	\$1,613,428	\$718,677	\$1,146,546	\$427,869	60%	0.45	0.71	6%
Select Specialty Hospital - Orlando	2.68	7	188	\$751,557	\$255,996	\$168,056	\$127,329	-\$40,727	-24%	0.66	0.50	13%
Select Specialty Hospital Miami	2.77	2	56	\$181,399	\$58,975	\$24,375	\$30,413	\$6,037	25%	0.41	0.52	32%
Select Specialty Hospital Panama City	3.49	3	28	\$95,025	\$27,192	\$23,013	\$32,349	\$9,337	41%	0.85	1.19	0%
Seven Rivers Community Hospital	0.88	958	2,730	\$24,170,233	\$4,325,933	\$1,669,537	\$3,076,600	\$1,407,064	84%	0.39	0.71	0%
Shands At Lake Shore	0.59	1,872	5,420	\$20,496,152	\$6,815,361	\$5,476,898	\$6,649,530	\$1,172,632	21%	0.80	0.98	0%
Shands at Live Oak	0.79	75	197	\$891,729	\$317,741	\$338,164	\$366,409	\$28,245	8%	1.06	1.15	0%
Shands at Starke	0.88	125	325	\$1,718,490	\$571,228	\$611,105	\$672,159	\$61,054	10%	1.07	1.18	0%
Shands Jacksonville Medical Center	1.23	10,391	54,728	\$309,659,637	\$84,488,923	\$83,223,303	\$77,294,597	-\$5,928,706	-7%	0.99	0.91	6%
Shands Teaching Hospital	1.44	12,253	69,609	\$357,419,664	\$144,195,070	\$152,126,868	\$131,379,845	\$20,747,022	-14%	1.06	0.91	10%
Shriners Hospital for Children	1.38	34	56	\$908,180	\$752,025	\$139,183	\$188,401	\$49,218	35%	0.19	0.25	10%
Smith Hospital	1.35	1	1	\$12,225	\$3,569	\$361	\$4,871	\$4,510	1249%	0.10	1.36	0%
South Baldwin Hospital	0.59	9	27	\$157,033	\$94,646	\$13,112	\$41,722	\$28,610	218%	0.14	0.44	54%
South Bay Hospital	1.29	197	861	\$10,098,092	\$1,365,616	\$1,391,982	\$1,516,882	\$124,900	9%	1.02	1.11	0%

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
South Florida Baptist	0.82	1,024	3,499	\$21,894,045	\$5,989,754	\$5,904,670	\$6,174,205	\$269,535	5%	0.99	1.03	3%
South Georgia Medical Center	0.80	33	79	\$338,102	\$153,468	\$46,370	\$95,203	\$48,834	105%	0.30	0.62	0%
South Lake Memorial Hospital	0.78	927	3,094	\$20,985,279	\$5,645,764	\$5,948,522	\$5,695,759	-\$252,763	-4%	1.05	1.01	2%
South Miami Hospital	0.96	3,772	17,365	\$134,513,595	\$38,328,403	\$13,776,927	\$18,625,138	\$4,848,212	35%	0.36	0.49	31%
Southeast Alabama General	1.63	150	633	\$4,823,584	\$1,255,738	\$486,080	\$881,739	\$395,659	81%	0.39	0.70	0%
Southeast Georgia Medical Center	1.12	4	15	\$69,577	\$25,090	\$11,113	\$14,786	\$3,673	33%	0.44	0.59	0%
Southwest Florida Regional Medical	0.67	3,662	12,002	\$57,092,533	\$19,437,155	\$18,108,244	\$17,301,602	-\$806,642	-4%	0.93	0.89	2%
Specialty Hospital - Gainesville	3.18	3	64	\$153,964	\$88,943	\$69,236	\$56,276	-\$12,960	-19%	0.78	0.63	0%
Specialty Hospital - Palm Beach	1.94	1	8	\$56,345	\$27,470	\$8,433	\$11,440	\$3,007	36%	0.31	0.42	0%
Specialty Hospital - Pensacola	1.95	14	231	\$666,116	\$266,673	\$283,581	\$155,302	-\$128,279	-45%	1.06	0.58	1%
Specialty Hospital - Tallahassee	1.90	2	26	\$66,383	\$34,216	\$30,446	\$22,469	-\$7,977	-26%	0.89	0.66	0%
St Anthony's Hospital	1.46	924	5,268	\$31,979,968	\$7,675,180	\$8,258,221	\$8,542,741	\$284,520	3%	1.08	1.11	1%
St. Cloud Regional Center	1.10	256	1,064	\$8,980,224	\$1,760,829	\$1,039,020	\$1,074,315	\$35,296	3%	0.59	0.61	6%
St. John's Rehabilitation Hospital	1.70	20	247	\$606,884	\$283,904	\$165,037	\$165,626	\$590	0%	0.58	0.58	0%
St. Joseph's Hospital	1.12	9,953	46,139	\$282,697,919	\$74,000,414	\$70,555,394	\$64,635,094	-\$5,920,300	-8%	0.95	0.87	6%
St. Lukes- St. Vincent's Healthcare	0.71	998	3,759	\$15,199,270	\$3,941,180	\$2,635,295	\$2,552,959	-\$82,335	-3%	0.67	0.65	2%
St. Mary's Hospital	0.98	7,537	41,499	\$271,801,318	\$53,867,876	\$49,676,770	\$46,342,348	-\$3,334,423	-7%	0.92	0.86	9%
St. Petersburg General Hospital	0.72	1,547	5,518	\$51,241,717	\$7,744,312	\$6,804,577	\$7,457,975	\$653,398	10%	0.88	0.96	7%
St. Vincent's Hospital	0.92	2,557	10,680	\$52,750,273	\$14,349,503	\$12,137,951	\$13,372,134	\$1,234,183	10%	0.85	0.93	3%
St.Catherine's Rehabilitation Hospital	1.65	97	1,441	\$3,461,424	\$1,436,979	\$799,060	\$746,213	-\$52,847	-7%	0.56	0.52	0%
St.Lucie Medical Center	0.63	1,918	6,374	\$45,503,591	\$7,886,811	\$7,418,245	\$8,570,924	\$1,152,678	16%	0.94	1.09	1%
Tallahassee Memorial Regional Medical Center	1.09	4,234	20,475	\$89,047,365	\$28,716,503	\$24,224,287	\$27,684,706	\$3,460,419	14%	0.84	0.96	4%
Tampa General Hospital	1.21	11,048	61,012	\$481,408,559	\$113,524,076	\$113,561,049	\$110,202,754	-\$3,358,295	-3%	1.00	0.97	9%
The Villages Regional Hospital	1.26	365	1,542	\$10,650,935	\$2,817,113	\$2,001,945	\$1,710,185	-\$291,760	-15%	0.71	0.61	3%
Town and Country Hospital	0.97	390	1,753	\$11,253,666	\$1,993,019	\$2,915,427	\$2,650,973	-\$264,454	-9%	1.46	1.33	1%
Tri-County Hospital Williston	0.63	187	445	\$1,145,397	\$552,570	\$385,399	\$692,311	\$306,912	80%	0.70	1.25	0%
U.S.A Children's & Women's Hospital	1.07	23	105	\$197,687	\$107,037	\$73,320	\$88,391	\$15,071	21%	0.68	0.83	0%
UCHLTACH at Connerton	1.35	4	56	\$173,508	\$84,469	\$44,975	\$31,945	-\$13,030	-29%	0.53	0.38	0%
University Community Hospital Carrollwood	1.36	240	974	\$7,795,019	\$1,808,840	\$1,611,822	\$1,626,596	\$14,775	1%	0.89	0.90	0%
University Community Hospital-Tampa	1.07	2,030	9,681	\$58,054,936	\$10,474,655	\$11,422,394	\$11,550,948	\$128,554	1%	1.09	1.10	1%
University Hospital & Medical Center	0.90	838	3,499	\$28,918,104	\$4,450,862	\$1,763,505	\$2,840,103	\$1,076,598	61%	0.40	0.64	7%
University of Miami Hospital	1.62	95	389	\$5,607,940	\$1,611,030	\$1,076,514	\$792,542	-\$283,972	-26%	0.67	0.49	4%
University of South Alabama Medical Center	2.03	19	120	\$372,598	\$147,302	\$99,669	\$138,548	\$38,879	39%	0.68	0.94	1%
Venice Hospital	2.02	269	1,851	\$17,138,813	\$3,373,510	\$1,241,598	\$2,270,638	\$1,029,040	83%	0.37	0.67	14%
Viera Hospital	1.42	14	69	\$452,080	\$228,011	\$96,536	\$93,761	-\$2,775	-3%	0.42	0.41	24%
Volusia Medical Center	1.43	604	2,606	\$16,975,088	\$4,388,234	\$4,694,951	\$4,404,666	-\$290,285	-6%	1.07	1.00	1%
Wellington Regional Medical Center	0.83	2,510	10,107	\$51,776,292	\$12,145,857	\$9,977,874	\$10,203,330	\$225,456	2%	0.82	0.84	2%
West Boca Medical Center.	0.76	1,951	8,563	\$45,014,071	\$12,533,853	\$7,202,173	\$7,729,779	\$527,606	7%	0.57	0.62	17%

Provider Name	APR-DRG Casemix Re-centered	Stays	Days	Charges	Estimated Cost	Baseline Payment	Simulated Payment	Payment Change	Percent Payment Change	Baseline Pay-to-Cost	Simulated Pay-to-Cost	Simulated Outlier Percentage
West Florida Regional Medical Center	1.09	1,567	6,539	\$57,815,837	\$8,957,432	\$4,260,389	\$6,423,656	\$2,163,267	51%	0.48	0.72	3%
West Gables Rehabilitation	1.14	59	637	\$1,065,564	\$529,138	\$271,203	\$291,909	\$20,706	8%	0.51	0.55	0%
West Kendall	0.98	60	200	\$2,326,017	\$630,155	\$196,236	\$241,889	\$45,653	23%	0.31	0.38	13%
Westchester General Hospital	0.91	1,035	5,161	\$17,500,183	\$5,475,379	\$4,231,883	\$5,376,342	\$1,144,459	27%	0.77	0.98	2%
Westside Regional Medical Center.	1.49	442	2,076	\$28,886,014	\$4,258,541	\$1,843,543	\$2,822,178	\$978,635	53%	0.43	0.66	16%
Winter Haven Hospital	0.74	2,504	9,489	\$52,188,129	\$12,016,459	\$12,893,359	\$13,694,684	\$801,325	6%	1.07	1.14	1%
Wiregrass Hospital	0.79	45	139	\$338,756	\$170,593	\$61,669	\$124,692	\$63,023	102%	0.36	0.73	0%
Wuesthoff Medical Center Melbourne	0.75	708	2,569	\$12,527,019	\$3,181,325	\$2,049,900	\$2,009,929	-\$39,971	-2%	0.64	0.63	6%
Wuesthoff Memorial Hospital	0.86	1,353	5,865	\$23,687,865	\$4,325,682	\$3,898,604	\$4,147,059	\$248,454	6%	0.90	0.96	1%
Totals		418,007	1,892,597	\$12,730,050,330	\$3,083,405,860	\$2,805,235,667	\$2,791,004,718	\$(14,230,949)	-1%	0.91	0.91	7.5%

Appendix G – APR-DRGs

The table in this section shows a list of APR-DRGs including relative weights, average lengths of stay, prevalence in the DRG simulation dataset and payment levels.

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
001-1	Liver &/or Intest Transpl	9.26	7.05	7.2	1	8	\$180,233	\$20,914	\$78,831
001-2	Liver &/or Intest Transpl	10.19	7.76	8.02	1	6	\$194,868	\$15,685	\$86,715
001-3	Liver &/or Intest Transpl	12.84	9.78	12.14	5	153	\$2,778,848	\$392,980	\$895,816
001-4	Liver &/or Intest Transpl	24.25	18.46	28.68	10	206	\$4,600,081	\$512,851	\$1,933,911
002-1	Heart &/or Lung Transpl	13.47	10.25	10.3	0	0	\$0	\$0	\$0
002-2	Heart &/or Lung Transpl	14.97	11.40	13.34	1	192	\$1,166,552	\$449,975	\$375,222
002-3	Heart &/or Lung Transpl	20.34	15.49	22.13	3	483	\$5,361,618	\$1,161,462	\$1,304,918
002-4	Heart &/or Lung Transpl	31.01	23.61	38.33	2	463	\$7,544,423	\$1,144,812	\$1,669,318
003-1	Bone Marrow Transpl	7.22	5.50	16.81	43	1,068	\$11,025,671	\$2,626,437	\$2,949,151
003-2	Bone Marrow Transpl	10.11	7.69	22.52	35	841	\$9,586,892	\$2,078,726	\$2,777,935
003-3	Bone Marrow Transpl	17.03	12.97	34.36	10	313	\$3,202,312	\$738,217	\$1,051,254
003-4	Bone Marrow Transpl	29.59	22.53	51.49	6	233	\$3,969,119	\$457,895	\$1,406,680
004-1	Trach, MV 96+ Hrs, w Ext Proc	8.12	6.18	17.7	3	265	\$2,585,055	\$544,724	\$567,972
004-2	Trach, MV 96+ Hrs, w Ext Proc	10.41	7.92	20.45	8	198	\$2,418,691	\$346,646	\$568,522
004-3	Trach, MV 96+ Hrs, w Ext Proc	13.81	10.51	26.82	60	1,918	\$26,837,918	\$3,743,944	\$6,998,731
004-4	Trach, MV 96+ Hrs, w Ext Proc	20.80	15.84	38.37	271	11,156	\$157,235,899	\$20,869,766	\$42,493,298
005-1	Trach, MV 96+ Hrs, w/o Ext Proc	6.61	5.03	19.04	6	172	\$1,671,922	\$277,370	\$269,443
005-2	Trach, MV 96+ Hrs, w/o Ext Proc	7.92	6.03	18.52	11	410	\$3,382,696	\$783,336	\$660,525
005-3	Trach, MV 96+ Hrs, w/o Ext Proc	9.74	7.42	23.71	97	2,786	\$28,399,160	\$4,641,713	\$6,417,260
005-4	Trach, MV 96+ Hrs, w/o Ext Proc	14.49	11.03	31.61	252	9,270	\$116,913,298	\$14,767,156	\$25,705,902
006-1	Pancreas Transpl	8.24	6.28	5.88	0	0	\$0	\$0	\$0
006-2	Pancreas Transpl	10.71	8.16	7.87	0	0	\$0	\$0	\$0
006-3	Pancreas Transpl	12.15	9.25	9.79	0	0	\$0	\$0	\$0
006-4	Pancreas Transpl	19.02	14.48	22.86	0	0	\$0	\$0	\$0
020-1	Craniotomy for Trauma	2.41	1.83	5.17	29	123	\$1,615,017	\$243,112	\$474,882

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
020-2	Craniotomy for Trauma	3.40	2.59	6.36	17	140	\$1,980,367	\$263,791	\$420,593
020-3	Craniotomy for Trauma	5.14	3.91	10.91	48	616	\$8,104,456	\$1,110,356	\$1,645,860
020-4	Craniotomy for Trauma	10.50	7.99	20.44	61	1,258	\$20,381,742	\$2,367,452	\$4,787,654
021-1	Craniotomy Exc for Trauma	2.66	2.02	3.92	163	978	\$12,884,763	\$1,934,259	\$3,152,791
021-2	Craniotomy Exc for Trauma	3.62	2.76	5.82	264	1,860	\$28,317,920	\$3,675,299	\$6,808,100
021-3	Craniotomy Exc for Trauma	5.80	4.42	10.83	169	1,989	\$25,762,136	\$3,868,777	\$6,753,014
021-4	Craniotomy Exc for Trauma	11.36	8.65	21.09	134	2,850	\$42,780,117	\$5,709,304	\$11,560,360
022-1	Ventricular Shunt Procs	1.58	1.21	2.66	137	403	\$5,235,901	\$812,386	\$1,530,421
022-2	Ventricular Shunt Procs	2.37	1.80	5.09	212	1,120	\$13,027,726	\$2,358,898	\$3,764,007
022-3	Ventricular Shunt Procs	5.44	4.14	12.1	130	1,547	\$17,060,290	\$3,148,574	\$5,030,317
022-4	Ventricular Shunt Procs	11.44	8.71	23.96	91	2,025	\$25,934,240	\$4,149,581	\$7,605,180
023-1	Spinal Procs	1.88	1.43	3.08	63	306	\$3,866,174	\$564,807	\$780,436
023-2	Spinal Procs	2.75	2.09	5.5	96	618	\$7,390,452	\$1,233,022	\$1,911,602
023-3	Spinal Procs	5.54	4.22	9.89	83	999	\$12,950,713	\$1,690,405	\$2,900,814
023-4	Spinal Procs	10.38	7.90	20.05	24	750	\$10,586,700	\$1,285,976	\$2,140,565
024-1	Extracranial Vascular Procs	1.39	1.06	1.45	102	240	\$6,228,534	\$430,411	\$951,555
024-2	Extracranial Vascular Procs	1.93	1.47	2.66	104	578	\$9,751,998	\$1,038,531	\$1,586,093
024-3	Extracranial Vascular Procs	4.03	3.07	7.35	94	976	\$13,539,550	\$1,790,312	\$2,661,166
024-4	Extracranial Vascular Procs	8.82	6.72	15.27	26	517	\$8,446,765	\$790,077	\$1,887,148
026-1	Oth Nerv Sys & Related Procs	1.71	1.30	2.37	99	258	\$4,117,332	\$484,017	\$1,160,260
026-2	Oth Nerv Sys & Related Procs	2.37	1.81	4.01	53	317	\$3,754,956	\$502,444	\$798,863
026-3	Oth Nerv Sys & Related Procs	3.63	2.76	8.15	48	745	\$5,435,522	\$1,441,784	\$1,324,002
026-4	Oth Nerv Sys & Related Procs	8.07	6.15	19.33	9	176	\$2,267,755	\$273,010	\$513,123
040-1	Spinal Dis & Injuries	1.28	0.97	3.56	8	18	\$301,154	\$26,668	\$51,638
040-2	Spinal Dis & Injuries	1.52	1.16	4.68	16	92	\$639,369	\$150,095	\$147,409
040-3	Spinal Dis & Injuries	2.17	1.65	7.24	15	217	\$1,789,077	\$333,544	\$217,761
040-4	Spinal Dis & Injuries	5.99	4.56	15.96	4	64	\$338,029	\$93,908	\$129,378
041-1	Nervous Sys Malign	1.05	0.80	2.71	41	126	\$976,842	\$200,218	\$256,975
041-2	Nervous Sys Malign	1.12	0.85	3.73	155	662	\$5,105,719	\$1,073,925	\$1,044,855
041-3	Nervous Sys Malign	1.62	1.24	5.88	153	1,111	\$8,268,940	\$2,014,639	\$1,623,069

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
041-4	Nervous Sys Malig	3.27	2.49	10.11	26	437	\$3,824,463	\$866,008	\$846,622
042-1	Degen Nerv Sys Dis Exc Ms	0.76	0.58	4.11	58	174	\$1,722,346	\$286,127	\$299,740
042-2	Degen Nerv Sys Dis Exc Ms	0.94	0.72	7.57	103	503	\$3,307,404	\$893,646	\$580,369
042-3	Degen Nerv Sys Dis Exc Ms	1.44	1.10	8.02	49	463	\$3,516,694	\$853,739	\$527,647
042-4	Degen Nerv Sys Dis Exc Ms	4.01	3.06	12.36	15	320	\$2,633,446	\$768,507	\$645,789
043-1	Mult Sclerosis	1.06	0.81	3.46	149	537	\$4,175,253	\$928,857	\$970,712
043-2	Mult Sclerosis	1.29	0.98	4.45	107	463	\$3,665,559	\$797,755	\$840,788
043-3	Mult Sclerosis	2.15	1.64	7.22	17	153	\$1,197,986	\$298,546	\$233,854
043-4	Mult Sclerosis	4.95	3.77	12.06	1	20	\$225,787	\$44,786	\$37,249
044-1	Intracranial Hemorrhage	1.14	0.86	3.58	61	309	\$2,492,386	\$493,823	\$435,494
044-2	Intracranial Hemorrhage	1.53	1.16	4.91	98	741	\$6,037,674	\$1,296,243	\$962,576
044-3	Intracranial Hemorrhage	2.31	1.76	6.69	189	1,469	\$15,099,498	\$2,523,801	\$2,870,793
044-4	Intracranial Hemorrhage	5.08	3.86	13.62	110	1,407	\$17,064,537	\$2,442,826	\$3,996,337
045-1	CVA & Precereb Occl w Infarct	0.98	0.75	2.76	363	1,234	\$12,313,621	\$2,045,926	\$2,157,239
045-2	CVA & Precereb Occl w Infarct	1.19	0.90	3.84	1,025	5,261	\$45,108,891	\$8,495,915	\$7,505,232
045-3	CVA & Precereb Occl w Infarct	1.78	1.36	6.18	446	3,821	\$31,854,510	\$6,164,420	\$4,858,248
045-4	CVA & Precereb Occl w Infarct	4.09	3.11	12.42	130	1,899	\$18,155,571	\$2,924,618	\$3,363,545
046-1	Nonspec CVA w/o Infarct	0.93	0.71	2.39	19	61	\$667,030	\$92,160	\$103,411
046-2	Nonspec CVA w/o Infarct	1.09	0.83	3.2	54	233	\$2,235,009	\$389,938	\$353,831
046-3	Nonspec CVA w/o Infarct	1.50	1.14	4.77	11	49	\$476,230	\$78,286	\$96,815
046-4	Nonspec CVA w/o Infarct	2.57	1.96	8.88	1	11	\$162,161	\$17,760	\$16,073
047-1	Transient Ischemia	0.79	0.60	1.88	261	552	\$6,690,388	\$855,564	\$1,214,435
047-2	Transient Ischemia	0.85	0.65	2.48	351	923	\$9,853,675	\$1,354,273	\$1,695,987
047-3	Transient Ischemia	1.12	0.85	3.67	59	223	\$2,156,924	\$338,563	\$384,078
047-4	Transient Ischemia	2.44	1.86	8.35	4	37	\$253,958	\$61,338	\$58,998
048-1	Nerve Disorders	0.80	0.61	2.63	375	1,092	\$9,649,283	\$1,731,601	\$1,879,679
048-2	Nerve Disorders	0.92	0.70	3.67	464	1,960	\$13,857,857	\$3,135,613	\$2,546,191
048-3	Nerve Disorders	1.27	0.97	5.04	161	1,013	\$7,230,740	\$1,576,195	\$1,257,721
048-4	Nerve Disorders	3.42	2.60	12.38	6	94	\$1,229,792	\$144,120	\$183,625
049-1	Bact & Tub Inf of Nervous Sys	1.25	0.95	5.71	15	119	\$438,544	\$226,828	\$116,856

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
049-2	Bact & Tub Inf of Nervous Sys	2.55	1.94	6.66	65	683	\$5,100,528	\$1,224,288	\$1,172,459
049-3	Bact & Tub Inf of Nervous Sys	3.32	2.53	10.42	44	590	\$4,167,430	\$1,040,281	\$902,693
049-4	Bact & Tub Inf of Nervous Sys	5.84	4.45	15.72	18	395	\$4,907,998	\$637,796	\$949,916
050-1	Non-Bact Inf of Nerv Sys	0.86	0.66	3.79	30	135	\$1,005,586	\$253,166	\$172,621
050-2	Non-Bact Inf of Nerv Sys	1.49	1.13	5.37	54	380	\$2,327,102	\$661,897	\$513,143
050-3	Non-Bact Inf of Nerv Sys	2.52	1.92	8.82	39	517	\$4,144,302	\$981,171	\$769,309
050-4	Non-Bact Inf of Nerv Sys	6.19	4.71	16.59	15	207	\$2,056,505	\$336,916	\$552,467
051-1	Viral Meningitis	0.67	0.51	2.55	238	694	\$4,315,222	\$1,227,879	\$1,025,491
051-2	Viral Meningitis	0.98	0.75	3.61	106	495	\$3,053,429	\$841,026	\$650,346
051-3	Viral Meningitis	1.81	1.38	6.31	19	127	\$1,049,492	\$185,289	\$188,896
051-4	Viral Meningitis	4.46	3.40	12.43	4	61	\$457,746	\$88,665	\$92,486
052-1	Nontraumatic Stupor & Coma	0.74	0.57	2.01	59	122	\$882,411	\$235,183	\$299,170
052-2	Nontraumatic Stupor & Coma	0.88	0.67	3.07	104	341	\$2,774,526	\$565,159	\$598,215
052-3	Nontraumatic Stupor & Coma	1.27	0.97	4.98	219	1,182	\$8,683,949	\$1,868,129	\$1,690,896
052-4	Nontraumatic Stupor & Coma	3.49	2.66	11.14	34	467	\$4,624,096	\$793,469	\$923,835
053-1	Seizure	0.67	0.51	2.23	1,704	3,593	\$28,276,048	\$6,226,484	\$7,096,301
053-2	Seizure	0.82	0.62	2.8	1,705	4,764	\$37,560,587	\$8,383,471	\$8,794,954
053-3	Seizure	1.22	0.93	4.17	1,006	4,117	\$35,114,176	\$8,077,755	\$8,796,945
053-4	Seizure	3.27	2.49	9.16	115	1,439	\$14,621,894	\$2,815,369	\$3,184,251
054-1	Migraine & Oth Headaches	0.70	0.53	2.29	467	1,024	\$9,965,569	\$1,735,000	\$2,010,678
054-2	Migraine & Oth Headaches	0.83	0.63	2.73	380	1,088	\$9,667,774	\$1,818,027	\$1,945,918
054-3	Migraine & Oth Headaches	1.14	0.87	3.86	62	258	\$2,056,643	\$501,477	\$461,182
054-4	Migraine & Oth Headaches	1.95	1.48	7.18	3	10	\$86,942	\$22,208	\$36,893
055-1	Head Trauma w Coma >1 Hr	0.88	0.67	2.14	140	308	\$3,111,917	\$554,237	\$760,402
055-2	Head Trauma w Coma >1 Hr	1.23	0.93	3.45	110	440	\$3,854,711	\$748,703	\$807,663
055-3	Head Trauma w Coma >1 Hr	2.08	1.58	5.95	101	588	\$5,171,402	\$1,041,530	\$1,284,412
055-4	Head Trauma w Coma >1 Hr	4.96	3.77	13.27	52	597	\$6,268,454	\$1,131,031	\$1,724,006
056-1	Complic Skull Fx, Coma <1 Hr	0.93	0.71	2.19	43	114	\$1,111,988	\$216,468	\$273,437
056-2	Complic Skull Fx, Coma <1 Hr	1.33	1.02	3.44	42	228	\$1,567,154	\$386,139	\$352,736
056-3	Complic Skull Fx, Coma <1 Hr	2.20	1.67	5.98	22	166	\$1,449,654	\$352,545	\$336,560

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
056-4	Complic Skull Fx, Coma <1 Hr	5.65	4.30	14.12	15	299	\$2,713,934	\$631,891	\$664,843
057-1	Uncomplic Head Trauma	0.88	0.67	1.44	219	341	\$3,317,118	\$651,053	\$1,205,102
057-2	Uncomplic Head Trauma	1.14	0.87	2.3	99	254	\$3,049,349	\$491,550	\$717,752
057-3	Uncomplic Head Trauma	1.73	1.31	4.19	14	79	\$749,653	\$129,896	\$155,333
057-4	Uncomplic Head Trauma	4.40	3.35	10.61	3	66	\$353,525	\$102,219	\$79,888
058-1	Oth Dis of Nervous Sys	0.84	0.64	2.61	542	1,315	\$12,301,449	\$2,364,033	\$2,846,687
058-2	Oth Dis of Nervous Sys	1.05	0.80	3.7	349	1,266	\$10,894,125	\$2,147,117	\$2,241,541
058-3	Oth Dis of Nervous Sys	1.47	1.12	5.38	120	867	\$6,178,438	\$1,622,424	\$1,213,625
058-4	Oth Dis of Nervous Sys	3.68	2.80	11.33	25	381	\$2,889,267	\$636,860	\$635,760
070-1	Orbital Procs	1.14	0.86	2	17	36	\$565,639	\$71,659	\$123,534
070-2	Orbital Procs	1.68	1.28	3.63	24	96	\$1,150,126	\$196,461	\$259,295
070-3	Orbital Procs	2.78	2.12	5.59	8	55	\$630,916	\$118,838	\$166,893
070-4	Orbital Procs	5.62	4.28	11.76	0	0	\$0	\$0	\$0
073-1	Eye Procs Exc Orbit	0.99	0.76	2.16	27	68	\$844,670	\$142,008	\$189,667
073-2	Eye Procs Exc Orbit	1.27	0.97	2.93	17	75	\$605,055	\$144,526	\$144,218
073-3	Eye Procs Exc Orbit	2.36	1.80	6.32	2	8	\$53,223	\$13,692	\$29,265
073-4	Eye Procs Exc Orbit	6.54	4.98	13.53	2	48	\$358,083	\$93,281	\$94,962
080-1	Acute Maj Eye Inf	0.53	0.40	2.81	74	218	\$1,110,475	\$381,046	\$251,384
080-2	Acute Maj Eye Inf	0.77	0.59	3.79	45	225	\$1,202,153	\$465,493	\$248,728
080-3	Acute Maj Eye Inf	1.31	0.99	5.7	9	83	\$737,876	\$146,532	\$77,116
080-4	Acute Maj Eye Inf	3.22	2.45	10.17	0	0	\$0	\$0	\$0
082-1	Eye Dis Exc Maj Inf	0.65	0.49	2.25	152	375	\$2,199,219	\$653,586	\$608,725
082-2	Eye Dis Exc Maj Inf	0.84	0.64	2.66	128	374	\$2,627,028	\$689,675	\$662,992
082-3	Eye Dis Exc Maj Inf	1.15	0.87	4.1	21	138	\$1,340,832	\$251,723	\$207,301
082-4	Eye Dis Exc Maj Inf	3.84	2.92	12.31	4	41	\$469,944	\$98,835	\$149,798
089-1	Maj Cranial/Facial Bone Procs	2.01	1.53	2.24	78	244	\$4,716,147	\$509,532	\$1,119,296
089-2	Maj Cranial/Facial Bone Procs	2.65	2.02	3.71	70	286	\$4,779,863	\$615,871	\$1,389,803
089-3	Maj Cranial/Facial Bone Procs	4.80	3.65	8.07	48	550	\$7,462,533	\$1,194,112	\$1,848,213
089-4	Maj Cranial/Facial Bone Procs	11.06	8.42	19.56	6	86	\$2,083,970	\$182,357	\$592,450
090-1	Maj Larynx & Trachea Procs	1.10	0.84	2.49	10	18	\$191,308	\$37,238	\$79,702

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
090-2	Maj Larynx & Trachea Procs	3.10	2.36	7.84	45	429	\$4,238,020	\$898,890	\$963,731
090-3	Maj Larynx & Trachea Procs	5.02	3.82	13.14	18	198	\$1,997,876	\$437,127	\$610,640
090-4	Maj Larynx & Trachea Procs	10.74	8.18	25.92	2	43	\$423,137	\$77,442	\$134,717
091-1	Oth Maj Head & Neck Procs	1.86	1.41	3.07	15	54	\$987,669	\$123,594	\$188,984
091-2	Oth Maj Head & Neck Procs	2.87	2.18	4.53	22	126	\$1,730,847	\$253,163	\$395,493
091-3	Oth Maj Head & Neck Procs	5.08	3.87	9.47	2	55	\$497,202	\$49,860	\$47,366
091-4	Oth Maj Head & Neck Procs	8.63	6.57	17.43	2	53	\$653,998	\$102,761	\$151,118
092-1	Facial Bone Procs Exc Major	1.42	1.08	2	104	256	\$4,569,225	\$508,701	\$998,562
092-2	Facial Bone Procs Exc Major	2.00	1.52	2.88	60	261	\$3,808,961	\$485,047	\$792,734
092-3	Facial Bone Procs Exc Major	3.33	2.54	5.64	15	152	\$1,825,361	\$327,797	\$374,843
092-4	Facial Bone Procs Exc Major	7.20	5.48	14.81	6	117	\$1,144,935	\$241,087	\$305,882
093-1	Sinus & Mastoid Procs	1.35	1.02	2.25	30	126	\$1,289,395	\$235,752	\$253,413
093-2	Sinus & Mastoid Procs	1.81	1.38	3.54	27	217	\$1,970,944	\$416,039	\$332,647
093-3	Sinus & Mastoid Procs	3.10	2.36	7.77	7	57	\$496,459	\$131,047	\$158,224
093-4	Sinus & Mastoid Procs	4.36	3.32	11.44	1	11	\$111,596	\$14,920	\$24,341
095-1	Cleft Lip & Palate Repair	0.85	0.64	1.36	174	280	\$4,310,429	\$578,345	\$1,040,122
095-2	Cleft Lip & Palate Repair	1.05	0.80	1.88	38	78	\$1,061,691	\$163,008	\$275,744
095-3	Cleft Lip & Palate Repair	1.51	1.15	3.05	8	29	\$313,389	\$63,931	\$84,186
095-4	Cleft Lip & Palate Repair	2.89	2.20	5.85	2	9	\$177,671	\$17,384	\$39,465
097-1	Tonsil & Adenoid Procs	0.57	0.44	1.56	421	621	\$5,565,314	\$1,144,790	\$1,533,345
097-2	Tonsil & Adenoid Procs	0.93	0.71	2.63	124	359	\$3,039,238	\$666,465	\$726,953
097-3	Tonsil & Adenoid Procs	2.07	1.57	5.39	25	186	\$1,374,758	\$358,866	\$341,558
097-4	Tonsil & Adenoid Procs	6.47	4.92	14.79	7	89	\$966,018	\$185,550	\$301,819
098-1	Oth Ear, Nose Throat Procs	0.99	0.75	2.01	161	480	\$4,547,014	\$891,728	\$1,041,031
098-2	Oth Ear, Nose Throat Procs	1.35	1.03	3.08	96	492	\$4,191,509	\$897,811	\$825,270
098-3	Oth Ear, Nose Throat Procs	2.38	1.81	6.23	26	245	\$2,034,144	\$459,977	\$404,646
098-4	Oth Ear, Nose Throat Procs	5.07	3.86	13.71	11	234	\$2,387,936	\$434,576	\$414,951
110-1	Ear, Nose, Throat, Facial Malig	0.88	0.67	2.86	31	136	\$1,193,348	\$251,331	\$182,801
110-2	Ear, Nose, Throat, Facial Malig	1.11	0.84	3.97	77	425	\$2,881,765	\$729,095	\$521,013
110-3	Ear, Nose, Throat, Facial Malig	1.74	1.33	6.48	91	800	\$6,238,935	\$1,414,281	\$1,074,009

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
110-4	Ear, Nose, Throat, Facial Malig	3.57	2.72	12.07	31	465	\$4,418,233	\$882,127	\$844,175
111-1	Vertigo & Oth Labyrinth Dis	0.68	0.52	1.95	154	285	\$3,382,749	\$458,656	\$647,617
111-2	Vertigo & Oth Labyrinth Dis	0.75	0.57	2.43	132	303	\$3,294,022	\$472,148	\$607,413
111-3	Vertigo & Oth Labyrinth Dis	0.94	0.72	3.36	8	48	\$368,405	\$77,571	\$45,250
111-4	Vertigo & Oth Labyrinth Dis	1.98	1.51	7.58	0	0	\$0	\$0	\$0
113-1	Inf of Upper Resp Tract	0.38	0.29	1.83	1,099	2,296	\$12,409,614	\$4,065,181	\$2,670,874
113-2	Inf of Upper Resp Tract	0.57	0.43	2.39	1,031	2,726	\$16,077,235	\$4,969,841	\$3,827,317
113-3	Inf of Upper Resp Tract	1.01	0.77	3.68	253	1,079	\$6,816,122	\$2,171,090	\$1,752,148
113-4	Inf of Upper Resp Tract	2.49	1.90	7.19	25	139	\$1,265,373	\$293,747	\$439,536
114-1	Dental & Oral Conditions	0.59	0.45	2.16	232	557	\$3,525,538	\$962,273	\$864,242
114-2	Dental & Oral Conditions	0.84	0.64	2.86	147	488	\$3,204,832	\$829,599	\$750,951
114-3	Dental & Oral Conditions	1.46	1.11	5.36	64	359	\$2,541,464	\$674,514	\$609,975
114-4	Dental & Oral Conditions	3.55	2.70	11.03	5	88	\$841,935	\$197,891	\$197,780
115-1	Oth Ear, Nose, Throat Diags	0.61	0.46	2.17	265	610	\$4,364,272	\$1,052,703	\$994,255
115-2	Oth Ear, Nose, Throat Diags	0.87	0.66	2.87	218	700	\$5,167,441	\$1,350,917	\$1,288,776
115-3	Oth Ear, Nose, Throat Diags	1.27	0.96	4.64	71	650	\$3,931,848	\$1,267,531	\$683,620
115-4	Oth Ear, Nose, Throat Diags	2.97	2.26	9.14	10	103	\$1,022,774	\$229,363	\$232,247
120-1	Maj Resp & Chest Procs	2.22	1.69	4.73	61	383	\$4,468,866	\$671,598	\$866,897
120-2	Maj Resp & Chest Procs	2.77	2.11	6.65	99	1,015	\$10,431,544	\$1,748,360	\$1,733,664
120-3	Maj Resp & Chest Procs	4.30	3.27	11.24	85	1,564	\$15,839,554	\$2,896,056	\$2,961,715
120-4	Maj Resp & Chest Procs	8.01	6.10	19.18	47	1,300	\$14,629,067	\$2,157,153	\$2,922,343
121-1	Oth Resp & Chest Procs	1.51	1.15	3.25	83	387	\$3,712,439	\$736,111	\$844,503
121-2	Oth Resp & Chest Procs	2.03	1.55	5.3	191	1,604	\$14,732,248	\$2,809,330	\$2,607,930
121-3	Oth Resp & Chest Procs	3.51	2.68	10.19	162	2,126	\$19,920,409	\$3,713,432	\$3,893,016
121-4	Oth Resp & Chest Procs	7.52	5.73	18.5	65	1,747	\$18,792,622	\$2,777,238	\$3,775,606
130-1	Resp Sys Diag w MV 96+ Hrs	3.76	2.87	10.42	7	97	\$1,016,336	\$167,844	\$191,667
130-2	Resp Sys Diag w MV 96+ Hrs	4.17	3.18	11.5	100	1,589	\$17,839,252	\$2,705,996	\$3,423,342
130-3	Resp Sys Diag w MV 96+ Hrs	5.22	3.98	13.64	328	5,201	\$59,363,111	\$9,011,969	\$13,233,695
130-4	Resp Sys Diag w MV 96+ Hrs	7.41	5.64	18.11	281	5,124	\$60,218,291	\$8,874,045	\$14,727,031
131-1	Cystic Fibrosis - Pulmon Dis	1.79	1.36	6.52	53	454	\$3,219,777	\$1,013,034	\$686,988

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
131-2	Cystic Fibrosis - Pulmon Dis	2.32	1.77	8.42	215	2,215	\$14,969,819	\$4,718,875	\$3,463,675
131-3	Cystic Fibrosis - Pulmon Dis	3.02	2.30	10.62	130	1,540	\$10,774,935	\$3,007,485	\$2,653,754
131-4	Cystic Fibrosis - Pulmon Dis	3.95	3.01	13.87	37	495	\$3,465,495	\$875,569	\$917,645
132-1	Chronic Resp Dis Fm Perinatal	0.62	0.47	2.93	17	44	\$171,239	\$86,975	\$62,079
132-2	Chronic Resp Dis Fm Perinatal	0.80	0.61	3.6	72	320	\$1,842,249	\$543,578	\$374,689
132-3	Chronic Resp Dis Fm Perinatal	1.30	0.99	5.55	89	460	\$2,803,272	\$868,577	\$755,546
132-4	Chronic Resp Dis Fm Perinatal	2.53	1.92	8.1	44	600	\$5,396,179	\$1,294,997	\$1,274,572
133-1	Pulmon Edema & Resp Failure	0.73	0.56	2.48	9	16	\$117,842	\$36,259	\$50,481
133-2	Pulmon Edema & Resp Failure	1.02	0.77	4.14	449	2,134	\$16,722,999	\$3,621,522	\$2,997,035
133-3	Pulmon Edema & Resp Failure	1.56	1.18	5.62	489	3,187	\$27,515,945	\$5,172,292	\$4,866,552
133-4	Pulmon Edema & Resp Failure	2.77	2.11	7.61	596	4,926	\$52,647,149	\$8,346,686	\$11,253,145
134-1	Pulmonary Embolism	0.91	0.70	3.66	156	684	\$5,110,276	\$1,082,009	\$860,014
134-2	Pulmonary Embolism	1.19	0.90	4.59	393	2,031	\$15,385,009	\$3,176,974	\$2,805,786
134-3	Pulmonary Embolism	1.75	1.33	6.32	207	1,651	\$13,210,360	\$2,662,858	\$2,165,385
134-4	Pulmonary Embolism	3.19	2.43	10.16	45	426	\$5,906,021	\$715,302	\$1,115,609
135-1	Maj Chest & Resp Trauma	0.89	0.68	2.7	40	124	\$1,079,937	\$215,739	\$227,161
135-2	Maj Chest & Resp Trauma	1.13	0.86	3.55	68	286	\$2,262,676	\$508,427	\$498,439
135-3	Maj Chest & Resp Trauma	1.69	1.29	5.62	28	152	\$1,504,446	\$262,051	\$315,599
135-4	Maj Chest & Resp Trauma	3.22	2.45	8.44	13	103	\$1,312,313	\$163,052	\$346,023
136-1	Resp Malign	0.87	0.66	2.94	45	193	\$1,308,908	\$343,945	\$271,099
136-2	Resp Malign	1.16	0.88	4.2	322	1,714	\$13,526,004	\$2,946,345	\$2,290,161
136-3	Resp Malign	1.82	1.39	6.63	485	3,960	\$29,801,069	\$6,596,462	\$5,400,231
136-4	Resp Malign	2.95	2.24	10.12	83	761	\$6,969,540	\$1,406,286	\$1,574,091
137-1	Maj Resp Inf & Inflammations	0.85	0.65	4.29	105	1,395	\$2,990,354	\$1,477,939	\$1,085,070
137-2	Maj Resp Inf & Inflammations	1.15	0.87	5.23	342	2,129	\$12,912,331	\$3,592,072	\$2,436,693
137-3	Maj Resp Inf & Inflammations	1.74	1.32	7.19	430	3,984	\$26,205,809	\$6,522,196	\$4,721,826
137-4	Maj Resp Inf & Inflammations	3.01	2.29	10.27	212	2,904	\$26,024,345	\$4,930,387	\$4,897,106
138-1	Bronchiolitis & RSV Pneumonia	0.40	0.30	2.29	1,810	4,593	\$20,926,983	\$8,128,086	\$4,681,233
138-2	Bronchiolitis & RSV Pneumonia	0.55	0.42	3.02	1,014	3,467	\$16,476,966	\$6,397,361	\$3,649,912
138-3	Bronchiolitis & RSV Pneumonia	1.23	0.94	5.27	163	911	\$5,262,052	\$1,850,513	\$1,358,114

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
138-4	Bronchiolitis & RSV Pneumonia	2.82	2.15	8.52	18	382	\$4,217,029	\$912,779	\$890,622
139-1	Oth Pneumonia	0.54	0.41	2.62	2,259	6,372	\$37,344,115	\$10,884,720	\$7,688,860
139-2	Oth Pneumonia	0.79	0.60	3.68	3,410	12,369	\$80,803,731	\$21,128,800	\$16,953,988
139-3	Oth Pneumonia	1.33	1.01	5.54	1,292	7,964	\$59,477,574	\$13,715,255	\$10,923,355
139-4	Oth Pneumonia	2.63	2.00	9.12	235	2,506	\$22,292,296	\$4,445,538	\$4,459,472
140-1	COPD	0.66	0.50	3.07	1,639	5,267	\$35,552,130	\$7,822,980	\$6,248,909
140-2	COPD	0.85	0.64	3.77	2,599	9,963	\$69,225,343	\$14,874,387	\$12,667,209
140-3	COPD	1.20	0.91	5.06	1,183	6,614	\$47,794,582	\$9,522,563	\$8,044,384
140-4	COPD	2.49	1.89	8.69	112	1,185	\$9,796,598	\$1,864,537	\$1,922,482
141-1	Asthma	0.49	0.37	2.08	2,776	6,108	\$35,781,917	\$10,581,066	\$8,620,742
141-2	Asthma	0.70	0.53	2.93	1,326	4,162	\$26,969,832	\$7,199,819	\$5,851,956
141-3	Asthma	1.09	0.83	4.21	203	1,011	\$7,190,970	\$1,678,220	\$1,380,348
141-4	Asthma	2.06	1.57	5.5	27	219	\$2,144,407	\$427,386	\$525,899
142-1	Interstitial & Alveolar Lung Dis	0.84	0.64	3.18	50	161	\$1,063,519	\$259,176	\$251,793
142-2	Interstitial & Alveolar Lung Dis	1.04	0.79	4.06	103	455	\$3,036,641	\$778,457	\$663,318
142-3	Interstitial & Alveolar Lung Dis	1.55	1.18	6.06	71	548	\$3,941,748	\$930,279	\$707,405
142-4	Interstitial & Alveolar Lung Dis	2.99	2.28	10.38	12	170	\$1,433,077	\$284,848	\$369,289
143-1	Oth Resp Diags Exc Minor	0.59	0.45	2.72	226	584	\$3,406,294	\$997,368	\$829,419
143-2	Oth Resp Diags Exc Minor	0.94	0.72	3.65	438	1,794	\$12,460,625	\$3,094,052	\$2,579,544
143-3	Oth Resp Diags Exc Minor	1.52	1.16	5.49	274	1,814	\$12,738,096	\$3,378,299	\$2,726,822
143-4	Oth Resp Diags Exc Minor	2.60	1.98	8.12	111	1,069	\$9,623,320	\$2,039,392	\$2,185,852
144-1	Resp Symptoms & Minor Diags	0.59	0.45	2.08	658	1,375	\$11,046,661	\$2,191,602	\$2,334,246
144-2	Resp Symptoms & Minor Diags	0.74	0.56	2.88	656	1,903	\$14,888,024	\$3,122,860	\$2,942,398
144-3	Resp Symptoms & Minor Diags	1.09	0.83	4.11	287	1,480	\$11,046,840	\$2,704,852	\$2,145,211
144-4	Resp Symptoms & Minor Diags	2.32	1.77	7.47	33	270	\$2,322,701	\$539,910	\$566,952
160-1	Maj Repair of Heart Anomaly	3.99	3.04	4.34	15	98	\$2,132,484	\$218,710	\$441,664
160-2	Maj Repair of Heart Anomaly	5.01	3.82	6.15	43	391	\$8,621,290	\$882,220	\$1,904,356
160-3	Maj Repair of Heart Anomaly	6.84	5.21	9.26	90	1,453	\$26,204,130	\$3,242,244	\$6,649,183
160-4	Maj Repair of Heart Anomaly	15.49	11.79	24.44	22	610	\$8,241,325	\$1,343,691	\$2,776,065
161-1	Defib & Heart Assist Implant	5.55	4.23	2.96	300	1,459	\$41,103,788	\$2,430,420	\$10,245,408

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
161-2	Defib & Heart Assist Implant	7.44	5.67	7.76	151	1,442	\$26,839,860	\$2,403,820	\$7,023,322
161-3	Defib & Heart Assist Implant	11.81	8.99	15.83	50	791	\$15,483,816	\$1,391,968	\$3,925,593
161-4	Defib & Heart Assist Implant	29.09	22.15	31.96	3	83	\$1,902,480	\$211,878	\$622,727
162-1	Cardiac Valve Procs w Cath	5.73	4.36	8.07	8	66	\$1,441,170	\$128,001	\$312,243
162-2	Cardiac Valve Procs w Cath	6.55	4.99	9.12	22	265	\$4,372,129	\$465,926	\$927,609
162-3	Cardiac Valve Procs w Cath	8.75	6.66	13.29	71	1,264	\$19,394,287	\$2,220,556	\$4,266,580
162-4	Cardiac Valve Procs w Cath	13.75	10.47	21.57	41	1,172	\$21,135,087	\$1,936,360	\$4,279,370
163-1	Cardiac Valve Procs w/o Cath	4.76	3.62	5.38	31	186	\$4,304,341	\$395,934	\$1,028,134
163-2	Cardiac Valve Procs w/o Cath	5.31	4.04	6.28	46	356	\$7,561,188	\$640,727	\$1,579,233
163-3	Cardiac Valve Procs w/o Cath	7.12	5.42	9.22	80	853	\$15,396,092	\$1,594,630	\$3,845,111
163-4	Cardiac Valve Procs w/o Cath	12.59	9.58	18.58	45	1,327	\$23,038,761	\$2,301,002	\$4,484,551
165-1	Coronary Bypass w Cath	4.55	3.46	6.65	23	179	\$3,524,426	\$313,510	\$668,779
165-2	Coronary Bypass w Cath	5.27	4.01	8.04	227	2,131	\$40,141,110	\$3,397,794	\$7,219,180
165-3	Coronary Bypass w Cath	6.63	5.05	10.37	188	2,236	\$39,575,883	\$3,694,421	\$7,824,726
165-4	Coronary Bypass w Cath	10.72	8.17	17.45	64	1,338	\$23,829,828	\$2,339,460	\$5,038,741
166-1	Coronary Bypass w/o Cath	3.57	2.72	4.91	28	170	\$2,859,975	\$310,581	\$647,725
166-2	Coronary Bypass w/o Cath	4.05	3.08	5.91	123	919	\$16,772,924	\$1,607,793	\$3,277,638
166-3	Coronary Bypass w/o Cath	5.37	4.09	8.44	76	799	\$13,715,439	\$1,292,100	\$2,450,153
166-4	Coronary Bypass w/o Cath	9.38	7.15	15.88	28	597	\$9,928,980	\$1,063,963	\$2,306,223
167-1	Oth Cardiothoracic Procs	3.61	2.75	4.21	47	195	\$4,677,610	\$390,157	\$1,146,388
167-2	Oth Cardiothoracic Procs	4.29	3.27	5.43	25	178	\$3,428,542	\$358,701	\$768,902
167-3	Oth Cardiothoracic Procs	5.90	4.49	9.06	53	534	\$8,306,710	\$1,052,434	\$2,321,098
167-4	Oth Cardiothoracic Procs	10.85	8.26	18.13	18	409	\$5,305,251	\$845,787	\$1,481,376
169-1	Maj Vascular Procs	2.17	1.65	4.21	14	82	\$1,376,326	\$149,832	\$201,786
169-2	Maj Vascular Procs	2.99	2.28	5.51	61	462	\$5,462,132	\$832,851	\$1,138,480
169-3	Maj Vascular Procs	4.88	3.71	9.21	54	742	\$10,471,023	\$1,345,075	\$2,245,324
169-4	Maj Vascular Procs	9.52	7.25	17.85	33	808	\$11,577,655	\$1,600,044	\$2,831,587
170-1	Pacemaker Impl w AMI or Shock	2.92	2.22	3.79	0	0	\$0	\$0	\$0
170-2	Pacemaker Impl w AMI or Shock	3.20	2.43	5.13	7	34	\$991,745	\$51,927	\$148,921
170-3	Pacemaker Impl w AMI or Shock	3.99	3.04	8.76	5	45	\$597,088	\$63,573	\$122,921

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
170-4	Pacemaker Impl w/ AMI or Shock	6.95	5.29	16.33	4	80	\$836,232	\$132,042	\$176,217
171-1	Pacemaker Impl w/o AMI or Shock	2.06	1.57	2.46	66	196	\$3,764,748	\$339,210	\$851,205
171-2	Pacemaker Impl w/o AMI or Shock	2.43	1.85	3.81	76	365	\$5,893,179	\$595,552	\$1,099,253
171-3	Pacemaker Impl w/o AMI or Shock	3.20	2.43	6.4	35	308	\$4,041,131	\$589,188	\$743,985
171-4	Pacemaker Impl w/o AMI or Shock	5.70	4.34	12.58	5	86	\$1,182,526	\$148,304	\$201,522
173-1	Oth Vascular Procs	2.29	1.74	2.31	197	737	\$12,550,413	\$1,218,908	\$2,727,787
173-2	Oth Vascular Procs	2.77	2.11	3.85	368	1,807	\$32,527,443	\$2,943,442	\$6,356,837
173-3	Oth Vascular Procs	3.94	3.00	8	315	3,247	\$39,913,103	\$5,587,467	\$8,247,463
173-4	Oth Vascular Procs	7.76	5.91	17.55	98	2,016	\$28,777,618	\$3,198,589	\$5,469,755
174-1	Percut CV Procs w AMI	2.58	1.97	2.41	358	930	\$27,384,031	\$1,384,204	\$5,268,953
174-2	Percut CV Procs w AMI	2.78	2.12	3.05	451	1,512	\$38,634,309	\$2,352,111	\$7,289,417
174-3	Percut CV Procs w AMI	3.60	2.74	5.24	125	731	\$14,530,176	\$1,058,170	\$2,596,663
174-4	Percut CV Procs w AMI	5.78	4.40	9.17	143	1,875	\$32,488,810	\$3,000,019	\$6,152,129
175-1	Percut CV Procs w/o AMI	2.31	1.76	1.56	455	1,008	\$32,706,192	\$1,642,696	\$6,631,405
175-2	Percut CV Procs w/o AMI	2.60	1.98	2.34	492	1,604	\$40,612,522	\$2,564,936	\$7,691,485
175-3	Percut CV Procs w/o AMI	3.40	2.59	4.8	200	1,229	\$22,939,778	\$2,186,831	\$4,739,752
175-4	Percut CV Procs w/o AMI	5.85	4.46	9.86	49	667	\$9,070,111	\$1,235,557	\$2,193,306
176-1	Pacemaker & Defib Replacement	1.87	1.42	2.73	16	47	\$1,048,511	\$60,951	\$194,747
176-2	Pacemaker & Defib Replacement	3.90	2.97	2.19	7	21	\$557,140	\$36,464	\$177,868
176-3	Pacemaker & Defib Replacement	4.14	3.15	3.97	19	97	\$2,052,166	\$153,671	\$510,913
176-4	Pacemaker & Defib Replacement	6.97	5.31	13.11	2	10	\$181,899	\$15,196	\$86,465
177-1	Pacemaker & Defib Revision	1.46	1.11	2.32	23	76	\$1,131,648	\$117,681	\$199,917
177-2	Pacemaker & Defib Revision	2.05	1.56	3.88	25	141	\$1,615,891	\$226,163	\$317,774
177-3	Pacemaker & Defib Revision	3.04	2.32	7.06	18	200	\$1,966,270	\$347,773	\$331,306
177-4	Pacemaker & Defib Revision	6.10	4.65	15.86	4	101	\$1,439,486	\$129,415	\$171,645
180-1	Oth Circulatory Sys Procs	1.47	1.12	3.86	17	119	\$1,123,482	\$225,353	\$168,066
180-2	Oth Circulatory Sys Procs	2.07	1.57	5.65	46	333	\$3,599,834	\$537,797	\$605,585
180-3	Oth Circulatory Sys Procs	3.24	2.47	9.33	95	1,059	\$10,418,244	\$1,724,337	\$1,962,888
180-4	Oth Circulatory Sys Procs	6.18	4.71	15.64	32	709	\$7,300,552	\$1,318,274	\$1,531,852
190-1	Acute Myocardial Infarction	1.08	0.82	2.44	171	352	\$5,161,191	\$582,396	\$1,090,421

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
190-2	Acute Myocardial Infarction	1.21	0.92	3.52	373	1,174	\$13,788,983	\$1,829,765	\$2,499,230
190-3	Acute Myocardial Infarction	1.67	1.27	5.67	240	1,353	\$13,379,217	\$2,107,641	\$2,251,600
190-4	Acute Myocardial Infarction	3.14	2.39	9.49	95	960	\$11,665,662	\$1,431,062	\$2,015,236
191-1	Cardiac Cath Exc Ischem Disease	1.32	1.00	2.38	133	379	\$5,500,323	\$595,067	\$1,051,075
191-2	Cardiac Cath Exc Ischem Disease	1.61	1.22	3.53	210	791	\$10,330,108	\$1,375,736	\$2,091,155
191-3	Cardiac Cath Exc Ischem Disease	2.11	1.61	5.63	510	3,364	\$35,543,141	\$5,896,350	\$7,138,928
191-4	Cardiac Cath Exc Ischem Disease	4.69	3.57	12.36	62	866	\$10,656,203	\$1,502,487	\$2,275,646
192-1	Cardiac Cath for Ischem Disease	1.15	0.88	1.85	549	1,228	\$20,885,721	\$1,831,837	\$3,568,250
192-2	Cardiac Cath for Ischem Disease	1.33	1.01	2.51	800	2,301	\$34,681,494	\$3,456,688	\$5,975,078
192-3	Cardiac Cath for Ischem Disease	1.83	1.39	4.32	135	677	\$8,051,420	\$1,034,922	\$1,402,179
192-4	Cardiac Cath for Ischem Disease	3.90	2.97	9.93	7	61	\$787,466	\$104,289	\$153,266
193-1	Acute & Subacute Endocarditis	1.25	0.95	5.35	9	44	\$415,440	\$67,985	\$55,078
193-2	Acute & Subacute Endocarditis	1.67	1.27	7.41	18	182	\$1,370,438	\$257,228	\$214,423
193-3	Acute & Subacute Endocarditis	2.51	1.91	9.93	39	572	\$4,076,743	\$824,300	\$584,850
193-4	Acute & Subacute Endocarditis	4.36	3.32	14.41	31	589	\$5,522,466	\$878,532	\$944,359
194-1	Heart Failure	0.67	0.51	2.8	547	1,506	\$10,884,437	\$2,507,198	\$2,304,675
194-2	Heart Failure	0.86	0.66	3.68	1,958	7,178	\$52,131,709	\$11,787,831	\$10,280,880
194-3	Heart Failure	1.35	1.03	5.58	1,161	6,879	\$50,335,889	\$10,965,061	\$9,485,957
194-4	Heart Failure	2.73	2.08	9.55	170	2,390	\$24,393,886	\$4,209,231	\$4,775,298
196-1	Cardiac Arrest	0.61	0.46	2.39	5	20	\$127,617	\$17,041	\$14,991
196-2	Cardiac Arrest	0.68	0.52	2.57	12	38	\$281,387	\$63,869	\$53,337
196-3	Cardiac Arrest	1.52	1.16	4.9	27	57	\$899,844	\$95,390	\$272,380
196-4	Cardiac Arrest	3.56	2.71	9.54	31	140	\$2,874,862	\$226,105	\$709,535
197-1	Peripheral & Oth Vascular Dis	0.64	0.49	3.15	384	1,327	\$8,459,320	\$2,113,111	\$1,462,205
197-2	Peripheral & Oth Vascular Dis	0.89	0.68	3.98	658	2,971	\$19,631,814	\$4,927,203	\$3,573,037
197-3	Peripheral & Oth Vascular Dis	1.39	1.06	5.41	446	3,021	\$20,764,108	\$4,763,674	\$3,659,507
197-4	Peripheral & Oth Vascular Dis	3.05	2.32	9.91	46	489	\$8,245,827	\$857,136	\$1,681,829
198-1	Angina Pect & Atherosclerosis	0.58	0.44	1.62	779	1,350	\$14,338,539	\$2,053,839	\$2,612,809
198-2	Angina Pect & Atherosclerosis	0.69	0.52	2.12	1,091	2,563	\$23,865,108	\$3,843,340	\$4,281,439
198-3	Angina Pect & Atherosclerosis	0.98	0.75	3.39	158	588	\$4,954,541	\$994,961	\$921,398

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
198-4	Angina Pect & Atherosclerosis	2.38	1.81	8.32	4	36	\$371,906	\$67,271	\$64,788
199-1	Hypertension	0.61	0.46	1.91	516	1,064	\$10,039,006	\$1,591,685	\$1,838,086
199-2	Hypertension	0.73	0.55	2.53	527	1,420	\$11,921,213	\$2,264,637	\$2,333,062
199-3	Hypertension	1.09	0.83	3.91	99	401	\$3,052,731	\$650,586	\$636,387
199-4	Hypertension	2.47	1.88	7.88	7	86	\$719,598	\$202,947	\$138,453
200-1	Cardiac Structural Dis	0.70	0.53	2.24	29	73	\$599,065	\$133,831	\$135,335
200-2	Cardiac Structural Dis	0.85	0.65	3.01	65	264	\$1,829,125	\$530,545	\$361,759
200-3	Cardiac Structural Dis	1.32	1.00	5.12	47	270	\$1,832,971	\$562,467	\$428,929
200-4	Cardiac Structural Dis	3.21	2.45	10.4	6	210	\$2,228,937	\$505,721	\$383,997
201-1	Cardiac Arrhythmias	0.58	0.44	1.95	603	1,228	\$11,110,190	\$1,995,983	\$2,106,045
201-2	Cardiac Arrhythmias	0.75	0.57	2.9	858	2,648	\$21,007,152	\$4,205,172	\$3,769,983
201-3	Cardiac Arrhythmias	1.16	0.88	4.58	391	1,701	\$12,613,252	\$2,772,192	\$2,201,715
201-4	Cardiac Arrhythmias	2.69	2.05	9.34	31	375	\$4,058,904	\$675,871	\$670,601
203-1	Chest Pain	0.60	0.46	1.41	1,804	2,754	\$32,398,196	\$4,322,046	\$6,573,470
203-2	Chest Pain	0.71	0.54	1.88	1,594	3,214	\$34,036,977	\$5,069,709	\$6,695,278
203-3	Chest Pain	0.98	0.75	2.98	219	707	\$6,575,454	\$1,153,645	\$1,293,385
203-4	Chest Pain	2.28	1.74	7.24	6	38	\$355,157	\$52,650	\$68,789
204-1	Syncope & Collapse	0.69	0.53	1.94	512	985	\$10,667,114	\$1,584,747	\$2,165,024
204-2	Syncope & Collapse	0.80	0.61	2.57	706	1,831	\$17,898,207	\$2,846,957	\$3,320,624
204-3	Syncope & Collapse	1.05	0.80	3.76	120	509	\$4,189,086	\$895,582	\$819,545
204-4	Syncope & Collapse	2.44	1.86	8.38	2	20	\$91,460	\$24,514	\$25,889
205-1	Cardiomyopathy	0.67	0.51	2.21	21	50	\$389,508	\$80,029	\$82,301
205-2	Cardiomyopathy	0.81	0.62	2.91	27	64	\$488,856	\$100,963	\$126,396
205-3	Cardiomyopathy	1.25	0.95	4.89	19	113	\$1,111,787	\$182,436	\$194,858
205-4	Cardiomyopathy	3.42	2.61	10.68	5	232	\$4,100,859	\$521,761	\$871,664
206-1	Complic of CV Device or Proc	0.75	0.57	2.21	18	69	\$466,871	\$112,768	\$75,627
206-2	Complic of CV Device or Proc	0.92	0.70	3.31	154	584	\$4,398,749	\$1,008,997	\$873,413
206-3	Complic of CV Device or Proc	1.56	1.19	5.38	141	893	\$6,905,657	\$1,598,335	\$1,537,716
206-4	Complic of CV Device or Proc	3.36	2.55	10.64	51	933	\$6,472,428	\$1,730,971	\$1,533,878
207-1	Oth Circulatory Sys Diags	0.65	0.50	2.29	199	467	\$3,863,222	\$723,451	\$767,129

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
207-2	Oth Circulatory Sys Diags	0.91	0.70	3.27	182	678	\$5,325,179	\$1,146,360	\$998,848
207-3	Oth Circulatory Sys Diags	1.34	1.02	4.79	109	584	\$4,969,263	\$1,056,725	\$1,067,406
207-4	Oth Circulatory Sys Diags	2.75	2.10	8.72	18	176	\$1,910,584	\$331,193	\$370,054
220-1	Maj Stomach & Esophag Procs	1.69	1.29	3.8	77	427	\$4,361,897	\$805,177	\$920,711
220-2	Maj Stomach & Esophag Procs	2.77	2.11	7.14	120	1,232	\$9,278,514	\$2,170,138	\$2,097,965
220-3	Maj Stomach & Esophag Procs	4.49	3.41	11.95	106	1,806	\$19,201,499	\$3,225,597	\$3,897,891
220-4	Maj Stomach & Esophag Procs	9.14	6.96	21.61	67	1,704	\$18,376,369	\$3,120,187	\$4,920,636
221-1	Maj Small & Large Bowel Procs	1.73	1.32	4.92	268	2,089	\$20,051,212	\$4,051,176	\$3,658,901
221-2	Maj Small & Large Bowel Procs	2.31	1.76	7.05	591	5,462	\$52,335,080	\$9,583,710	\$9,161,609
221-3	Maj Small & Large Bowel Procs	3.88	2.96	12.05	390	5,712	\$55,058,036	\$9,764,122	\$10,268,907
221-4	Maj Small & Large Bowel Procs	8.16	6.21	20.82	184	4,354	\$53,669,105	\$7,472,941	\$11,665,923
222-1	Oth Stomach & Esophag Procs	1.07	0.82	2.18	397	962	\$7,503,591	\$1,841,369	\$2,906,663
222-2	Oth Stomach & Esophag Procs	1.61	1.23	3.39	64	330	\$3,376,804	\$534,159	\$658,087
222-3	Oth Stomach & Esophag Procs	2.98	2.27	8.16	34	466	\$3,222,390	\$974,365	\$834,980
222-4	Oth Stomach & Esophag Procs	7.77	5.92	18.2	9	225	\$1,507,087	\$426,760	\$476,242
223-1	Oth Small & Large Bowel Procs	1.39	1.06	4.36	143	716	\$6,068,119	\$1,182,025	\$1,233,313
223-2	Oth Small & Large Bowel Procs	1.89	1.44	6.33	106	857	\$6,860,472	\$1,607,855	\$1,427,950
223-3	Oth Small & Large Bowel Procs	3.31	2.52	10.7	45	589	\$4,960,521	\$980,746	\$1,066,379
223-4	Oth Small & Large Bowel Procs	7.44	5.67	19.85	13	243	\$3,093,423	\$431,986	\$662,100
224-1	Peritoneal Adhesiolysis	1.53	1.16	5.17	60	331	\$3,139,802	\$525,801	\$538,155
224-2	Peritoneal Adhesiolysis	2.11	1.61	7.67	48	373	\$3,072,893	\$648,788	\$652,874
224-3	Peritoneal Adhesiolysis	3.32	2.53	11.41	40	546	\$4,395,009	\$895,887	\$855,974
224-4	Peritoneal Adhesiolysis	6.58	5.01	18.29	13	290	\$2,617,465	\$464,875	\$539,478
225-1	Appendectomy	1.03	0.78	1.51	1,722	2,996	\$57,222,637	\$5,071,171	\$11,036,365
225-2	Appendectomy	1.42	1.08	3.64	783	3,355	\$36,144,564	\$5,820,805	\$6,965,094
225-3	Appendectomy	2.53	1.92	7.18	55	487	\$5,445,028	\$773,427	\$927,925
225-4	Appendectomy	5.22	3.98	13.29	14	147	\$1,752,125	\$221,860	\$428,310
226-1	Anal Procs	0.82	0.62	2.42	167	524	\$5,432,937	\$871,078	\$852,263
226-2	Anal Procs	1.17	0.89	3.92	90	464	\$3,379,049	\$748,272	\$664,342
226-3	Anal Procs	2.02	1.54	6.97	23	238	\$2,107,976	\$366,825	\$301,313

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
226-4	Anal Procs	4.62	3.52	13.74	2	52	\$581,003	\$80,980	\$77,448
227-1	Oth Hernia Procs	1.26	0.96	2.75	195	608	\$8,320,793	\$1,004,183	\$1,499,884
227-2	Oth Hernia Procs	1.64	1.25	4.2	191	974	\$11,167,869	\$1,637,593	\$1,913,911
227-3	Oth Hernia Procs	2.87	2.18	7.71	52	490	\$5,351,395	\$796,965	\$911,044
227-4	Oth Hernia Procs	6.50	4.95	15.89	11	228	\$2,425,032	\$373,110	\$503,031
228-1	Inguin, Fem & Umbil Hernia Procs	0.95	0.72	1.88	172	344	\$5,100,208	\$570,819	\$1,008,744
228-2	Inguin, Fem & Umbil Hernia Procs	1.27	0.97	3.31	77	297	\$3,371,497	\$506,329	\$611,593
228-3	Inguin, Fem & Umbil Hernia Procs	2.13	1.62	6.1	26	211	\$1,959,523	\$366,394	\$365,399
228-4	Inguin, Fem & Umbil Hernia Procs	4.62	3.52	13.78	6	91	\$867,594	\$180,161	\$164,738
229-1	Oth Digestive & Abdo Procs	1.38	1.05	3.6	55	247	\$2,587,570	\$427,124	\$476,384
229-2	Oth Digestive & Abdo Procs	2.00	1.52	5.45	76	509	\$4,786,050	\$850,983	\$913,055
229-3	Oth Digestive & Abdo Procs	3.26	2.48	9.5	56	699	\$7,755,991	\$1,297,950	\$1,538,649
229-4	Oth Digestive & Abdo Procs	6.95	5.29	18.28	19	340	\$2,941,074	\$540,424	\$745,498
240-1	Digestive Malig	0.93	0.71	3.26	45	174	\$1,469,448	\$298,475	\$249,825
240-2	Digestive Malig	1.12	0.85	4.13	219	1,160	\$8,717,938	\$2,038,372	\$1,499,254
240-3	Digestive Malig	1.73	1.32	6.56	291	2,498	\$19,863,713	\$4,482,670	\$3,433,097
240-4	Digestive Malig	3.41	2.59	11.73	57	850	\$8,274,876	\$1,417,011	\$1,555,825
241-1	Peptic Ulcer & Gastritis	0.73	0.56	2.42	578	1,508	\$14,497,467	\$2,381,541	\$2,468,082
241-2	Peptic Ulcer & Gastritis	0.93	0.71	3.18	748	2,510	\$23,596,066	\$3,910,946	\$4,028,596
241-3	Peptic Ulcer & Gastritis	1.41	1.07	4.73	294	1,502	\$12,445,886	\$2,487,448	\$2,516,182
241-4	Peptic Ulcer & Gastritis	3.54	2.69	10.4	27	395	\$4,254,395	\$648,406	\$793,085
242-1	Maj Esophageal Dis	0.69	0.52	2.16	28	74	\$644,416	\$117,665	\$111,371
242-2	Maj Esophageal Dis	0.95	0.72	3.14	75	304	\$2,430,966	\$533,011	\$428,628
242-3	Maj Esophageal Dis	1.38	1.05	4.52	94	537	\$4,594,348	\$983,708	\$842,776
242-4	Maj Esophageal Dis	3.45	2.63	10.53	23	245	\$3,505,434	\$433,248	\$687,824
243-1	Oth Esophageal Dis	0.63	0.48	1.82	452	1,052	\$7,319,491	\$1,978,285	\$1,832,646
243-2	Oth Esophageal Dis	0.81	0.62	2.67	582	1,933	\$13,493,960	\$3,390,193	\$2,891,904
243-3	Oth Esophageal Dis	1.24	0.94	4.6	175	1,022	\$7,492,803	\$1,799,110	\$1,379,976
243-4	Oth Esophageal Dis	3.04	2.32	9.99	11	204	\$1,551,644	\$474,550	\$325,608
244-1	Diverticulitis & Diverticulosis	0.68	0.52	2.86	472	1,332	\$10,992,676	\$2,046,375	\$1,898,973

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
244-2	Diverticulitis & Diverticulosis	0.87	0.66	3.56	417	1,569	\$12,500,853	\$2,383,890	\$2,090,552
244-3	Diverticulitis & Diverticulosis	1.34	1.02	5.29	65	350	\$3,132,466	\$536,079	\$496,747
244-4	Diverticulitis & Diverticulosis	3.05	2.32	10.44	8	80	\$638,283	\$146,108	\$150,334
245-1	Inflammatory Bowel Disease	0.79	0.60	3.3	322	1,205	\$8,968,818	\$2,087,592	\$1,532,103
245-2	Inflammatory Bowel Disease	0.95	0.73	4.04	417	1,747	\$13,676,264	\$2,934,438	\$2,391,329
245-3	Inflammatory Bowel Disease	1.46	1.11	6.05	118	893	\$6,414,520	\$1,528,454	\$1,115,554
245-4	Inflammatory Bowel Disease	2.94	2.24	11.79	28	424	\$3,423,130	\$802,263	\$764,719
246-1	Gastroint Vasc Insufficiency	0.82	0.63	3.05	39	110	\$996,666	\$151,355	\$184,111
246-2	Gastroint Vasc Insufficiency	1.04	0.79	4.01	64	287	\$2,505,240	\$436,878	\$379,952
246-3	Gastroint Vasc Insufficiency	1.55	1.18	6.11	25	280	\$2,012,881	\$478,454	\$316,872
246-4	Gastroint Vasc Insufficiency	3.62	2.75	11.81	5	92	\$738,448	\$146,579	\$106,472
247-1	Intestinal Obstruction	0.64	0.49	2.8	526	1,547	\$10,729,600	\$2,541,908	\$2,057,934
247-2	Intestinal Obstruction	0.83	0.63	3.7	569	2,250	\$14,991,404	\$3,640,989	\$2,831,573
247-3	Intestinal Obstruction	1.34	1.02	5.84	196	1,230	\$8,332,703	\$2,193,797	\$1,648,757
247-4	Intestinal Obstruction	3.27	2.49	11.33	31	352	\$3,214,939	\$540,915	\$675,661
248-1	Maj Gastroint & Peritoneal Inf	0.67	0.51	3.21	326	998	\$5,607,340	\$1,659,829	\$1,334,389
248-2	Maj Gastroint & Peritoneal Inf	1.00	0.76	4.66	516	2,595	\$16,476,742	\$4,655,823	\$3,280,874
248-3	Maj Gastroint & Peritoneal Inf	1.56	1.19	7.03	320	2,512	\$16,765,862	\$4,509,331	\$3,213,522
248-4	Maj Gastroint & Peritoneal Inf	3.35	2.55	12.12	58	700	\$5,671,365	\$1,169,726	\$1,261,409
249-1	Non-Bact Gastroenteritis, N & V	0.49	0.37	2.08	1,942	4,151	\$28,006,107	\$6,766,854	\$5,744,009
249-2	Non-Bact Gastroenteritis, N & V	0.65	0.50	2.76	1,659	4,816	\$33,791,753	\$7,946,179	\$6,536,710
249-3	Non-Bact Gastroenteritis, N & V	0.98	0.74	4.11	432	1,957	\$13,501,409	\$3,515,739	\$2,681,402
249-4	Non-Bact Gastroenteritis, N & V	2.61	1.98	9.14	32	389	\$2,778,755	\$715,661	\$572,291
251-1	Abdominal Pain	0.64	0.49	2.12	871	1,895	\$17,992,707	\$3,025,822	\$3,294,998
251-2	Abdominal Pain	0.79	0.60	2.81	879	2,512	\$23,059,283	\$4,013,349	\$4,161,461
251-3	Abdominal Pain	1.12	0.86	4.08	149	569	\$4,623,004	\$949,107	\$1,042,855
251-4	Abdominal Pain	2.27	1.73	7.94	7	34	\$220,977	\$46,312	\$84,655
252-1	Complic of Gi Device or Proc	0.68	0.51	3.09	91	319	\$2,159,530	\$526,590	\$379,073
252-2	Complic of Gi Device or Proc	0.93	0.71	3.9	272	1,196	\$7,908,984	\$2,105,590	\$1,578,836
252-3	Complic of Gi Device or Proc	1.54	1.17	6.04	193	1,391	\$9,592,043	\$2,583,527	\$2,029,072

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
252-4	Complic of Gi Device or Proc	3.53	2.69	11.19	48	846	\$7,163,113	\$1,876,111	\$1,937,147
253-1	Oth & Unspec Gi Hemorrhage	0.69	0.53	2.48	249	618	\$5,924,951	\$998,172	\$1,024,181
253-2	Oth & Unspec Gi Hemorrhage	0.91	0.70	3.36	463	1,524	\$13,038,095	\$2,407,350	\$2,512,022
253-3	Oth & Unspec Gi Hemorrhage	1.41	1.07	5.03	253	1,297	\$10,548,461	\$2,187,247	\$2,139,532
253-4	Oth & Unspec Gi Hemorrhage	3.03	2.30	9.29	61	745	\$7,573,890	\$1,333,300	\$1,655,576
254-1	Oth Digestive Sys Diags	0.64	0.49	2.4	1,258	3,086	\$24,268,225	\$5,059,843	\$4,882,220
254-2	Oth Digestive Sys Diags	0.87	0.66	3.41	839	3,213	\$22,609,519	\$5,677,359	\$4,501,627
254-3	Oth Digestive Sys Diags	1.32	1.01	5.07	381	2,511	\$17,985,871	\$4,698,425	\$3,432,000
254-4	Oth Digestive Sys Diags	3.06	2.33	9.89	60	771	\$6,520,557	\$1,562,495	\$1,560,413
260-1	Maj Pancreas & Liver Procs	2.17	1.65	4.58	26	195	\$1,719,387	\$388,485	\$409,540
260-2	Maj Pancreas & Liver Procs	2.81	2.14	5.95	68	535	\$5,409,324	\$1,040,564	\$1,317,592
260-3	Maj Pancreas & Liver Procs	4.63	3.52	10.68	71	919	\$8,876,838	\$1,706,074	\$2,282,873
260-4	Maj Pancreas & Liver Procs	10.23	7.79	22.45	68	1,540	\$18,960,825	\$2,754,918	\$5,216,108
261-1	Maj Biliary Tract Procs	1.68	1.28	4.59	9	36	\$384,092	\$68,134	\$92,445
261-2	Maj Biliary Tract Procs	2.47	1.88	7.02	27	218	\$2,044,576	\$367,805	\$414,702
261-3	Maj Biliary Tract Procs	3.66	2.79	10.75	24	319	\$3,574,091	\$597,891	\$610,636
261-4	Maj Biliary Tract Procs	7.06	5.38	18.16	5	91	\$874,694	\$182,993	\$249,132
262-1	Cholecystectomy Exc Laparo	1.48	1.13	4.02	67	311	\$3,784,677	\$569,199	\$634,781
262-2	Cholecystectomy Exc Laparo	1.96	1.49	5.65	88	498	\$5,922,670	\$781,207	\$1,030,510
262-3	Cholecystectomy Exc Laparo	3.14	2.39	9.05	33	271	\$2,661,936	\$450,119	\$624,955
262-4	Cholecystectomy Exc Laparo	6.58	5.01	16.41	10	144	\$2,225,565	\$222,010	\$496,755
263-1	Laparoscopic Cholecystectomy	1.21	0.92	2.31	1,610	4,273	\$67,700,815	\$6,914,234	\$11,919,797
263-2	Laparoscopic Cholecystectomy	1.57	1.20	3.53	1,280	4,967	\$67,177,913	\$7,806,697	\$11,919,074
263-3	Laparoscopic Cholecystectomy	2.28	1.74	6.14	332	2,359	\$25,359,677	\$3,681,808	\$4,500,025
263-4	Laparoscopic Cholecystectomy	5.05	3.85	13.3	14	282	\$3,244,451	\$406,316	\$501,804
264-1	Oth Hepatobiliary & Abdo Procs	1.83	1.40	4.23	11	65	\$612,882	\$137,719	\$138,313
264-2	Oth Hepatobiliary & Abdo Procs	2.02	1.54	5.22	24	217	\$1,977,233	\$387,643	\$330,185
264-3	Oth Hepatobiliary & Abdo Procs	3.54	2.69	10.43	34	439	\$3,559,360	\$777,258	\$788,296
264-4	Oth Hepatobiliary & Abdo Procs	8.89	6.77	22.82	12	305	\$3,806,556	\$647,717	\$1,090,593
279-1	Hepatic Coma & Oth Maj Liver Dis	0.67	0.51	2.76	45	156	\$1,055,545	\$214,293	\$171,079

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
279-2	Hepatic Coma & Oth Maj Liver Dis	0.91	0.69	3.56	317	1,246	\$8,026,624	\$2,161,408	\$1,802,787
279-3	Hepatic Coma & Oth Maj Liver Dis	1.55	1.18	5.66	437	2,941	\$20,474,966	\$4,851,420	\$4,240,795
279-4	Hepatic Coma & Oth Maj Liver Dis	4.12	3.14	12.03	120	1,510	\$14,686,632	\$2,765,495	\$3,565,617
280-1	Alcoholic Liver Disease	0.67	0.51	2.73	27	89	\$725,142	\$142,247	\$131,646
280-2	Alcoholic Liver Disease	0.88	0.67	3.33	414	1,336	\$9,820,113	\$2,243,946	\$2,208,996
280-3	Alcoholic Liver Disease	1.42	1.08	5.18	712	3,902	\$29,881,212	\$6,111,480	\$5,895,694
280-4	Alcoholic Liver Disease	3.33	2.54	10.56	158	1,713	\$16,307,695	\$2,834,595	\$3,387,120
281-1	Malig of Hepatobiliary Sys	1.01	0.77	3.09	32	188	\$1,140,268	\$281,114	\$193,514
281-2	Malig of Hepatobiliary Sys	1.21	0.92	4.1	197	957	\$7,485,497	\$1,552,797	\$1,428,947
281-3	Malig of Hepatobiliary Sys	1.70	1.30	5.91	275	1,913	\$16,024,702	\$3,319,584	\$2,972,701
281-4	Malig of Hepatobiliary Sys	3.08	2.34	9.78	41	520	\$4,297,735	\$904,075	\$905,075
282-1	Dis of Pancreas Exc Malig	0.74	0.56	3.13	690	2,172	\$16,017,687	\$3,433,245	\$2,976,116
282-2	Dis of Pancreas Exc Malig	0.94	0.72	3.94	940	4,379	\$32,166,436	\$7,018,584	\$5,181,297
282-3	Dis of Pancreas Exc Malig	1.63	1.24	6.37	320	2,304	\$17,136,779	\$3,722,716	\$3,208,598
282-4	Dis of Pancreas Exc Malig	4.81	3.66	14.63	62	1,080	\$10,288,647	\$1,770,819	\$2,075,067
283-1	Oth Dis of the Liver	0.71	0.54	2.71	94	277	\$2,118,494	\$485,872	\$398,353
283-2	Oth Dis of the Liver	0.92	0.70	3.3	385	1,306	\$10,268,939	\$2,155,535	\$2,189,503
283-3	Oth Dis of the Liver	1.36	1.04	4.86	415	2,120	\$16,641,272	\$3,605,766	\$3,432,534
283-4	Oth Dis of the Liver	2.97	2.26	8.92	65	833	\$8,432,294	\$1,577,415	\$1,725,431
284-1	Dis of Gallbladder	0.77	0.58	2.38	360	784	\$7,867,162	\$1,296,517	\$1,688,367
284-2	Dis of Gallbladder	1.05	0.80	3.47	368	1,364	\$11,814,607	\$2,223,223	\$2,273,243
284-3	Dis of Gallbladder	1.59	1.21	5.42	153	831	\$6,829,936	\$1,435,522	\$1,490,224
284-4	Dis of Gallbladder	3.48	2.65	10.51	21	287	\$2,659,837	\$571,640	\$572,597
301-1	Hip Joint Replacement	2.08	1.58	3.61	227	1,051	\$15,254,093	\$1,653,443	\$2,727,923
301-2	Hip Joint Replacement	2.31	1.76	3.88	225	1,224	\$18,493,112	\$1,990,696	\$3,137,837
301-3	Hip Joint Replacement	3.14	2.39	5.13	64	446	\$7,250,422	\$758,519	\$1,259,243
301-4	Hip Joint Replacement	5.47	4.16	13.18	4	66	\$852,207	\$112,124	\$175,394
302-1	Knee Joint Replacement	1.97	1.50	2.95	171	550	\$10,350,362	\$837,991	\$1,883,578
302-2	Knee Joint Replacement	2.22	1.69	3.35	191	721	\$13,224,070	\$1,069,894	\$2,310,747
302-3	Knee Joint Replacement	2.88	2.19	4.99	21	162	\$2,156,518	\$282,529	\$397,447

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
302-4	Knee Joint Replacement	6.00	4.57	12.49	2	14	\$215,150	\$24,172	\$82,275
303-1	Lumb Fusion for Back Curvature	6.22	4.74	4.42	52	274	\$10,260,381	\$570,341	\$2,357,752
303-2	Lumb Fusion for Back Curvature	7.42	5.65	5.5	59	359	\$12,624,460	\$729,572	\$3,127,137
303-3	Lumb Fusion for Back Curvature	10.91	8.31	8.09	39	445	\$12,411,607	\$883,689	\$2,980,186
303-4	Lumb Fusion for Back Curvature	14.30	10.89	15.54	5	96	\$2,118,712	\$175,370	\$559,192
304-1	Lumb Fusion Exc Back Curvature	3.78	2.88	3	185	726	\$20,124,260	\$1,208,888	\$4,266,471
304-2	Lumb Fusion Exc Back Curvature	4.50	3.43	3.91	116	648	\$14,922,269	\$1,074,581	\$3,195,716
304-3	Lumb Fusion Exc Back Curvature	6.71	5.11	6.89	74	814	\$14,150,551	\$1,536,086	\$3,338,175
304-4	Lumb Fusion Exc Back Curvature	11.55	8.79	17	4	85	\$1,515,504	\$164,534	\$350,591
305-1	Amput of Lower Limb Exc Toes	1.35	1.03	5.1	42	296	\$1,998,218	\$468,388	\$331,817
305-2	Amput of Lower Limb Exc Toes	1.87	1.43	7.14	134	1,234	\$9,243,375	\$2,036,884	\$1,536,494
305-3	Amput of Lower Limb Exc Toes	3.03	2.31	10.82	122	1,590	\$12,469,886	\$2,786,689	\$2,370,773
305-4	Amput of Lower Limb Exc Toes	6.64	5.05	19.63	47	1,130	\$9,467,813	\$2,063,671	\$2,231,935
308-1	Hip & Femur Procs for Trauma	1.54	1.17	4.11	91	341	\$4,254,770	\$562,072	\$873,024
308-2	Hip & Femur Procs for Trauma	1.90	1.45	4.9	250	1,329	\$16,572,442	\$2,260,958	\$2,988,158
308-3	Hip & Femur Procs for Trauma	2.72	2.07	6.81	144	1,275	\$13,622,245	\$2,263,042	\$2,746,798
308-4	Hip & Femur Procs for Trauma	5.39	4.11	12.96	27	564	\$6,637,262	\$891,129	\$1,213,133
309-1	Hip & Femur Procs Non-Trauma	1.54	1.18	2.62	129	343	\$4,857,545	\$668,547	\$1,336,743
309-2	Hip & Femur Procs Non-Trauma	2.15	1.64	4.66	120	668	\$7,726,091	\$1,195,121	\$1,705,118
309-3	Hip & Femur Procs Non-Trauma	3.20	2.44	8.29	57	780	\$6,717,479	\$1,354,614	\$1,315,700
309-4	Hip & Femur Procs Non-Trauma	6.91	5.26	18.89	8	211	\$2,019,554	\$302,002	\$333,314
310-1	Disc Excision & Decompress	1.12	0.85	1.69	206	527	\$9,932,334	\$852,718	\$1,431,641
310-2	Disc Excision & Decompress	1.51	1.15	2.82	109	480	\$6,500,999	\$785,487	\$1,012,914
310-3	Disc Excision & Decompress	2.25	1.71	5.92	45	409	\$4,036,381	\$635,462	\$609,044
310-4	Disc Excision & Decompress	5.87	4.47	15.54	7	118	\$1,574,802	\$187,925	\$313,987
312-1	Skin Graft for Connect Tis Diags	2.03	1.55	5.08	13	127	\$1,276,230	\$265,023	\$230,852
312-2	Skin Graft for Connect Tis Diags	2.99	2.28	8.27	24	315	\$2,738,212	\$632,829	\$536,570
312-3	Skin Graft for Connect Tis Diags	5.79	4.41	17.27	13	306	\$2,116,196	\$582,219	\$586,137
312-4	Skin Graft for Connect Tis Diags	12.70	9.67	31.23	4	120	\$1,661,614	\$205,115	\$358,132
313-1	Knee & Lower Leg Procs Exc Foot	1.37	1.04	2.51	443	1,392	\$21,149,757	\$2,407,489	\$3,779,503

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
313-2	Knee & Lower Leg Procs Exc Foot	1.98	1.51	4.11	362	2,038	\$24,392,596	\$3,645,613	\$4,635,605
313-3	Knee & Lower Leg Procs Exc Foot	3.14	2.39	7.26	111	1,232	\$12,969,123	\$2,300,449	\$2,646,074
313-4	Knee & Lower Leg Procs Exc Foot	6.74	5.13	16.55	16	304	\$3,536,985	\$541,283	\$783,039
314-1	Foot & Toe Procs	1.23	0.94	2.29	82	290	\$3,061,861	\$543,976	\$686,532
314-2	Foot & Toe Procs	1.46	1.11	4.8	270	1,983	\$15,695,300	\$3,292,533	\$2,587,038
314-3	Foot & Toe Procs	2.22	1.69	7.7	208	2,273	\$18,392,661	\$3,797,049	\$3,013,571
314-4	Foot & Toe Procs	4.87	3.71	14.55	26	414	\$4,051,786	\$663,543	\$806,112
315-1	Shoulder And Arm Procs	1.13	0.86	1.74	258	444	\$6,664,634	\$795,390	\$1,868,236
315-2	Shoulder And Arm Procs	1.95	1.48	2.56	308	966	\$15,108,716	\$1,697,276	\$3,875,139
315-3	Shoulder And Arm Procs	3.02	2.30	6.19	44	389	\$4,380,765	\$702,873	\$874,065
315-4	Shoulder And Arm Procs	6.24	4.75	14.17	8	219	\$2,281,219	\$359,774	\$366,762
316-1	Hand & Wrist Procs	0.99	0.75	2.11	122	308	\$3,600,206	\$573,540	\$810,697
316-2	Hand & Wrist Procs	1.50	1.14	3.68	55	250	\$2,836,460	\$475,180	\$573,168
316-3	Hand & Wrist Procs	2.50	1.91	6.73	10	68	\$621,814	\$87,939	\$133,730
316-4	Hand & Wrist Procs	5.05	3.84	13.65	0	0	\$0	\$0	\$0
317-1	Soft Tissue Procs	1.07	0.81	2.75	129	452	\$4,218,930	\$782,495	\$863,698
317-2	Soft Tissue Procs	1.64	1.25	5.18	101	782	\$5,575,415	\$1,282,650	\$1,000,884
317-3	Soft Tissue Procs	3.00	2.28	9.38	51	558	\$4,278,786	\$928,922	\$961,959
317-4	Soft Tissue Procs	6.97	5.30	19.17	15	312	\$3,950,102	\$520,432	\$975,201
320-1	Oth Muscskl & Connect Tis Procs	1.24	0.95	2.1	57	165	\$2,182,104	\$294,698	\$464,183
320-2	Oth Muscskl & Connect Tis Procs	1.86	1.42	4.36	130	828	\$7,794,285	\$1,536,251	\$1,586,774
320-3	Oth Muscskl & Connect Tis Procs	2.93	2.23	8.32	46	629	\$5,894,206	\$1,071,509	\$963,672
320-4	Oth Muscskl & Connect Tis Procs	6.18	4.71	16.4	13	342	\$3,814,699	\$590,509	\$822,700
321-1	Cervical Spinal Fusion	2.13	1.62	1.61	264	623	\$18,504,413	\$1,093,111	\$3,421,815
321-2	Cervical Spinal Fusion	2.82	2.15	3.02	125	553	\$11,133,630	\$1,005,320	\$2,124,989
321-3	Cervical Spinal Fusion	5.08	3.87	8.3	39	403	\$6,141,573	\$707,970	\$1,335,367
321-4	Cervical Spinal Fusion	9.59	7.30	17.85	7	151	\$1,565,815	\$264,764	\$434,793
340-1	Fracture of Femur	0.60	0.46	3.07	50	138	\$1,007,025	\$171,550	\$177,560
340-2	Fracture of Femur	0.75	0.57	3.58	120	412	\$2,911,620	\$657,908	\$608,172
340-3	Fracture of Femur	1.22	0.93	5.45	17	104	\$639,550	\$174,611	\$129,323

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
340-4	Fracture of Femur	2.58	1.96	8.92	7	67	\$721,940	\$102,591	\$136,088
341-1	Fx of Pelvis or Dislocation of Hip	0.61	0.46	2.92	15	31	\$370,847	\$56,116	\$57,288
341-2	Fx of Pelvis or Dislocation of Hip	0.74	0.56	3.56	28	112	\$761,632	\$180,486	\$123,432
341-3	Fx of Pelvis or Dislocation of Hip	1.06	0.81	4.72	18	113	\$771,930	\$167,993	\$115,592
341-4	Fx of Pelvis or Dislocation of Hip	2.88	2.20	10.78	1	16	\$76,374	\$13,568	\$10,400
342-1	Fx & Disc Exc Femur, Pelvis, Back	0.61	0.46	2.08	225	388	\$3,831,881	\$679,156	\$874,974
342-2	Fx & Disc Exc Femur, Pelvis, Back	0.81	0.62	3.23	124	392	\$2,771,768	\$644,504	\$605,883
342-3	Fx & Disc Exc Femur, Pelvis, Back	1.22	0.93	4.97	46	241	\$1,720,518	\$421,460	\$345,656
342-4	Fx & Disc Exc Femur, Pelvis, Back	3.33	2.54	11.29	7	130	\$1,289,861	\$192,211	\$227,949
343-1	Muscskl Malig & Pathol Fx	0.96	0.73	3.48	20	70	\$564,304	\$131,810	\$127,912
343-2	Muscskl Malig & Pathol Fx	1.19	0.90	4.53	103	488	\$3,626,523	\$798,844	\$743,599
343-3	Muscskl Malig & Pathol Fx	1.95	1.48	7.28	159	1,308	\$9,127,816	\$2,344,403	\$1,965,457
343-4	Muscskl Malig & Pathol Fx	3.66	2.79	12.99	12	156	\$1,274,883	\$312,533	\$281,422
344-1	Musculoskeletal Inf	0.92	0.70	4.27	76	462	\$2,633,878	\$728,026	\$437,169
344-2	Musculoskeletal Inf	1.22	0.93	5.54	305	2,253	\$12,503,309	\$3,910,999	\$2,335,457
344-3	Musculoskeletal Inf	1.94	1.48	8.49	128	1,472	\$9,171,963	\$2,478,896	\$1,630,133
344-4	Musculoskeletal Inf	3.52	2.68	13.53	31	578	\$3,911,356	\$922,811	\$704,682
346-1	Connective Tissue Dis	0.79	0.60	2.93	239	797	\$5,687,155	\$1,420,951	\$1,214,739
346-2	Connective Tissue Dis	1.09	0.83	4.06	273	1,301	\$10,273,340	\$2,332,429	\$1,950,671
346-3	Connective Tissue Dis	1.91	1.46	6.92	162	1,235	\$10,578,231	\$2,124,749	\$2,110,352
346-4	Connective Tissue Dis	5.36	4.08	15.22	37	814	\$8,783,744	\$1,516,389	\$2,162,034
347-1	Oth Back & Neck Dis, Fx & Injuries	0.73	0.55	2.8	474	1,235	\$10,766,636	\$1,852,326	\$1,973,831
347-2	Oth Back & Neck Dis, Fx & Injuries	0.95	0.72	3.75	307	1,136	\$9,465,408	\$1,782,584	\$1,683,050
347-3	Oth Back & Neck Dis, Fx & Injuries	1.40	1.07	5.17	83	703	\$4,369,529	\$1,228,360	\$793,775
347-4	Oth Back & Neck Dis, Fx & Injuries	3.42	2.61	12.22	7	155	\$678,563	\$286,728	\$149,813
349-1	Complic of Ortho Device or Proc	0.58	0.44	2.12	25	71	\$483,998	\$106,252	\$86,270
349-2	Complic of Ortho Device or Proc	0.92	0.70	4.15	137	693	\$4,040,762	\$1,197,629	\$812,522
349-3	Complic of Ortho Device or Proc	1.57	1.20	6.57	51	363	\$2,480,947	\$527,160	\$460,544
349-4	Complic of Ortho Device or Proc	3.53	2.69	12.14	9	179	\$1,317,675	\$314,204	\$226,147
351-1	Oth Muscskl & Connect Tis Diags	0.61	0.46	2.38	327	776	\$5,996,584	\$1,312,914	\$1,238,919

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
351-2	Oth Muscsl & Connect Tis Diags	0.78	0.59	3.38	562	2,037	\$13,148,459	\$3,169,772	\$2,613,073
351-3	Oth Muscsl & Connect Tis Diags	1.32	1.01	5.21	150	951	\$7,649,114	\$1,496,937	\$1,417,986
351-4	Oth Muscsl & Connect Tis Diags	3.05	2.32	11.14	15	259	\$1,896,011	\$352,628	\$314,247
361-1	Skin Graft for Cutaneous Diags	1.70	1.29	3.67	59	381	\$3,177,838	\$796,828	\$691,562
361-2	Skin Graft for Cutaneous Diags	2.24	1.70	6.84	37	317	\$2,875,249	\$539,390	\$543,212
361-3	Skin Graft for Cutaneous Diags	3.45	2.63	11.99	34	567	\$4,233,323	\$964,868	\$830,051
361-4	Skin Graft for Cutaneous Diags	8.14	6.20	24.6	8	243	\$1,946,423	\$360,040	\$464,405
362-1	Mastectomy Procs	1.36	1.04	1.72	219	413	\$7,731,896	\$755,650	\$1,823,491
362-2	Mastectomy Procs	1.82	1.38	2.22	79	234	\$3,828,875	\$410,256	\$836,541
362-3	Mastectomy Procs	2.64	2.01	5.79	9	149	\$1,266,120	\$247,813	\$160,448
362-4	Mastectomy Procs	6.31	4.81	12.91	0	0	\$0	\$0	\$0
363-1	Breast Procs Exc Mastectomy	1.26	0.96	1.79	80	350	\$3,501,973	\$618,460	\$644,309
363-2	Breast Procs Exc Mastectomy	2.13	1.62	2.97	23	93	\$1,490,514	\$168,061	\$300,180
363-3	Breast Procs Exc Mastectomy	2.67	2.03	4.95	7	36	\$609,729	\$71,777	\$129,130
363-4	Breast Procs Exc Mastectomy	6.18	4.70	18.4	1	25	\$256,420	\$57,618	\$52,741
364-1	Oth Cutaneous & Related Procs	1.09	0.83	2.62	216	809	\$6,516,495	\$1,288,681	\$1,416,372
364-2	Oth Cutaneous & Related Procs	1.50	1.14	4.82	143	975	\$7,198,885	\$1,617,391	\$1,313,494
364-3	Oth Cutaneous & Related Procs	2.46	1.87	8.63	88	975	\$7,161,354	\$1,645,679	\$1,345,187
364-4	Oth Cutaneous & Related Procs	4.94	3.76	16.09	19	349	\$2,781,138	\$648,685	\$627,192
380-1	Skin Ulcers	0.73	0.56	3.84	77	276	\$1,505,022	\$438,004	\$356,938
380-2	Skin Ulcers	0.89	0.67	4.54	230	1,137	\$6,976,764	\$1,795,997	\$1,209,986
380-3	Skin Ulcers	1.33	1.01	6.48	156	1,208	\$6,925,418	\$2,062,113	\$1,257,448
380-4	Skin Ulcers	2.71	2.06	11.13	20	300	\$2,022,401	\$470,361	\$343,137
381-1	Maj Skin Dis	0.60	0.46	2.9	88	304	\$1,558,187	\$575,755	\$340,063
381-2	Maj Skin Dis	0.88	0.67	4.03	62	327	\$1,745,463	\$602,069	\$360,816
381-3	Maj Skin Dis	1.65	1.25	6.46	19	166	\$1,112,073	\$279,730	\$184,364
381-4	Maj Skin Dis	5.21	3.97	13.88	9	138	\$1,538,193	\$291,121	\$442,465
382-1	Malignant Breast Dis	0.63	0.48	2.4	7	22	\$151,958	\$37,400	\$28,069
382-2	Malignant Breast Dis	0.95	0.73	3.94	43	255	\$1,709,190	\$434,113	\$265,485
382-3	Malignant Breast Dis	1.62	1.24	6.17	51	329	\$2,781,337	\$520,194	\$520,054

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
382-4	Malignant Breast Dis	2.85	2.17	9.98	9	179	\$1,909,563	\$359,239	\$321,887
383-1	Cellulitis & Oth Bact Skin Inf	0.57	0.43	2.89	3,016	9,203	\$49,840,642	\$15,142,773	\$10,544,655
383-2	Cellulitis & Oth Bact Skin Inf	0.79	0.60	4.04	1,799	7,629	\$47,193,317	\$11,969,185	\$8,494,027
383-3	Cellulitis & Oth Bact Skin Inf	1.28	0.97	5.89	520	3,672	\$23,066,218	\$6,058,211	\$4,117,285
383-4	Cellulitis & Oth Bact Skin Inf	3.17	2.42	11.76	30	536	\$4,340,994	\$941,611	\$799,813
384-1	Trauma To Cutaneous Tissue	0.73	0.55	1.86	207	387	\$3,653,220	\$695,941	\$950,334
384-2	Trauma To Cutaneous Tissue	0.85	0.65	2.87	135	461	\$3,632,592	\$763,014	\$675,308
384-3	Trauma To Cutaneous Tissue	1.29	0.98	4.63	31	156	\$1,465,393	\$279,565	\$254,856
384-4	Trauma To Cutaneous Tissue	3.71	2.82	11.07	1	17	\$108,399	\$24,422	\$21,775
385-1	Oth Cutaneous Tis & Breast Dis	0.52	0.39	2.36	399	1,093	\$6,785,187	\$1,940,839	\$1,333,061
385-2	Oth Cutaneous Tis & Breast Dis	0.74	0.56	3.4	193	802	\$4,665,203	\$1,353,954	\$868,118
385-3	Oth Cutaneous Tis & Breast Dis	1.20	0.91	5.21	51	302	\$2,068,591	\$551,453	\$403,951
385-4	Oth Cutaneous Tis & Breast Dis	3.99	3.04	12.43	3	33	\$338,403	\$64,106	\$70,782
401-1	Pituitary & Adrenal Procs	1.82	1.38	2.98	43	161	\$2,281,052	\$312,737	\$528,849
401-2	Pituitary & Adrenal Procs	2.52	1.92	4.18	19	195	\$1,727,770	\$365,988	\$343,584
401-3	Pituitary & Adrenal Procs	4.36	3.32	8.67	15	277	\$2,357,306	\$555,236	\$536,700
401-4	Pituitary & Adrenal Procs	10.23	7.79	21.97	0	0	\$0	\$0	\$0
403-1	Procs for Obesity	1.78	1.36	1.74	330	754	\$14,816,550	\$1,587,429	\$4,370,266
403-2	Procs for Obesity	1.99	1.51	2.17	101	287	\$5,001,565	\$603,325	\$1,377,063
403-3	Procs for Obesity	3.18	2.42	4.89	8	73	\$1,432,227	\$117,629	\$233,740
403-4	Procs for Obesity	9.67	7.36	18.81	3	78	\$952,276	\$144,401	\$245,886
404-1	Thyroid Procs	0.98	0.75	1.28	132	210	\$4,372,501	\$376,437	\$794,066
404-2	Thyroid Procs	1.30	0.99	2.07	74	274	\$3,688,392	\$482,200	\$584,517
404-3	Thyroid Procs	2.84	2.16	6.48	10	87	\$960,873	\$122,927	\$157,655
404-4	Thyroid Procs	6.35	4.84	15.7	0	0	\$0	\$0	\$0
405-1	Oth Procs for Metabolic Dis	1.74	1.32	3.41	4	17	\$219,948	\$27,330	\$45,688
405-2	Oth Procs for Metabolic Dis	2.17	1.65	5.4	19	208	\$1,498,944	\$395,620	\$288,257
405-3	Oth Procs for Metabolic Dis	3.41	2.60	9.48	32	411	\$3,418,059	\$708,907	\$752,094
405-4	Oth Procs for Metabolic Dis	7.72	5.88	21.8	12	338	\$2,981,504	\$599,792	\$650,100
420-1	Diabetes	0.53	0.41	2.51	1,026	2,598	\$16,366,120	\$4,114,255	\$3,280,892

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
420-2	Diabetes	0.70	0.53	2.68	1,873	5,463	\$39,313,580	\$8,775,285	\$7,890,066
420-3	Diabetes	1.11	0.84	4.12	572	2,764	\$20,700,846	\$4,402,973	\$3,769,817
420-4	Diabetes	3.13	2.38	9.51	64	795	\$6,561,622	\$1,199,206	\$1,243,363
421-1	Nutritional Dis	0.49	0.37	3.16	138	388	\$1,297,855	\$698,972	\$416,318
421-2	Nutritional Dis	0.73	0.56	4.07	177	873	\$3,216,024	\$1,711,779	\$813,397
421-3	Nutritional Dis	1.18	0.90	5.77	137	1,156	\$5,353,529	\$2,283,610	\$1,178,836
421-4	Nutritional Dis	3.05	2.32	12.04	15	192	\$929,580	\$378,031	\$294,314
422-1	Hypovolemia	0.38	0.29	1.91	315	635	\$3,517,355	\$1,057,814	\$735,811
422-2	Hypovolemia	0.60	0.46	2.82	443	1,300	\$7,879,581	\$2,232,392	\$1,637,355
422-3	Hypovolemia	0.93	0.71	4.25	169	852	\$5,344,772	\$1,507,081	\$986,748
422-4	Hypovolemia	2.40	1.83	9.09	11	108	\$774,273	\$138,501	\$161,436
423-1	Inborn Errors of Metabolism	0.71	0.54	2.37	21	56	\$464,560	\$91,751	\$94,581
423-2	Inborn Errors of Metabolism	0.95	0.72	3.33	67	249	\$2,074,832	\$457,674	\$418,225
423-3	Inborn Errors of Metabolism	1.58	1.20	5.5	67	313	\$3,106,838	\$641,582	\$715,647
423-4	Inborn Errors of Metabolism	6.41	4.88	16.48	17	140	\$1,221,095	\$312,109	\$564,546
424-1	Oth Endocrine Dis	0.64	0.49	2.42	214	548	\$3,741,659	\$948,600	\$813,252
424-2	Oth Endocrine Dis	0.95	0.72	3.84	196	878	\$5,947,372	\$1,409,550	\$1,083,770
424-3	Oth Endocrine Dis	1.40	1.07	5.72	116	791	\$5,282,160	\$1,316,293	\$1,004,770
424-4	Oth Endocrine Dis	3.40	2.59	11.23	16	228	\$2,091,153	\$411,275	\$386,860
425-1	Electrolyte Dis Exc Hypovolemia	0.53	0.41	2.33	217	532	\$3,494,253	\$808,967	\$692,080
425-2	Electrolyte Dis Exc Hypovolemia	0.70	0.53	2.93	537	1,695	\$11,360,680	\$2,681,914	\$2,244,196
425-3	Electrolyte Dis Exc Hypovolemia	1.10	0.83	4.46	289	1,529	\$10,495,859	\$2,542,310	\$1,967,071
425-4	Electrolyte Dis Exc Hypovolemia	2.81	2.14	9.58	33	499	\$5,365,617	\$887,171	\$820,443
440-1	Kidney Transpl	6.14	4.67	4.61	3	21	\$503,448	\$45,068	\$141,560
440-2	Kidney Transpl	6.89	5.24	5.48	5	27	\$763,247	\$64,035	\$277,821
440-3	Kidney Transpl	8.48	6.46	8.38	6	64	\$1,583,799	\$145,060	\$440,647
440-4	Kidney Transpl	14.07	10.71	17.82	1	31	\$361,034	\$79,288	\$119,772
441-1	Maj Bladder Procs	1.83	1.39	4.59	2	6	\$71,760	\$14,803	\$25,735
441-2	Maj Bladder Procs	2.84	2.16	7.15	26	235	\$2,325,953	\$469,168	\$504,246
441-3	Maj Bladder Procs	3.91	2.98	9.76	22	272	\$3,048,278	\$541,084	\$755,169

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
441-4	Maj Bladder Procs	8.38	6.38	21.08	3	57	\$861,623	\$94,162	\$174,589
442-1	Kidney & Urinary Procs for Malig	1.66	1.26	3.23	50	234	\$2,578,512	\$383,511	\$511,132
442-2	Kidney & Urinary Procs for Malig	1.99	1.51	4.2	57	315	\$3,783,321	\$554,900	\$685,614
442-3	Kidney & Urinary Procs for Malig	3.22	2.45	7.84	40	466	\$5,565,178	\$790,356	\$989,061
442-4	Kidney & Urinary Procs for Malig	7.52	5.72	16.13	4	96	\$775,529	\$180,235	\$200,318
443-1	Kidney & Urinary Procs Nonmalig	1.42	1.08	2.43	221	694	\$9,373,401	\$1,388,601	\$2,208,120
443-2	Kidney & Urinary Procs Nonmalig	1.76	1.34	3.35	138	711	\$7,631,240	\$1,304,343	\$1,617,568
443-3	Kidney & Urinary Procs Nonmalig	2.82	2.15	7.82	88	923	\$7,941,473	\$1,668,382	\$1,600,869
443-4	Kidney & Urinary Procs Nonmalig	6.67	5.08	16.83	9	288	\$2,146,339	\$588,970	\$460,489
444-1	Renal Dialysis Access Proc	1.39	1.06	2.45	23	129	\$1,332,115	\$226,613	\$212,888
444-2	Renal Dialysis Access Proc	1.91	1.45	4.22	112	726	\$6,959,218	\$1,273,027	\$1,408,084
444-3	Renal Dialysis Access Proc	3.24	2.46	8.72	160	1,832	\$16,756,724	\$3,069,887	\$3,371,275
444-4	Renal Dialysis Access Proc	6.04	4.60	15.58	10	171	\$2,211,347	\$229,824	\$365,812
445-1	Oth Bladder Procs	1.03	0.79	1.87	20	56	\$660,155	\$105,276	\$129,438
445-2	Oth Bladder Procs	1.52	1.16	3.01	6	43	\$242,239	\$74,364	\$62,936
445-3	Oth Bladder Procs	2.35	1.79	7.6	15	162	\$1,498,016	\$240,564	\$239,318
445-4	Oth Bladder Procs	4.54	3.46	14.54	3	52	\$537,577	\$117,522	\$107,698
446-1	Urethral Procs	0.86	0.65	1.75	57	115	\$1,788,618	\$195,232	\$293,333
446-2	Urethral Procs	1.13	0.86	2.47	313	960	\$13,224,998	\$1,490,621	\$2,123,755
446-3	Urethral Procs	1.94	1.47	5.89	68	542	\$5,282,737	\$880,267	\$886,968
446-4	Urethral Procs	4.30	3.27	12.74	4	40	\$317,335	\$65,333	\$102,481
447-1	Oth Kidney & Urinary Procs	1.56	1.19	1.85	5	38	\$268,285	\$73,758	\$51,403
447-2	Oth Kidney & Urinary Procs	1.94	1.48	3.27	48	200	\$2,665,601	\$295,470	\$579,380
447-3	Oth Kidney & Urinary Procs	2.93	2.23	6.68	73	769	\$8,298,604	\$1,301,501	\$1,437,302
447-4	Oth Kidney & Urinary Procs	7.29	5.55	18.06	13	349	\$2,468,042	\$635,204	\$687,225
460-1	Renal Failure	0.78	0.59	2.76	117	277	\$2,009,137	\$526,120	\$500,382
460-2	Renal Failure	0.93	0.71	3.55	435	1,605	\$11,678,553	\$2,623,915	\$2,505,696
460-3	Renal Failure	1.16	0.89	4.87	1,762	10,347	\$74,253,625	\$16,594,543	\$12,538,397
460-4	Renal Failure	3.26	2.48	11.22	126	1,691	\$16,356,962	\$2,720,714	\$2,942,752
461-1	Kidney & Urinary Tract Malig	0.82	0.62	2.38	9	25	\$215,044	\$38,775	\$45,963

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
461-2	Kidney & Urinary Tract Malig	0.95	0.72	3.45	52	213	\$1,604,882	\$381,881	\$313,652
461-3	Kidney & Urinary Tract Malig	1.50	1.15	5.86	35	266	\$2,361,094	\$444,499	\$355,439
461-4	Kidney & Urinary Tract Malig	3.21	2.45	11.1	2	12	\$144,065	\$23,603	\$46,391
462-1	Nephritis & Nephrosis	0.58	0.44	2.53	36	100	\$564,158	\$214,154	\$153,867
462-2	Nephritis & Nephrosis	0.81	0.62	3.62	85	305	\$1,847,883	\$589,414	\$469,534
462-3	Nephritis & Nephrosis	1.47	1.12	6.19	40	249	\$1,753,907	\$469,160	\$411,382
462-4	Nephritis & Nephrosis	3.90	2.97	13.6	1	153	\$1,284,838	\$391,325	\$376,060
463-1	Kidney & Urinary Tract Inf	0.55	0.42	2.58	1,486	4,441	\$25,451,546	\$7,557,269	\$5,100,280
463-2	Kidney & Urinary Tract Inf	0.73	0.55	3.4	2,076	7,454	\$47,102,459	\$12,457,654	\$9,378,578
463-3	Kidney & Urinary Tract Inf	1.05	0.80	4.85	766	4,373	\$27,696,708	\$7,456,804	\$5,051,900
463-4	Kidney & Urinary Tract Inf	2.22	1.69	8.67	60	622	\$4,849,668	\$1,098,670	\$876,093
465-1	Urinary Stones & Obstruction	0.58	0.44	1.61	166	345	\$3,256,530	\$544,124	\$585,593
465-2	Urinary Stones & Obstruction	0.74	0.57	1.94	671	1,635	\$18,103,643	\$2,558,624	\$2,954,703
465-3	Urinary Stones & Obstruction	1.23	0.94	3.8	95	469	\$3,703,356	\$845,226	\$745,034
465-4	Urinary Stones & Obstruction	2.41	1.83	7.81	2	22	\$201,296	\$45,727	\$36,537
466-1	Complic Genitourin Dev or Proc	0.52	0.39	1.86	9	16	\$110,024	\$26,933	\$28,146
466-2	Complic Genitourin Dev or Proc	0.86	0.66	3.27	208	718	\$5,577,222	\$1,219,590	\$1,098,226
466-3	Complic Genitourin Dev or Proc	1.45	1.10	5.14	360	2,258	\$15,385,573	\$4,007,643	\$3,449,665
466-4	Complic Genitourin Dev or Proc	2.82	2.15	9.29	90	1,019	\$7,885,685	\$1,819,474	\$1,875,786
468-1	Oth Kidney & Urinary Diags	0.63	0.48	2.35	291	770	\$5,945,724	\$1,266,859	\$1,096,497
468-2	Oth Kidney & Urinary Diags	0.84	0.64	3.16	468	1,567	\$12,429,481	\$2,631,583	\$2,501,197
468-3	Oth Kidney & Urinary Diags	1.27	0.97	4.9	266	1,646	\$11,958,435	\$2,732,472	\$2,124,123
468-4	Oth Kidney & Urinary Diags	2.93	2.23	9.97	22	315	\$2,721,059	\$558,057	\$460,973
480-1	Maj Male Pelvic Procs	1.54	1.18	1.76	43	107	\$2,054,577	\$197,175	\$440,013
480-2	Maj Male Pelvic Procs	1.76	1.34	2.42	18	48	\$1,068,146	\$87,741	\$209,475
480-3	Maj Male Pelvic Procs	3.18	2.42	6.21	1	4	\$40,876	\$6,714	\$19,868
480-4	Maj Male Pelvic Procs	7.71	5.87	16	1	17	\$164,600	\$34,538	\$43,950
481-1	Penis Procs	0.98	0.75	2.07	18	38	\$487,493	\$77,631	\$121,641
481-2	Penis Procs	1.68	1.28	2.35	12	70	\$540,949	\$133,901	\$120,928
481-3	Penis Procs	2.66	2.02	8.16	2	24	\$224,973	\$48,755	\$37,010

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
481-4	Penis Procs	6.44	4.90	20.05	3	70	\$776,506	\$100,184	\$132,769
482-1	Transurethral Prostatectomy	0.74	0.57	1.64	26	47	\$706,068	\$74,881	\$119,558
482-2	Transurethral Prostatectomy	0.97	0.74	2.56	19	99	\$877,305	\$127,554	\$107,242
482-3	Transurethral Prostatectomy	2.05	1.56	6.77	5	41	\$386,038	\$48,978	\$49,592
482-4	Transurethral Prostatectomy	4.26	3.24	12.39	1	10	\$104,412	\$17,918	\$28,038
483-1	Testes & Scrotal Procs	0.83	0.63	1.77	60	106	\$1,434,077	\$188,921	\$318,710
483-2	Testes & Scrotal Procs	1.79	1.37	5.26	14	110	\$875,818	\$188,533	\$152,194
483-3	Testes & Scrotal Procs	3.18	2.42	10.12	7	105	\$1,398,852	\$238,427	\$325,381
483-4	Testes & Scrotal Procs	7.26	5.53	18.18	2	40	\$612,534	\$69,973	\$86,899
484-1	Oth Male Reproductive Procs	1.11	0.85	2.41	6	25	\$212,995	\$26,729	\$40,181
484-2	Oth Male Reproductive Procs	1.64	1.25	1.97	3	7	\$184,385	\$16,098	\$34,695
484-3	Oth Male Reproductive Procs	2.10	1.60	4.81	6	45	\$465,551	\$90,685	\$81,267
484-4	Oth Male Reproductive Procs	6.50	4.95	18.08	2	46	\$257,308	\$97,726	\$83,273
500-1	Malig, Male Reproductive Sys	0.69	0.52	2.44	4	24	\$109,017	\$50,496	\$20,451
500-2	Malig, Male Reproductive Sys	0.97	0.74	4.02	22	112	\$1,073,127	\$193,296	\$144,254
500-3	Malig, Male Reproductive Sys	1.42	1.08	6.07	7	61	\$392,430	\$114,826	\$75,756
500-4	Malig, Male Reproductive Sys	2.79	2.12	10.97	1	15	\$115,445	\$30,262	\$20,316
501-1	Male Reproduct Diags Exc Malig	0.58	0.44	2.52	110	297	\$1,865,476	\$505,564	\$388,341
501-2	Male Reproduct Diags Exc Malig	0.78	0.59	3.44	143	564	\$3,602,596	\$873,093	\$678,945
501-3	Male Reproduct Diags Exc Malig	1.22	0.93	5.12	57	424	\$3,054,297	\$764,082	\$605,153
501-4	Male Reproduct Diags Exc Malig	3.05	2.32	10.55	8	64	\$834,196	\$125,911	\$178,168
510-1	Radical Hysterectomy	1.55	1.18	2.54	24	80	\$1,247,130	\$167,754	\$249,313
510-2	Radical Hysterectomy	1.96	1.49	3.85	22	109	\$1,464,067	\$212,785	\$303,173
510-3	Radical Hysterectomy	3.79	2.88	9	8	73	\$858,207	\$161,030	\$225,361
510-4	Radical Hysterectomy	8.27	6.30	17.23	3	41	\$711,469	\$67,981	\$172,891
511-1	Procs for Uterine/Adnexa Malig	1.53	1.16	3.24	7	27	\$331,848	\$34,325	\$56,627
511-2	Procs for Uterine/Adnexa Malig	2.00	1.52	4.76	32	206	\$1,835,319	\$374,302	\$420,602
511-3	Procs for Uterine/Adnexa Malig	3.14	2.39	8.45	23	370	\$4,361,871	\$637,938	\$787,510
511-4	Procs for Uterine/Adnexa Malig	7.37	5.61	17.91	6	111	\$1,028,994	\$198,356	\$315,681
512-1	Uterine/Adnexa Procs Oth Malig	1.42	1.08	2.3	15	34	\$593,208	\$64,514	\$143,164

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
512-2	Uterine/Adnexa Procs Oth Malig	1.62	1.23	3.17	43	185	\$2,180,413	\$355,143	\$467,520
512-3	Uterine/Adnexa Procs Oth Malig	2.76	2.10	6.68	7	79	\$813,859	\$135,185	\$133,267
512-4	Uterine/Adnexa Procs Oth Malig	6.35	4.83	15.47	1	17	\$790,996	\$15,348	\$164,601
513-1	Uterine/Adnexa Procs Non-Malig	1.00	0.76	1.85	800	1,732	\$26,847,288	\$2,776,471	\$4,777,961
513-2	Uterine/Adnexa Procs Non-Malig	1.19	0.91	2.45	323	1,060	\$14,331,051	\$1,768,504	\$2,338,790
513-3	Uterine/Adnexa Procs Non-Malig	2.11	1.61	5.5	28	174	\$2,007,264	\$309,376	\$388,574
513-4	Uterine/Adnexa Procs Non-Malig	5.77	4.39	14.26	1	19	\$259,554	\$20,271	\$28,064
514-1	Fem Reproduct Reconstr Procs	0.91	0.69	1.34	58	98	\$1,588,820	\$158,692	\$319,188
514-2	Fem Reproduct Reconstr Procs	1.22	0.93	1.7	22	40	\$804,318	\$71,752	\$157,904
514-3	Fem Reproduct Reconstr Procs	2.14	1.63	5.01	1	2	\$70,145	\$4,479	\$16,083
514-4	Fem Reproduct Reconstr Procs	6.96	5.30	15.24	0	0	\$0	\$0	\$0
517-1	D&C for Non-Obstetric Diags	0.84	0.64	1.8	65	109	\$1,371,172	\$145,802	\$295,602
517-2	D&C for Non-Obstetric Diags	1.11	0.84	2.88	51	153	\$1,522,328	\$208,985	\$308,219
517-3	D&C for Non-Obstetric Diags	2.03	1.54	6.29	12	109	\$787,541	\$167,132	\$139,992
517-4	D&C for Non-Obstetric Diags	3.82	2.91	11.6	0	0	\$0	\$0	\$0
518-1	Oth Fem Reproductive Procs	0.98	0.75	2.16	160	426	\$4,305,989	\$781,325	\$997,024
518-2	Oth Fem Reproductive Procs	1.38	1.05	3.6	90	382	\$3,759,075	\$669,056	\$757,037
518-3	Oth Fem Reproductive Procs	2.69	2.05	8.16	19	153	\$1,246,563	\$261,656	\$318,278
518-4	Oth Fem Reproductive Procs	5.65	4.30	17	6	122	\$1,179,924	\$210,470	\$273,418
519-1	Uterine/Adnexa Procs Leiomyoma	1.05	0.80	2.06	397	920	\$13,070,921	\$1,483,151	\$2,500,622
519-2	Uterine/Adnexa Procs Leiomyoma	1.23	0.94	2.69	130	455	\$5,427,265	\$759,852	\$971,019
519-3	Uterine/Adnexa Procs Leiomyoma	2.31	1.76	5.63	8	41	\$714,092	\$64,799	\$109,919
519-4	Uterine/Adnexa Procs Leiomyoma	5.32	4.05	12.92	1	6	\$113,806	\$13,436	\$40,054
530-1	Female Reproductive Sys Malig	0.73	0.56	2.48	22	67	\$596,101	\$145,961	\$106,452
530-2	Female Reproductive Sys Malig	0.95	0.72	3.64	98	487	\$3,642,335	\$913,340	\$609,544
530-3	Female Reproductive Sys Malig	1.60	1.22	6.13	85	711	\$5,563,299	\$1,325,755	\$968,098
530-4	Female Reproductive Sys Malig	3.36	2.56	11.78	10	75	\$774,423	\$153,802	\$238,530
531-1	Female Reproductive Sys Inf	0.63	0.48	2.61	251	713	\$5,390,326	\$1,165,758	\$965,942
531-2	Female Reproductive Sys Inf	0.87	0.67	3.7	132	532	\$3,997,566	\$902,526	\$706,366
531-3	Female Reproductive Sys Inf	1.49	1.14	6.24	43	253	\$1,878,839	\$424,910	\$364,135

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
531-4	Female Reproductive Sys Inf	3.03	2.30	11.1	5	62	\$541,813	\$101,903	\$87,617
532-1	Menstrual & Oth Fem Reprod Dis	0.58	0.44	1.66	324	630	\$6,208,528	\$1,022,136	\$1,137,460
532-2	Menstrual & Oth Fem Reprod Dis	0.70	0.53	2.28	219	579	\$4,919,080	\$962,001	\$924,343
532-3	Menstrual & Oth Fem Reprod Dis	1.17	0.89	4.17	25	122	\$860,723	\$210,269	\$194,212
532-4	Menstrual & Oth Fem Reprod Dis	1.85	1.40	7.8	4	50	\$1,039,796	\$97,184	\$146,317
540-1	Cesarean Del	0.71	0.54	2.97	24,665	69,925	\$497,320,505	\$102,477,959	\$107,105,221
540-2	Cesarean Del	0.86	0.65	3.63	8,732	32,131	\$218,651,936	\$48,192,911	\$46,700,583
540-3	Cesarean Del	1.28	0.97	5.73	2,663	15,501	\$100,380,721	\$24,170,510	\$22,002,316
540-4	Cesarean Del	3.57	2.72	10.11	119	1,194	\$12,545,872	\$1,937,207	\$3,121,637
541-1	Vag Del w Ster &/or D&C	0.66	0.50	2.09	81	190	\$1,736,456	\$232,847	\$290,469
541-2	Vag Del w Ster &/or D&C	0.73	0.56	2.37	123	350	\$2,940,717	\$475,847	\$539,639
541-3	Vag Del w Ster &/or D&C	1.17	0.89	4.22	45	200	\$1,639,468	\$271,756	\$323,102
541-4	Vag Del w Ster &/or D&C	4.06	3.09	8.62	5	34	\$524,413	\$39,991	\$124,270
542-1	Vag Del w Proc Exc Ster &/or D&C	0.45	0.34	2.14	90	197	\$1,031,071	\$289,068	\$252,885
542-2	Vag Del w Proc Exc Ster &/or D&C	0.56	0.43	2.4	108	336	\$1,604,123	\$490,605	\$393,317
542-3	Vag Del w Proc Exc Ster &/or D&C	1.21	0.92	4.57	16	74	\$455,506	\$128,537	\$135,575
542-4	Vag Del w Proc Exc Ster &/or D&C	5.04	3.84	8.44	1	5	\$72,004	\$3,022	\$18,189
544-1	D&C for Obstetric Diags	0.69	0.53	1.29	390	562	\$8,520,433	\$927,688	\$1,667,931
544-2	D&C for Obstetric Diags	0.82	0.62	1.8	255	544	\$6,749,134	\$875,340	\$1,288,489
544-3	D&C for Obstetric Diags	1.60	1.22	3.71	34	133	\$1,060,778	\$249,415	\$348,459
544-4	D&C for Obstetric Diags	4.27	3.25	8.05	7	52	\$981,391	\$71,945	\$205,487
545-1	Ectopic Pregnancy Proc	0.95	0.72	1.65	303	578	\$9,667,552	\$948,570	\$1,766,568
545-2	Ectopic Pregnancy Proc	1.10	0.83	1.94	220	436	\$7,575,171	\$710,780	\$1,481,921
545-3	Ectopic Pregnancy Proc	1.35	1.03	2.56	31	81	\$1,275,155	\$121,737	\$235,825
545-4	Ectopic Pregnancy Proc	2.82	2.15	4.79	1	5	\$108,087	\$7,905	\$17,408
546-1	Oth O.R. Proc for Ob Diag Exc Del	0.75	0.57	2.36	124	384	\$3,627,575	\$633,616	\$584,285
546-2	Oth O.R. Proc for Ob Diag Exc Del	1.06	0.81	3.55	104	423	\$3,138,057	\$696,734	\$670,190
546-3	Oth O.R. Proc for Ob Diag Exc Del	2.21	1.68	7.45	25	164	\$2,149,723	\$303,445	\$500,286
546-4	Oth O.R. Proc for Ob Diag Exc Del	6.50	4.95	13.94	7	149	\$2,124,097	\$258,133	\$436,425
560-1	Vaginal Del	0.42	0.32	2	42,952	95,230	\$464,813,470	\$132,227,606	\$110,138,110

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
560-2	Vaginal Del	0.48	0.36	2.28	17,476	43,871	\$216,487,552	\$62,553,999	\$51,441,344
560-3	Vaginal Del	0.71	0.54	3.38	2,330	9,039	\$43,087,719	\$13,448,447	\$10,408,368
560-4	Vaginal Del	2.17	1.65	6.99	16	204	\$2,181,367	\$322,738	\$483,104
561-1	Postpartum Diags w/o Proc	0.38	0.29	2.02	506	1,177	\$6,983,224	\$1,918,134	\$1,147,374
561-2	Postpartum Diags w/o Proc	0.57	0.43	2.47	786	2,182	\$15,497,842	\$3,558,187	\$2,666,411
561-3	Postpartum Diags w/o Proc	0.89	0.68	3.69	375	1,451	\$11,445,911	\$2,391,246	\$2,059,192
561-4	Postpartum Diags w/o Proc	2.53	1.92	6.96	41	355	\$4,872,962	\$579,578	\$852,115
563-1	Threatened Abortion	0.40	0.31	2.36	952	2,174	\$10,539,851	\$3,489,221	\$2,298,393
563-2	Threatened Abortion	0.55	0.42	3.57	588	2,030	\$9,446,773	\$3,540,207	\$2,010,683
563-3	Threatened Abortion	1.03	0.79	7	93	551	\$2,314,371	\$1,025,035	\$611,595
563-4	Threatened Abortion	1.23	0.94	15	1	12	\$33,608	\$21,153	\$8,219
564-1	Abortion w/o D&C	0.39	0.30	1.31	374	558	\$4,222,818	\$933,796	\$907,341
564-2	Abortion w/o D&C	0.46	0.35	1.58	193	349	\$2,582,433	\$618,937	\$571,653
564-3	Abortion w/o D&C	0.69	0.52	2.52	28	95	\$557,879	\$183,793	\$126,878
564-4	Abortion w/o D&C	3.65	2.78	7.65	6	36	\$302,052	\$72,914	\$137,945
565-1	False Labor	0.20	0.15	1.14	115	137	\$639,169	\$241,873	\$148,573
565-2	False Labor	0.29	0.22	1.78	28	36	\$178,846	\$57,626	\$47,371
565-3	False Labor	0.49	0.37	5.63	2	7	\$33,880	\$12,996	\$7,775
565-4	False Labor	0.54	0.41	6.19	0	0	\$0	\$0	\$0
566-1	Oth Antepartum Diags	0.37	0.29	1.99	2,261	5,127	\$27,835,997	\$8,478,152	\$5,161,457
566-2	Oth Antepartum Diags	0.50	0.38	2.66	3,156	8,935	\$47,429,968	\$15,168,184	\$9,527,130
566-3	Oth Antepartum Diags	0.81	0.62	5.02	1,236	7,186	\$32,313,589	\$11,768,499	\$6,141,069
566-4	Oth Antepartum Diags	2.63	2.00	8.61	36	319	\$2,711,580	\$580,739	\$655,462
580-1	Neo, Tsf<5 Days, Not Born Here	0.35	0.26	1.49	5	22	\$40,564	\$23,273	\$11,714
580-2	Neo, Tsf<5 Days, Not Born Here	0.54	0.41	1.62	12	34	\$152,330	\$34,425	\$41,177
580-3	Neo, Tsf<5 Days, Not Born Here	0.95	0.72	1.84	6	11	\$70,303	\$16,410	\$36,729
580-4	Neo, Tsf<5 Days, Not Born Here	1.36	1.04	1.74	7	19	\$192,221	\$17,681	\$60,761
581-1	Neo, Tsf<5 Days Old, Born Here	0.15	0.11	1.38	65	299	\$603,681	\$196,485	\$55,261
581-2	Neo, Tsf<5 Days Old, Born Here	0.22	0.17	1.29	98	493	\$1,425,539	\$333,874	\$123,386
581-3	Neo, Tsf<5 Days Old, Born Here	0.39	0.29	1.26	40	229	\$987,860	\$170,145	\$91,340

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
581-4	Neo, Tsf<5 Days Old, Born Here	0.79	0.60	1.36	23	144	\$1,316,692	\$82,591	\$116,558
583-1	Neo w Ecmo	18.02	13.72	16.2	1	135	\$882,556	\$249,714	\$287,774
583-2	Neo w Ecmo	20.03	15.25	18	2	77	\$1,171,549	\$178,845	\$300,170
583-3	Neo w Ecmo	23.06	17.56	35.64	18	693	\$8,941,914	\$1,443,304	\$3,073,181
583-4	Neo w Ecmo	36.65	27.91	66.26	10	867	\$14,072,058	\$1,785,955	\$3,901,511
588-1	Neo Bwt <1500G w Maj Proc	10.63	8.09	53.1	2	198	\$1,274,254	\$339,773	\$269,480
588-2	Neo Bwt <1500G w Maj Proc	11.81	8.99	59	8	835	\$5,953,869	\$1,571,175	\$1,209,002
588-3	Neo Bwt <1500G w Maj Proc	24.59	18.72	85.77	49	5,387	\$41,037,764	\$9,493,753	\$10,281,933
588-4	Neo Bwt <1500G w Maj Proc	35.71	27.19	113.3	91	11,142	\$90,853,834	\$19,607,266	\$26,229,591
589-1	Neo Bwt <500G or <24 Wks	18.39	14.00	82.93	6	353	\$2,719,011	\$591,689	\$936,330
589-2	Neo Bwt <500G or <24 Wks	16.72	12.73	93.89	10	702	\$6,768,444	\$1,215,222	\$1,687,346
589-3	Neo Bwt <500G or <24 Wks	12.77	9.73	83.92	33	2,119	\$15,095,644	\$4,199,962	\$3,522,702
589-4	Neo Bwt <500G or <24 Wks	0.43	0.33	3.57	47	3,553	\$20,389,983	\$6,186,769	\$3,523,937
591-1	Neo Bwt 500-749G w/o Maj Proc	8.83	6.72	4.5	2	191	\$1,143,697	\$449,825	\$308,296
591-2	Neo Bwt 500-749G w/o Maj Proc	14.46	11.01	60.48	14	1,435	\$6,628,616	\$2,775,796	\$1,842,464
591-3	Neo Bwt 500-749G w/o Maj Proc	18.23	13.88	76.68	39	2,955	\$19,574,761	\$5,406,454	\$4,805,998
591-4	Neo Bwt 500-749G w/o Maj Proc	28.48	21.69	98.21	78	7,923	\$56,840,872	\$13,208,681	\$15,634,401
593-1	Neo Bwt 750-999G w/o Maj Proc	5.64	4.29	30.43	3	106	\$387,518	\$232,937	\$111,712
593-2	Neo Bwt 750-999G w/o Maj Proc	11.94	9.09	55.79	59	4,057	\$17,122,344	\$7,054,152	\$4,794,040
593-3	Neo Bwt 750-999G w/o Maj Proc	14.99	11.41	66.69	143	11,263	\$52,192,758	\$20,222,598	\$15,295,755
593-4	Neo Bwt 750-999G w/o Maj Proc	22.41	17.06	84.62	105	8,710	\$54,202,243	\$15,011,944	\$16,219,409
602-1	Neo Bwt 1000-1249G w Maj Problem	6.20	4.72	31.66	5	295	\$1,079,108	\$523,975	\$255,730
602-2	Neo Bwt 1000-1249G w Maj Problem	8.85	6.74	45.16	76	3,920	\$13,252,253	\$6,750,586	\$4,495,936
602-3	Neo Bwt 1000-1249G w Maj Problem	11.93	9.08	55.2	155	8,676	\$38,203,074	\$15,677,651	\$12,571,150
602-4	Neo Bwt 1000-1249G w Maj Problem	17.50	13.32	69.8	56	4,823	\$23,649,296	\$8,865,362	\$7,395,239
603-1	Neo Bwt 1000-1249G	4.17	3.18	22.03	9	231	\$497,011	\$366,751	\$192,109
603-2	Neo Bwt 1000-1249G	6.83	5.20	36.55	67	2,859	\$9,996,523	\$4,622,491	\$3,047,119
603-3	Neo Bwt 1000-1249G	10.60	8.07	49.92	50	2,577	\$10,614,522	\$4,144,753	\$3,275,299
603-4	Neo Bwt 1000-1249G	17.26	13.14	62.61	10	516	\$2,992,595	\$743,108	\$980,407
607-1	Neo Bwt 1250-1499G w Maj Problem	4.57	3.48	25.74	14	403	\$1,134,075	\$626,680	\$410,691

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
607-2	Neo Bwt 1250-1499G w Maj Problem	7.10	5.41	36.28	96	4,092	\$13,849,580	\$6,409,016	\$4,327,814
607-3	Neo Bwt 1250-1499G w Maj Problem	8.81	6.71	44.1	117	5,092	\$22,070,553	\$8,684,639	\$6,778,884
607-4	Neo Bwt 1250-1499G w Maj Problem	13.75	10.47	54.64	20	1,191	\$5,810,557	\$2,103,278	\$2,004,336
608-1	Neo Bwt 1250-1499G	3.49	2.65	20.57	39	993	\$2,387,234	\$1,351,700	\$812,166
608-2	Neo Bwt 1250-1499G	5.54	4.22	30.23	141	4,691	\$15,658,957	\$7,210,366	\$4,902,028
608-3	Neo Bwt 1250-1499G	8.29	6.31	39.38	55	2,312	\$9,647,517	\$3,411,505	\$2,869,981
608-4	Neo Bwt 1250-1499G	12.77	9.72	54.82	11	658	\$2,819,725	\$1,040,760	\$946,036
609-1	Neo Bwt 1500-2499G w Maj Proc	5.05	3.84	22.5	1	23	\$153,255	\$41,170	\$36,756
609-2	Neo Bwt 1500-2499G w Maj Proc	5.52	4.20	19.68	8	269	\$1,457,198	\$412,836	\$350,089
609-3	Neo Bwt 1500-2499G w Maj Proc	9.73	7.41	35.86	31	1,577	\$7,753,067	\$2,994,531	\$2,580,114
609-4	Neo Bwt 1500-2499G w Maj Proc	18.94	14.42	61.19	39	1,891	\$16,063,677	\$3,649,617	\$5,839,889
611-1	Neo Bwt 1500-1999G w Maj Anomaly	2.49	1.90	13.82	29	573	\$1,708,838	\$835,522	\$459,996
611-2	Neo Bwt 1500-1999G w Maj Anomaly	3.98	3.03	21.67	105	2,201	\$8,693,746	\$3,196,371	\$2,603,720
611-3	Neo Bwt 1500-1999G w Maj Anomaly	6.68	5.09	32.84	81	2,936	\$11,988,295	\$4,602,221	\$3,691,389
611-4	Neo Bwt 1500-1999G w Maj Anomaly	13.20	10.05	45.08	15	654	\$5,235,781	\$1,369,681	\$1,661,260
612-1	Neo Bwt 1500-1999G Maj Resp Cond	3.12	2.38	17.26	41	869	\$2,445,540	\$1,262,311	\$820,018
612-2	Neo Bwt 1500-1999G Maj Resp Cond	4.49	3.42	24.18	145	3,973	\$12,502,188	\$6,021,140	\$4,117,933
612-3	Neo Bwt 1500-1999G Maj Resp Cond	6.51	4.96	32.12	145	5,009	\$21,004,792	\$8,267,920	\$6,376,544
612-4	Neo Bwt 1500-1999G Maj Resp Cond	10.01	7.62	40.68	23	862	\$4,208,158	\$1,329,197	\$1,510,175
613-1	Neo Bwt 1500-1999G w Inf	2.41	1.84	13.85	84	1,394	\$4,963,676	\$1,961,003	\$1,247,466
613-2	Neo Bwt 1500-1999G w Inf	3.99	3.04	21.38	100	2,336	\$8,663,088	\$3,150,695	\$2,358,016
613-3	Neo Bwt 1500-1999G w Inf	5.62	4.28	29.91	34	1,052	\$4,903,472	\$1,729,063	\$1,286,279
613-4	Neo Bwt 1500-1999G w Inf	9.79	7.45	44.21	3	264	\$1,018,964	\$410,532	\$266,231
614-1	Neo Bwt 1500-1999G	1.69	1.28	10.76	514	7,283	\$19,416,675	\$9,784,803	\$5,226,549
614-2	Neo Bwt 1500-1999G	3.55	2.71	19.49	404	8,719	\$27,436,476	\$13,029,993	\$9,024,742
614-3	Neo Bwt 1500-1999G	5.51	4.19	28.03	75	2,224	\$7,944,304	\$3,275,596	\$2,509,152
614-4	Neo Bwt 1500-1999G	8.55	6.51	36.48	3	117	\$557,122	\$218,949	\$172,593

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
621-1	Neo Bwt 2000-2499G w Maj Anomaly	1.33	1.01	8.07	38	400	\$1,282,180	\$562,717	\$338,247
621-2	Neo Bwt 2000-2499G w Maj Anomaly	2.60	1.98	13.77	94	1,501	\$5,832,153	\$2,202,358	\$1,624,592
621-3	Neo Bwt 2000-2499G w Maj Anomaly	4.45	3.39	21.39	74	1,614	\$7,143,105	\$2,638,440	\$2,266,702
621-4	Neo Bwt 2000-2499G w Maj Anomaly	8.57	6.53	29.3	23	985	\$6,340,927	\$1,951,378	\$1,789,619
622-1	Neo Bwt 2000-2499G Maj Resp Cond	2.00	1.53	10.84	76	911	\$2,918,613	\$1,229,378	\$936,733
622-2	Neo Bwt 2000-2499G Maj Resp Cond	2.80	2.13	14.3	160	2,633	\$9,367,771	\$3,818,778	\$2,844,197
622-3	Neo Bwt 2000-2499G Maj Resp Cond	4.02	3.06	19.21	91	2,020	\$9,220,114	\$2,860,160	\$2,327,328
622-4	Neo Bwt 2000-2499G Maj Resp Cond	7.63	5.81	24.13	10	291	\$1,942,406	\$441,945	\$473,923
623-1	Neo Bwt 2000-2499G w Inf	1.60	1.22	8.99	190	2,046	\$8,071,417	\$2,248,915	\$1,790,165
623-2	Neo Bwt 2000-2499G w Inf	2.50	1.90	13.36	177	2,504	\$10,609,520	\$3,341,490	\$2,684,411
623-3	Neo Bwt 2000-2499G w Inf	4.10	3.12	19.27	35	754	\$3,648,614	\$1,036,889	\$862,964
623-4	Neo Bwt 2000-2499G w Inf	6.26	4.76	24.81	1	13	\$14,914	\$11,184	\$14,914
625-1	Neo Bwt 2000-2499G w Oth Sig Cond	1.93	1.47	11.07	297	4,359	\$13,115,409	\$6,115,806	\$3,625,597
625-2	Neo Bwt 2000-2499G w Oth Sig Cond	2.81	2.14	15.79	144	2,718	\$10,216,981	\$4,419,561	\$2,704,507
625-3	Neo Bwt 2000-2499G w Oth Sig Cond	3.63	2.76	18.68	29	618	\$2,549,174	\$1,053,484	\$693,553
625-4	Neo Bwt 2000-2499G w Oth Sig Cond	5.22	3.98	20.2	1	27	\$127,980	\$28,925	\$29,569
626-1	Norm Newborn, Bwt 2000-2499G	0.19	0.14	2.64	183	1,387	\$3,103,641	\$1,488,405	\$217,766
626-2	Norm Newborn, Bwt 2000-2499G	0.52	0.40	4.4	295	2,432	\$5,644,932	\$2,769,855	\$992,064
626-3	Norm Newborn, Bwt 2000-2499G	1.30	0.99	8.15	619	6,521	\$18,276,237	\$8,295,194	\$4,975,588
626-4	Norm Newborn, Bwt 2000-2499G	4.17	3.17	22.82	1	21	\$87,235	\$30,217	\$23,069
630-1	Neo Bwt >2499G w Maj CV Proc	2.63	2.00	4.51	3	26	\$181,270	\$20,869	\$43,743
630-2	Neo Bwt >2499G w Maj CV Proc	4.34	3.30	7.89	9	175	\$1,693,342	\$376,738	\$352,500
630-3	Neo Bwt >2499G w Maj CV Proc	7.87	5.99	13.1	34	1,111	\$13,682,536	\$1,910,020	\$3,029,020
630-4	Neo Bwt >2499G w Maj CV Proc	16.58	12.62	36.64	64	3,647	\$41,404,054	\$7,079,057	\$10,954,338

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
631-1	Neo Bwt >2499G w Oth Maj Proc	1.42	1.08	3.15	12	164	\$1,045,969	\$261,126	\$171,681
631-2	Neo Bwt >2499G w Oth Maj Proc	2.64	2.01	7.52	52	1,000	\$5,746,998	\$1,792,157	\$1,155,072
631-3	Neo Bwt >2499G w Oth Maj Proc	5.89	4.48	19.5	96	4,001	\$21,651,711	\$7,220,481	\$5,004,614
631-4	Neo Bwt >2499G w Oth Maj Proc	16.98	12.93	48.37	86	5,081	\$42,394,795	\$9,813,690	\$12,529,829
633-1	Neo Bwt >2499G w Maj Anomaly	0.33	0.25	2.71	266	1,786	\$5,277,032	\$2,074,184	\$634,577
633-2	Neo Bwt >2499G w Maj Anomaly	1.11	0.85	5.57	419	4,862	\$18,971,806	\$7,047,087	\$3,264,624
633-3	Neo Bwt >2499G w Maj Anomaly	2.57	1.96	10.87	323	6,748	\$31,755,533	\$10,990,382	\$6,444,365
633-4	Neo Bwt >2499G w Maj Anomaly	8.16	6.21	24.7	157	6,360	\$52,289,116	\$12,707,485	\$13,059,202
634-1	Neo, Bwt >2499G w Maj Resp Cond	0.79	0.60	4.33	215	2,354	\$8,626,380	\$2,977,633	\$1,435,406
634-2	Neo, Bwt >2499G w Maj Resp Cond	1.48	1.12	6.9	425	5,811	\$23,699,503	\$8,075,576	\$4,483,672
634-3	Neo, Bwt >2499G w Maj Resp Cond	2.98	2.27	11.69	307	7,720	\$41,501,383	\$12,590,739	\$8,150,520
634-4	Neo, Bwt >2499G w Maj Resp Cond	7.66	5.83	22	148	7,033	\$53,003,605	\$12,226,508	\$12,542,286
636-1	Neo Bwt >2499G w Inf	0.94	0.72	5.4	1,166	10,398	\$34,501,619	\$12,120,434	\$6,946,476
636-2	Neo Bwt >2499G w Inf	1.47	1.12	7.36	614	6,993	\$27,308,881	\$8,668,077	\$5,647,882
636-3	Neo Bwt >2499G w Inf	2.60	1.98	11.19	114	1,826	\$8,497,887	\$2,505,038	\$1,919,722
636-4	Neo Bwt >2499G w Inf	6.48	4.94	20.03	10	416	\$2,867,544	\$634,187	\$626,451
639-1	Neo Bwt >2499G w Oth Sig Cond	0.56	0.43	3.49	1,243	15,824	\$41,514,310	\$21,543,600	\$4,986,146
639-2	Neo Bwt >2499G w Oth Sig Cond	1.11	0.84	6.01	507	7,864	\$23,743,730	\$11,476,663	\$3,943,438
639-3	Neo Bwt >2499G w Oth Sig Cond	2.00	1.52	8.71	80	1,539	\$6,048,132	\$2,386,214	\$1,196,596
639-4	Neo Bwt >2499G w Oth Sig Cond	5.09	3.88	15.13	7	168	\$734,170	\$277,654	\$223,829
640-1	Normal Newborn, Bwt >2499G	0.13	0.10	2.08	70,708	175,888	\$172,126,249	\$60,503,623	\$55,470,488
640-2	Normal Newborn, Bwt >2499G	0.19	0.14	2.35	14,598	48,054	\$62,542,947	\$22,006,754	\$16,776,810
640-3	Normal Newborn, Bwt >2499G	0.50	0.38	3.49	4,307	19,919	\$43,535,904	\$15,903,702	\$13,269,374
640-4	Normal Newborn, Bwt >2499G	2.49	1.89	12.71	2	33	\$187,444	\$30,950	\$29,909
650-1	Splenectomy	1.69	1.29	3.62	22	121	\$1,519,947	\$202,730	\$250,496
650-2	Splenectomy	2.24	1.71	5.19	18	129	\$1,508,673	\$232,948	\$299,691
650-3	Splenectomy	3.70	2.82	8.61	15	166	\$2,604,050	\$330,002	\$567,742
650-4	Splenectomy	7.44	5.66	15.78	10	212	\$1,925,172	\$329,342	\$493,344
651-1	Oth Procs of Blood & Rel Organs	1.28	0.98	3.15	43	194	\$1,598,770	\$317,293	\$345,228
651-2	Oth Procs of Blood & Rel Organs	1.80	1.37	4.32	25	153	\$1,463,840	\$264,942	\$278,347

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
651-3	Oth Procs of Blood & Rel Organs	2.96	2.26	9.03	14	233	\$1,736,149	\$417,139	\$297,471
651-4	Oth Procs of Blood & Rel Organs	9.03	6.87	24.68	4	86	\$1,444,592	\$159,002	\$304,814
660-1	Maj Hem/Immun Diag	0.87	0.66	2.95	131	458	\$3,426,142	\$847,207	\$752,271
660-2	Maj Hem/Immun Diag	1.06	0.81	3.97	503	2,244	\$15,869,866	\$4,109,361	\$3,557,474
660-3	Maj Hem/Immun Diag	1.82	1.38	6.36	318	2,369	\$20,117,417	\$4,422,008	\$4,166,647
660-4	Maj Hem/Immun Diag	5.05	3.84	13.58	37	827	\$7,722,750	\$1,723,048	\$1,999,020
661-1	Coagulation & Platelet Dis	1.14	0.87	2.63	138	455	\$5,284,313	\$941,084	\$1,130,358
661-2	Coagulation & Platelet Dis	1.36	1.04	3.6	118	466	\$4,823,607	\$880,979	\$1,111,458
661-3	Coagulation & Platelet Dis	2.63	2.00	5.3	89	410	\$6,228,438	\$734,512	\$1,653,707
661-4	Coagulation & Platelet Dis	5.79	4.41	13.06	14	389	\$6,160,993	\$798,821	\$1,289,452
662-1	Sickle Cell Anemia Crisis	0.77	0.59	4.05	2,121	8,642	\$40,750,788	\$15,576,946	\$10,470,181
662-2	Sickle Cell Anemia Crisis	1.03	0.79	5.2	1,168	6,562	\$34,723,112	\$11,743,387	\$7,786,743
662-3	Sickle Cell Anemia Crisis	1.68	1.28	7.54	262	2,235	\$13,584,086	\$3,844,954	\$2,705,878
662-4	Sickle Cell Anemia Crisis	4.14	3.16	13.22	40	752	\$6,639,809	\$1,442,251	\$1,415,422
663-1	Oth Dis of Blood & Rel Organs	0.62	0.47	2.25	1,260	2,867	\$19,800,130	\$4,824,571	\$4,838,623
663-2	Oth Dis of Blood & Rel Organs	0.80	0.61	2.91	672	1,971	\$15,953,117	\$3,207,622	\$3,250,774
663-3	Oth Dis of Blood & Rel Organs	1.18	0.90	4.35	249	1,438	\$11,464,814	\$2,365,956	\$1,864,285
663-4	Oth Dis of Blood & Rel Organs	2.55	1.94	8.18	27	330	\$2,833,259	\$564,944	\$448,905
680-1	Maj O.R. Proc Lymphatic Neoplasm	1.87	1.42	3.92	27	178	\$1,965,486	\$360,478	\$394,049
680-2	Maj O.R. Proc Lymphatic Neoplasm	2.66	2.02	6.11	40	482	\$4,751,808	\$905,199	\$772,553
680-3	Maj O.R. Proc Lymphatic Neoplasm	4.70	3.57	11.91	36	599	\$6,478,492	\$1,258,419	\$1,401,611
680-4	Maj O.R. Proc Lymphatic Neoplasm	10.63	8.09	25.36	21	544	\$7,846,906	\$1,202,158	\$2,364,652
681-1	Oth O.R. Proc Lymphatic Neoplasm	1.35	1.03	2.51	56	264	\$2,986,495	\$441,964	\$561,385
681-2	Oth O.R. Proc Lymphatic Neoplasm	1.93	1.47	4.82	81	606	\$5,899,869	\$1,026,504	\$1,000,884
681-3	Oth O.R. Proc Lymphatic Neoplasm	3.81	2.90	11.2	64	971	\$9,650,948	\$1,649,384	\$1,877,128
681-4	Oth O.R. Proc Lymphatic Neoplasm	9.48	7.22	24.53	14	331	\$4,640,763	\$556,183	\$998,750
690-1	Acute Leukemia	1.66	1.27	4.9	43	299	\$2,670,145	\$603,721	\$507,459
690-2	Acute Leukemia	2.71	2.06	7.89	80	826	\$7,211,249	\$1,678,230	\$1,668,456
690-3	Acute Leukemia	5.24	3.99	15.92	104	1,916	\$17,817,033	\$3,554,465	\$4,053,408
690-4	Acute Leukemia	11.31	8.61	28.9	75	2,123	\$25,204,921	\$4,163,962	\$6,643,578

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
691-1	Lymphoma, Myeloma & Non-Ac Leuk	1.32	1.00	3.74	61	347	\$3,063,133	\$619,719	\$550,379
691-2	Lymphoma, Myeloma & Non-Ac Leuk	1.64	1.25	5.32	139	982	\$7,796,988	\$1,769,491	\$1,539,853
691-3	Lymphoma, Myeloma & Non-Ac Leuk	2.56	1.95	8.46	111	1,339	\$10,592,895	\$2,659,055	\$2,240,819
691-4	Lymphoma, Myeloma & Non-Ac Leuk	5.76	4.38	16.82	39	743	\$7,536,113	\$1,305,574	\$1,701,921
692-1	Radiothapy	1.11	0.85	3.41	27	91	\$456,272	\$212,762	\$193,857
692-2	Radiothapy	1.97	1.50	4.3	17	94	\$638,980	\$194,456	\$213,629
692-3	Radiothapy	2.84	2.16	7.86	6	43	\$316,304	\$92,195	\$114,445
692-4	Radiothapy	5.06	3.85	14.72	0	0	\$0	\$0	\$0
693-1	Chemothapy	1.00	0.76	2.84	553	1,638	\$15,287,171	\$3,307,284	\$3,924,793
693-2	Chemothapy	1.26	0.96	3.46	1,918	7,101	\$65,038,221	\$14,350,796	\$16,156,044
693-3	Chemothapy	2.52	1.92	7.31	324	2,565	\$20,375,480	\$5,042,692	\$5,487,762
693-4	Chemothapy	8.43	6.42	24.26	74	1,684	\$18,168,245	\$3,263,814	\$4,549,153
694-1	Lymphatic & Oth Malig & Neoplasms	0.81	0.62	2.71	28	161	\$1,299,574	\$312,120	\$201,848
694-2	Lymphatic & Oth Malig & Neoplasms	1.05	0.80	3.85	84	463	\$3,593,903	\$809,397	\$555,983
694-3	Lymphatic & Oth Malig & Neoplasms	1.72	1.31	6.43	86	690	\$5,305,273	\$1,282,148	\$980,196
694-4	Lymphatic & Oth Malig & Neoplasms	3.66	2.78	11.91	14	189	\$1,976,771	\$308,102	\$421,882
710-1	Inf & Parasit Dis Incl HIV w O.R. Proc	1.34	1.02	4.18	25	183	\$1,653,388	\$275,887	\$221,485
710-2	Inf & Parasit Dis Incl HIV w O.R. Proc	2.21	1.69	6.68	84	769	\$6,586,356	\$1,224,125	\$1,236,194
710-3	Inf & Parasit Dis Incl HIV w O.R. Proc	3.66	2.79	11.06	212	3,214	\$29,104,249	\$5,211,520	\$5,214,095
710-4	Inf & Parasit Dis Incl HIV w O.R. Proc	7.99	6.08	19.02	365	8,565	\$111,528,581	\$14,330,849	\$23,012,644
711-1	Post-Op, Device Inf w O.R. Proc	1.37	1.05	4.41	68	441	\$3,093,554	\$784,130	\$605,678
711-2	Post-Op, Device Inf w O.R. Proc	1.99	1.51	6.38	153	1,353	\$12,231,004	\$2,170,161	\$1,975,736
711-3	Post-Op, Device Inf w O.R. Proc	3.48	2.65	10.76	93	1,250	\$10,790,234	\$2,259,605	\$2,312,972
711-4	Post-Op, Device Inf w O.R. Proc	8.32	6.34	20.76	46	1,179	\$14,286,580	\$2,185,793	\$3,251,021
720-1	Septicemia & Disseminated Inf	0.71	0.54	3.34	224	1,388	\$5,668,818	\$2,183,308	\$1,120,638
720-2	Septicemia & Disseminated Inf	1.01	0.77	4.44	666	4,178	\$26,084,741	\$6,487,637	\$4,199,929
720-3	Septicemia & Disseminated Inf	1.74	1.33	6.62	1,190	9,714	\$78,224,382	\$15,455,390	\$13,120,295
720-4	Septicemia & Disseminated Inf	4.01	3.05	11.34	1,383	17,982	\$197,517,767	\$29,472,187	\$39,716,863
721-1	Post-Op, Post-Trauma, Device Inf	0.75	0.57	3.45	265	967	\$6,402,031	\$1,634,187	\$1,249,497
721-2	Post-Op, Post-Trauma, Device Inf	1.05	0.80	4.48	426	2,277	\$14,975,618	\$4,042,860	\$2,876,082

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
721-3	Post-Op, Post-Trauma, Device Inf	1.76	1.34	6.64	417	3,648	\$24,166,974	\$6,466,901	\$4,752,977
721-4	Post-Op, Post-Trauma, Device Inf	3.41	2.60	10.59	232	3,344	\$28,074,171	\$5,999,028	\$6,071,130
722-1	Fever	0.47	0.36	2.22	828	1,927	\$8,868,233	\$3,356,521	\$2,449,316
722-2	Fever	0.73	0.56	2.89	434	1,177	\$7,137,960	\$2,085,938	\$1,991,387
722-3	Fever	1.11	0.84	4.18	123	535	\$3,852,706	\$1,008,258	\$903,680
722-4	Fever	2.16	1.64	6.91	19	103	\$1,234,155	\$171,540	\$289,439
723-1	Viral Illness	0.44	0.34	2.06	515	1,174	\$6,213,998	\$2,152,531	\$1,498,924
723-2	Viral Illness	0.67	0.51	2.74	321	900	\$5,448,361	\$1,697,008	\$1,417,861
723-3	Viral Illness	1.18	0.90	4.51	122	648	\$4,067,235	\$1,376,716	\$1,007,376
723-4	Viral Illness	4.04	3.07	11.69	15	289	\$4,067,577	\$708,468	\$885,056
724-1	Oth Inf & Parasit Diseases	0.80	0.61	3.78	257	1,197	\$5,655,758	\$2,222,846	\$1,321,748
724-2	Oth Inf & Parasit Diseases	1.01	0.77	4.49	165	1,031	\$5,519,629	\$1,950,597	\$1,120,935
724-3	Oth Inf & Parasit Diseases	1.68	1.28	6.57	102	792	\$4,852,609	\$1,467,660	\$1,104,408
724-4	Oth Inf & Parasit Diseases	4.11	3.13	12.26	42	652	\$5,233,228	\$1,257,964	\$1,322,768
740-1	Mental Illness Diag w O.R. Proc	1.65	1.26	6.31	2	19	\$86,340	\$45,492	\$26,078
740-2	Mental Illness Diag w O.R. Proc	1.95	1.48	11.15	9	81	\$783,736	\$131,483	\$110,035
740-3	Mental Illness Diag w O.R. Proc	3.61	2.75	16.97	0	0	\$0	\$0	\$0
740-4	Mental Illness Diag w O.R. Proc	5.91	4.50	26.74	0	0	\$0	\$0	\$0
750-1	Schizophrenia	0.83	0.63	8.96	1,293	8,272	\$20,122,321	\$13,547,101	\$6,207,492
750-2	Schizophrenia	0.94	0.72	9.83	2,005	14,385	\$34,585,600	\$23,176,298	\$11,004,027
750-3	Schizophrenia	1.32	1.01	12.51	134	1,092	\$2,936,845	\$1,892,447	\$961,841
750-4	Schizophrenia	2.70	2.05	22.46	6	112	\$414,040	\$143,140	\$80,331
751-1	Maj Depression	0.46	0.35	4.72	1,502	5,774	\$17,032,022	\$9,121,992	\$4,089,871
751-2	Maj Depression	0.66	0.51	6.5	1,673	8,673	\$26,811,195	\$13,806,885	\$6,432,805
751-3	Maj Depression	1.12	0.85	9.34	111	708	\$2,799,615	\$1,131,228	\$679,406
751-4	Maj Depression	2.07	1.58	17.73	14	239	\$835,722	\$301,470	\$161,041
752-1	Dis of Personality	0.44	0.34	4.52	2	5	\$20,385	\$6,825	\$3,848
752-2	Dis of Personality	0.60	0.46	5.67	14	82	\$248,867	\$126,372	\$53,483
752-3	Dis of Personality	1.12	0.86	8.59	3	24	\$213,994	\$46,895	\$22,392
752-4	Dis of Personality	1.24	0.94	9.45	0	0	\$0	\$0	\$0

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
753-1	Bipolar Dis	0.52	0.39	5.35	1,546	6,505	\$17,555,764	\$10,111,686	\$4,597,986
753-2	Bipolar Dis	0.71	0.54	7.15	1,313	6,829	\$19,083,492	\$10,830,021	\$5,349,845
753-3	Bipolar Dis	1.09	0.83	9.96	83	638	\$1,958,742	\$996,486	\$499,158
753-4	Bipolar Dis	1.99	1.52	17.36	8	110	\$307,381	\$203,596	\$102,068
754-1	Depression Exc Maj Dep	0.39	0.30	3.67	849	2,458	\$6,617,175	\$3,943,401	\$1,889,475
754-2	Depression Exc Maj Dep	0.53	0.41	4.81	376	1,425	\$3,913,491	\$2,406,627	\$1,169,359
754-3	Depression Exc Maj Dep	0.84	0.64	6.73	23	105	\$304,197	\$186,284	\$116,210
754-4	Depression Exc Maj Dep	1.84	1.40	13.68	1	4	\$18,694	\$2,808	\$6,620
755-1	Adjust Dis & Neuroses Exc Dep	0.33	0.25	3.36	328	780	\$2,315,022	\$1,247,991	\$646,318
755-2	Adjust Dis & Neuroses Exc Dep	0.53	0.41	5.19	178	644	\$1,764,415	\$1,001,522	\$547,102
755-3	Adjust Dis & Neuroses Exc Dep	0.77	0.59	7.24	29	130	\$362,060	\$251,546	\$132,767
755-4	Adjust Dis & Neuroses Exc Dep	0.98	0.75	8.6	0	0	\$0	\$0	\$0
756-1	Acute Anxiety & Delirium States	0.57	0.44	2.81	222	502	\$3,324,657	\$864,830	\$746,916
756-2	Acute Anxiety & Delirium States	0.69	0.53	3.42	97	252	\$1,850,247	\$438,814	\$402,790
756-3	Acute Anxiety & Delirium States	0.84	0.64	4.01	14	71	\$527,701	\$115,550	\$67,142
756-4	Acute Anxiety & Delirium States	2.22	1.69	8.54	1	6	\$52,115	\$10,707	\$15,070
757-1	Organic Mental Health Disturb	0.74	0.56	7.12	38	209	\$899,393	\$332,341	\$213,744
757-2	Organic Mental Health Disturb	0.85	0.65	7.76	68	405	\$1,252,882	\$692,216	\$341,659
757-3	Organic Mental Health Disturb	1.15	0.87	8.84	17	131	\$575,402	\$210,940	\$118,618
757-4	Organic Mental Health Disturb	2.28	1.73	14.44	1	8	\$156,549	\$7,213	\$8,218
758-1	Childhood Behavioral Dis	0.57	0.43	5.82	176	576	\$1,311,067	\$1,015,078	\$586,874
758-2	Childhood Behavioral Dis	0.74	0.56	7.58	217	862	\$1,945,666	\$1,489,730	\$908,092
758-3	Childhood Behavioral Dis	1.06	0.81	9.72	14	53	\$141,876	\$84,356	\$81,463
758-4	Childhood Behavioral Dis	1.17	0.89	8	1	2	\$23,877	\$5,168	\$9,875
759-1	Eating Dis	1.30	0.99	9.45	2	8	\$43,439	\$17,272	\$19,224
759-2	Eating Dis	1.72	1.31	11.3	8	64	\$176,453	\$119,679	\$90,188
759-3	Eating Dis	1.84	1.40	12.09	6	37	\$179,036	\$75,630	\$70,373
759-4	Eating Dis	3.43	2.61	18.18	1	12	\$32,758	\$31,006	\$29,008
760-1	Oth Mental Health Dis	0.64	0.49	5.66	20	88	\$254,864	\$158,420	\$75,866
760-2	Oth Mental Health Dis	0.80	0.61	6.28	29	115	\$537,048	\$194,292	\$147,021

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
760-3	Oth Mental Health Dis	1.08	0.82	6.95	8	54	\$168,756	\$105,803	\$57,288
760-4	Oth Mental Health Dis	1.80	1.37	8.88	0	0	\$0	\$0	\$0
770-1	Drug & Alcohol Abuse, AMA	0.28	0.22	2.12	57	80	\$559,248	\$121,433	\$89,378
770-2	Drug & Alcohol Abuse, AMA	0.35	0.27	2.16	82	158	\$1,100,824	\$266,383	\$169,544
770-3	Drug & Alcohol Abuse, AMA	0.79	0.60	3.1	18	52	\$493,131	\$75,268	\$82,442
770-4	Drug & Alcohol Abuse, AMA	3.14	2.39	7.87	1	17	\$97,171	\$44,441	\$26,722
772-1	Alc & Drug Dep w Rehab or Detox	0.63	0.48	11.3	1	6	\$12,595	\$12,553	\$4,511
772-2	Alc & Drug Dep w Rehab or Detox	0.79	0.60	12.54	5	14	\$68,329	\$43,470	\$21,743
772-3	Alc & Drug Dep w Rehab or Detox	0.92	0.70	10.21	0	0	\$0	\$0	\$0
772-4	Alc & Drug Dep w Rehab or Detox	3.83	2.92	18.57	0	0	\$0	\$0	\$0
773-1	Opioid Abuse & Dependence	0.33	0.25	3.21	320	943	\$2,487,375	\$1,621,962	\$627,493
773-2	Opioid Abuse & Dependence	0.43	0.33	3.86	424	1,539	\$5,556,478	\$2,663,788	\$1,135,836
773-3	Opioid Abuse & Dependence	0.89	0.68	4.7	36	137	\$948,704	\$219,188	\$187,247
773-4	Opioid Abuse & Dependence	2.62	1.99	8.73	0	0	\$0	\$0	\$0
774-1	Cocaine Abuse & Dependence	0.41	0.32	2.89	19	46	\$254,873	\$80,472	\$46,427
774-2	Cocaine Abuse & Dependence	0.43	0.33	3.68	117	332	\$1,482,246	\$562,140	\$298,001
774-3	Cocaine Abuse & Dependence	0.89	0.68	4.23	19	70	\$388,579	\$128,251	\$101,594
774-4	Cocaine Abuse & Dependence	3.11	2.37	9.46	2	11	\$78,053	\$14,408	\$37,147
775-1	Alcohol Abuse & Dependence	0.40	0.31	2.93	233	667	\$2,762,487	\$1,109,907	\$563,262
775-2	Alcohol Abuse & Dependence	0.62	0.47	3.53	591	2,138	\$11,402,932	\$3,397,688	\$2,156,567
775-3	Alcohol Abuse & Dependence	1.24	0.94	5.35	193	1,385	\$8,328,170	\$2,237,073	\$1,392,944
775-4	Alcohol Abuse & Dependence	3.89	2.96	12.43	36	605	\$5,515,369	\$1,185,410	\$1,110,835
776-1	Oth Drug Abuse & Dependence	0.45	0.34	3.33	93	486	\$1,576,526	\$869,048	\$251,305
776-2	Oth Drug Abuse & Dependence	0.61	0.46	3.62	144	509	\$2,370,794	\$837,197	\$514,486
776-3	Oth Drug Abuse & Dependence	1.06	0.81	4.68	25	142	\$932,962	\$255,286	\$158,295
776-4	Oth Drug Abuse & Dependence	2.37	1.81	8.48	5	77	\$359,675	\$96,204	\$60,732
791-1	O.R. Proc for Complic of Care	1.21	0.92	2.88	73	205	\$2,476,554	\$379,856	\$570,233
791-2	O.R. Proc for Complic of Care	1.84	1.40	4.76	106	631	\$6,121,423	\$1,087,711	\$1,283,762
791-3	O.R. Proc for Complic of Care	3.20	2.43	8.81	54	602	\$5,102,176	\$1,103,107	\$1,211,980
791-4	O.R. Proc for Complic of Care	7.90	6.02	19.15	19	454	\$4,610,152	\$893,909	\$1,191,573

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
811-1	Allergic Reactions	0.39	0.30	1.49	100	162	\$1,077,573	\$291,177	\$246,209
811-2	Allergic Reactions	0.54	0.41	1.95	83	194	\$1,578,928	\$309,593	\$256,562
811-3	Allergic Reactions	1.20	0.92	3.76	16	53	\$501,940	\$86,577	\$112,658
811-4	Allergic Reactions	3.27	2.49	8.59	6	46	\$788,226	\$74,971	\$135,152
812-1	Poisoning of Medicinal Agents	0.44	0.34	1.56	563	1,033	\$8,266,440	\$1,618,197	\$1,683,073
812-2	Poisoning of Medicinal Agents	0.57	0.43	2.14	1,149	2,542	\$18,930,971	\$3,845,083	\$3,704,020
812-3	Poisoning of Medicinal Agents	1.07	0.81	3.36	490	1,862	\$15,780,772	\$2,946,993	\$2,978,773
812-4	Poisoning of Medicinal Agents	2.66	2.03	6.96	265	1,903	\$20,799,943	\$2,879,895	\$4,324,292
813-1	Oth Complics of Treatment	0.64	0.48	2.38	137	416	\$3,019,622	\$674,685	\$516,691
813-2	Oth Complics of Treatment	0.87	0.66	3.2	204	893	\$6,205,856	\$1,571,325	\$1,155,947
813-3	Oth Complics of Treatment	1.45	1.11	5.11	112	619	\$5,040,516	\$1,063,905	\$971,810
813-4	Oth Complics of Treatment	3.24	2.47	9.94	16	342	\$3,948,415	\$512,011	\$716,952
815-1	Oth Inj And Poisoning Diags	0.66	0.50	1.57	80	136	\$987,396	\$238,515	\$318,216
815-2	Oth Inj And Poisoning Diags	0.71	0.54	2.57	79	211	\$1,245,282	\$378,516	\$345,773
815-3	Oth Inj And Poisoning Diags	1.18	0.90	4.18	67	310	\$2,042,323	\$595,571	\$488,732
815-4	Oth Inj And Poisoning Diags	3.78	2.88	10.47	41	386	\$4,754,980	\$660,229	\$1,068,649
816-1	Toxic Eff of Non-Medicinal Subst	0.75	0.57	1.61	164	290	\$3,091,564	\$459,705	\$704,987
816-2	Toxic Eff of Non-Medicinal Subst	0.75	0.57	2.24	185	460	\$3,996,144	\$749,992	\$820,472
816-3	Toxic Eff of Non-Medicinal Subst	1.20	0.91	3.42	132	516	\$4,527,481	\$870,148	\$925,907
816-4	Toxic Eff of Non-Medicinal Subst	2.97	2.27	7.52	87	849	\$8,946,267	\$1,314,251	\$1,621,496
841-1	Ext 3Rd Deg Burns w Skin Graft	7.00	5.33	8.1	0	0	\$0	\$0	\$0
841-2	Ext 3Rd Deg Burns w Skin Graft	7.78	5.92	9	0	0	\$0	\$0	\$0
841-3	Ext 3Rd Deg Burns w Skin Graft	9.05	6.89	22.41	8	217	\$2,904,991	\$512,288	\$921,403
841-4	Ext 3Rd Deg Burns w Skin Graft	28.21	21.48	44.61	9	361	\$7,435,634	\$828,050	\$2,188,696
842-1	Full Thick Burns w Graft	2.24	1.70	6.7	20	128	\$846,600	\$289,433	\$326,904
842-2	Full Thick Burns w Graft	3.39	2.58	9.54	24	261	\$1,704,883	\$589,459	\$621,915
842-3	Full Thick Burns w Graft	6.13	4.67	15.65	15	261	\$1,821,028	\$575,175	\$653,829
842-4	Full Thick Burns w Graft	16.83	12.81	27.96	6	225	\$3,343,221	\$504,309	\$894,708
843-1	Ext Burns w/o Skin Graft	0.81	0.62	3.1	3	5	\$15,751	\$10,251	\$15,484
843-2	Ext Burns w/o Skin Graft	1.09	0.83	4.31	8	34	\$119,788	\$75,872	\$51,186

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
843-3	Ext Burns w/o Skin Graft	1.99	1.52	7.43	8	36	\$333,969	\$79,066	\$100,878
843-4	Ext Burns w/o Skin Graft	7.91	6.02	20.33	5	40	\$407,223	\$81,087	\$256,991
844-1	Part Thick Burns w or w/o Graft	0.83	0.63	2.68	114	250	\$1,072,239	\$476,766	\$530,283
844-2	Part Thick Burns w or w/o Graft	1.30	0.99	4.33	72	318	\$1,681,982	\$686,111	\$620,928
844-3	Part Thick Burns w or w/o Graft	2.56	1.95	7.36	18	126	\$815,683	\$282,292	\$312,684
844-4	Part Thick Burns w or w/o Graft	9.51	7.24	19.56	5	167	\$2,510,139	\$358,725	\$497,869
850-1	Proc w Diag of Rehab or Other	1.64	1.25	2.32	47	166	\$1,574,786	\$305,598	\$609,001
850-2	Proc w Diag of Rehab or Other	1.93	1.47	4.45	34	222	\$1,743,812	\$417,355	\$556,209
850-3	Proc w Diag of Rehab or Other	3.94	3.00	14.64	16	305	\$1,744,265	\$462,959	\$457,066
850-4	Proc w Diag of Rehab or Other	8.57	6.52	30.16	8	474	\$2,641,118	\$984,602	\$693,889
860-1	Rehabilitation	0.97	0.74	8.76	119	1,536	\$4,204,149	\$2,088,111	\$782,002
860-2	Rehabilitation	1.38	1.05	11.25	565	6,836	\$19,175,397	\$10,293,716	\$5,426,318
860-3	Rehabilitation	2.11	1.60	14.79	811	12,890	\$41,724,965	\$19,431,517	\$11,669,677
860-4	Rehabilitation	3.01	2.30	18.44	187	3,455	\$12,435,521	\$5,113,569	\$3,805,943
861-1	Signs, Symptoms & Oth Factors	0.52	0.39	2.35	587	1,303	\$8,304,187	\$2,223,959	\$1,881,114
861-2	Signs, Symptoms & Oth Factors	0.72	0.55	3.19	832	2,534	\$16,529,325	\$4,454,656	\$3,686,052
861-3	Signs, Symptoms & Oth Factors	1.07	0.82	4.61	255	1,391	\$8,768,371	\$2,582,942	\$1,739,930
861-4	Signs, Symptoms & Oth Factors	2.62	1.99	9.44	28	209	\$1,862,365	\$348,764	\$433,881
862-1	Oth Aftercare & Convalescence	0.49	0.38	5.46	7	14	\$101,944	\$30,284	\$24,809
862-2	Oth Aftercare & Convalescence	0.79	0.61	8.52	18	53	\$295,366	\$106,370	\$87,129
862-3	Oth Aftercare & Convalescence	1.10	0.84	9.34	21	70	\$561,475	\$111,710	\$155,109
862-4	Oth Aftercare & Convalescence	1.78	1.35	11	4	99	\$704,849	\$122,028	\$65,503
863-1	Neonatal Aftercare	0.91	0.69	8.8	11	90	\$171,135	\$126,306	\$48,485
863-2	Neonatal Aftercare	3.07	2.34	17.98	21	306	\$1,002,522	\$519,741	\$317,010
863-3	Neonatal Aftercare	5.22	3.97	27.67	25	673	\$2,373,693	\$1,307,442	\$788,907
863-4	Neonatal Aftercare	11.75	8.95	46.34	10	615	\$4,615,600	\$1,275,327	\$1,203,995
890-1	HIV w Mult Maj Related Cond	1.52	1.15	3	0	0	\$0	\$0	\$0
890-2	HIV w Mult Maj Related Cond	1.92	1.46	6.51	32	206	\$1,324,526	\$413,468	\$379,438
890-3	HIV w Mult Maj Related Cond	2.58	1.96	9.02	316	3,452	\$25,727,759	\$6,012,026	\$5,377,314
890-4	HIV w Mult Maj Related Cond	5.49	4.18	15.07	419	7,393	\$70,497,552	\$12,840,327	\$16,794,543

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
892-1	HIV w Maj Related Cond	0.91	0.69	5.38	8	47	\$411,518	\$81,411	\$97,952
892-2	HIV w Maj Related Cond	1.39	1.06	5.07	280	1,549	\$10,873,825	\$2,706,978	\$2,479,806
892-3	HIV w Maj Related Cond	1.81	1.38	6.49	603	4,831	\$36,038,298	\$8,318,800	\$7,230,861
892-4	HIV w Maj Related Cond	3.41	2.60	10.86	133	1,817	\$16,438,286	\$3,055,747	\$3,298,674
893-1	HIV w Mult Sig Related Cond	1.14	0.86	4.48	8	55	\$447,735	\$79,581	\$55,398
893-2	HIV w Mult Sig Related Cond	1.34	1.02	4.97	168	1,033	\$6,671,688	\$1,695,620	\$1,383,361
893-3	HIV w Mult Sig Related Cond	1.94	1.47	7.16	90	833	\$5,564,793	\$1,468,158	\$1,137,149
893-4	HIV w Mult Sig Related Cond	4.46	3.40	14.19	5	76	\$696,926	\$158,796	\$179,761
894-1	HIV	0.85	0.65	3.18	116	544	\$3,572,058	\$920,298	\$628,122
894-2	HIV	1.07	0.82	3.84	570	2,431	\$17,034,395	\$4,164,768	\$3,859,354
894-3	HIV	1.50	1.14	5.4	176	1,130	\$8,232,692	\$1,942,705	\$1,679,607
894-4	HIV	2.93	2.23	8.94	7	103	\$630,264	\$173,568	\$145,390
910-1	Craniotomy for Mult Sig Trauma	4.17	3.18	7.68	0	0	\$0	\$0	\$0
910-2	Craniotomy for Mult Sig Trauma	4.64	3.53	8.54	2	21	\$267,150	\$31,067	\$51,703
910-3	Craniotomy for Mult Sig Trauma	6.29	4.79	11.93	6	138	\$2,338,784	\$185,712	\$384,431
910-4	Craniotomy for Mult Sig Trauma	13.87	10.56	24.64	33	1,071	\$12,543,098	\$2,096,325	\$3,572,712
911-1	Ext Trunk Procs Mult Sig Trauma	2.15	1.63	6.25	0	0	\$0	\$0	\$0
911-2	Ext Trunk Procs Mult Sig Trauma	2.88	2.19	6.26	8	60	\$567,585	\$120,126	\$160,932
911-3	Ext Trunk Procs Mult Sig Trauma	4.02	3.06	8.32	22	206	\$2,190,437	\$413,715	\$608,376
911-4	Ext Trunk Procs Mult Sig Trauma	10.78	8.21	18.92	128	2,475	\$40,699,356	\$4,891,182	\$11,275,969
912-1	Musckl Procs Mult Sig Trauma	2.86	2.18	5.56	0	0	\$0	\$0	\$0
912-2	Musckl Procs Mult Sig Trauma	3.15	2.40	5.96	37	275	\$4,163,548	\$502,517	\$768,926
912-3	Musckl Procs Mult Sig Trauma	5.37	4.09	9.63	110	1,343	\$18,780,431	\$2,564,269	\$4,278,655
912-4	Musckl Procs Mult Sig Trauma	11.15	8.49	19.11	145	3,708	\$48,311,836	\$6,852,727	\$12,237,571
930-1	Mult Sig Trauma w/o O.R. Proc	1.13	0.86	3.19	1	2	\$49,751	\$5,228	\$9,602
930-2	Mult Sig Trauma w/o O.R. Proc	1.43	1.09	3.8	47	278	\$2,264,995	\$513,922	\$468,598
930-3	Mult Sig Trauma w/o O.R. Proc	2.37	1.81	6.28	63	388	\$3,913,016	\$770,068	\$1,022,426
930-4	Mult Sig Trauma w/o O.R. Proc	6.46	4.92	15.44	46	1,026	\$10,800,207	\$1,751,916	\$2,257,757
950-1	Ext Proc Unrel To Diag	1.92	1.46	3.12	42	299	\$3,716,803	\$564,659	\$757,241
950-2	Ext Proc Unrel To Diag	3.03	2.31	6.16	76	707	\$8,207,643	\$1,336,586	\$1,701,012

APR-DRG	Short Description	Relative Weight Re-Centered for Florida	Relative Weight National	Arithmetic Average Length of Stay	Stays	Medicaid Covered Days	Charges	Baseline Payment	Simulated DRG Payment
950-3	Ext Proc Unrel To Diag	4.77	3.63	11.56	122	1,835	\$18,558,750	\$3,350,063	\$4,149,924
950-4	Ext Proc Unrel To Diag	9.58	7.30	22.67	139	4,093	\$49,109,476	\$7,191,688	\$11,011,632
951-1	Mod Ext Proc Unrel To Diag	1.35	1.03	2.79	154	507	\$5,783,909	\$880,121	\$1,283,611
951-2	Mod Ext Proc Unrel To Diag	2.06	1.57	4.94	352	1,823	\$19,553,913	\$3,134,930	\$4,503,830
951-3	Mod Ext Proc Unrel To Diag	3.53	2.69	9.72	276	3,307	\$30,876,389	\$5,596,219	\$6,350,821
951-4	Mod Ext Proc Unrel To Diag	6.96	5.30	17.61	115	3,101	\$30,764,927	\$5,134,904	\$6,493,755
952-1	Nonext Proc Unrel To Diag	1.03	0.78	2.48	160	583	\$5,463,010	\$954,152	\$1,035,176
952-2	Nonext Proc Unrel To Diag	1.67	1.27	4.84	178	1,223	\$10,472,300	\$2,036,540	\$1,861,192
952-3	Nonext Proc Unrel To Diag	2.96	2.26	9.23	104	1,047	\$8,495,296	\$1,778,271	\$1,952,222
952-4	Nonext Proc Unrel To Diag	6.06	4.61	17.05	29	472	\$4,402,418	\$767,806	\$1,029,602
955-0	Principal Diag Invalid	0.00	0.00	0	0	0	\$0	\$0	\$0
956-0	Ungroupable	0.00	0.00	0	0	0	\$0	\$0	\$0
Totals					418,007	1,892,597	\$12,730,050,330	\$2,805,235,667	\$2,791,004,718