The State of Florida is implementing a new inpatient payment method utilizing Diagnosis-Related Groups (DRG) for Medicaid. The Agency for Health Care Administration (Agency), along with its consultant, Navigant Healthcare, is designing this new DRG-based inpatient payment method. Once rates have been determined, The Agency’s fiscal agent, DXC Technology (DXC), will update the Florida Medicaid Management Information Systems (FMMIS) to process claims according to the Agency’s direction. **As of July 1, 2013, all inpatient claims will be priced based on DRG, with only a few exceptions.**

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**Which provider types will be impacted by this change?**
All hospitals are included in the DRG payment method, with the exception of the four state-owned psychiatric facilities.

**Which types of services will be impacted by this change?**
All hospital inpatient stays will be paid via the new DRG method, with the following exceptions:

- **Transplant Cases:** For transplant cases currently paid via the global transplant fee, the global transplant fee will continue to be used even after DRG payment is implemented. Also, Reimbursement
levels defined in the global transplant fee will not be changed based on the conversion to DRG pricing.

- **Newborn Hearing Screening:** Any newborn hearing screening which is currently paid in addition to per diems will also be paid in addition to DRG payments. Reimbursement levels for newborn screening will not be changed based on the conversion to DRG pricing.

Florida Medicaid will continue to pay Outpatient claims with a line item rate. There is no change to pricing logic of Inpatient crossover (Medicare Part A) claims. Florida Medicaid will continue to pay the sum of Medicare coinsurance and deductible on Inpatient crossover claims.

### How is DRG Pricing determined and calculated?

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 following:

- Diagnosis describing the patient’s condition (admission diagnosis code is not considered)
- Surgical procedures performed (if any)
- Patient age
- Patient gender
- Discharge status

The classifications are labeled using codes referred to as DRG codes; 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. The vast majority of hospital stays are priced using the following formula, although variances can occur:

\[
[\text{DRG Base Payment}] = [\text{Hospital Base Rate}] \times [\text{DRG Relative Weight}] \times [\text{Maximum Applicable Policy Adjustor}]
\]

#### Hospital Base Rate
The Agency will determine an initial “base rate” for each active hospital provider for the FY 2013/2014 implementation. Thereafter, hospital base rates will be set annually and published at the beginning of each state fiscal year.

#### DRG-Relative Weight
Once the DRG code is assigned to a claim, a DRG-relative weight can be determined. Each DRG code has an associated relative weight. The weight indicates, on average, the relative amount of resources that the treating hospital utilizes to treat a patient with this DRG code. The DRG weight for an average admission for recipients
in the Florida Medicaid program is 1.0 and can be used as a quick measuring tool to analyze the relative complexity of each hospital stay.

Examples:
- A DRG weight of 2.0 indicates an admission that requires **twice** the amount of resources as an average admission.
- A DRG weight of 0.5 indicates an admission that only requires **half** of the resources as an average admission.

**Policy Adjustors**
As described in the DRG base payment formula, payment for a specific claim may be altered through a policy adjustor. Policy adjustors are numerical multipliers intended to help protect access to care to specific services and/or specific types of providers by increasing payment. Two types of adjustors are included in the proposed plan, service adjustors and provider adjustors. For the initial implementation on July 1, 2013, the following adjustors are planned.

**Service Adjusters:** Rehabilitation Services

**Provider Adjusters:**
- Rural hospitals
- Long-term acute care hospitals
- Hospitals with both high Medicaid utilization and high outlier payments percentage*

*Providers assigned the high Medicaid utilization and high outlier payment adjustor will be those with 50* or more Medicaid utilization, when looking at Medicaid fee-for-service and managed care recipients combined, and anticipated to received 30% or more payments in the form of outlier payments if no adjustor is applied.

**Note:** Specific values for these adjustors will be determined when the final Medicaid inpatient budget is set for state fiscal year 2013/2014.

**Adjustment to the DRG Base Payment**
A variety of special situations exist in which the DRG Base Payment may be adjusted. These are described below:

**Transfer pricing adjustment:** Payment may be reduced for the transferring hospital when a patient is transferred from one acute care facility to another. Transfer stays are identified by the patient discharge status and the statuses currently planned for the transfer pricing adjustment are 02, 05, 65, and 66. For stays with these statuses, payment is reduced if the length of stay at the transferring hospital is less than the DRG’s average length of stay minus 1. The transfer pricing adjustment does not apply to the
receiving hospital, which is paid the full DRG rate, unless it also transfers the patient to another acute care facility. The transfer payment adjustment affects only the DRG base payment, not supplemental Inter-Governmental Transfer (IGT) payments.

**Cost outlier adjustment**: Cost outlier adjustments are additional payments made for stays that are unusually costly to the hospital. Claims qualify for a cost outlier adjustment when the hospital's loss on the stay (equal to hospital cost minus [DRG Base Payment plus IGT payments]) is greater than an outlier threshold. For this calculation, hospital cost is estimated by multiplying the claim’s submitted charge times the hospital’s cost-to-charge ratio. The outlier adjustment amount equals the hospital loss above the outlier threshold times a marginal cost factor.

For implementation on July 1, 2013, the current plan is for the outlier threshold to be set at $31,000 and the marginal cost factor to be set at 0.80.

**Non-covered days adjustment**: A few scenarios exist in which some, but not all, of the days of a hospital stay will be covered by Medicaid fee-for-service. For these scenarios, payment is prorated based on the number of covered days in relation to the total length of stay.

The non-covered day adjustment applies to the following admission scenarios:

- Undocumented non-citizens;
- Emergency services for adults who have exhausted their annual 45-day benefit limit;
- Medicare dual eligibles in which the recipient’s Medicare Part A coverage is reached during the stay;
- Children enrolled in a Medicaid managed care plan and who exhaust their 45-day benefit limit during the stay; and
- Medically needy recipients, who gain Medicaid eligibility during the middle of a hospital stay.

Other scenarios involving non-covered days may also exist. Also, non-covered days adjustments affect all portions of the claim payment, DRG base payment, outlier payment, automatic IGT payment and self-funded IGT payment.

**Charge cap adjustment**: The final step in the calculation of the DRG allowed amount is a comparison of the allowed amount to the hospital charges. If the hospital charges are lesser, then the allowed amount gets reduced down to billed charges. This is done by reducing all four parts of the allowed amount proportionately. The four parts are DRG base payment, DRG outlier payment, automatic IGT payment and self-funded IGT payment.
Inter-Governmental Transfer (IGT) Payments
Per-claim payments of IGT funds will be made as supplemental add-on payments separate from the DRG payment. Because there is a clear distinction between automatic IGTs and self-funded IGTs, two supplemental add-on payments per claim – one for automatic IGTs and one for self-funded IGTs.

Are DRG pricing examples available?
The Agency has posted three helpful learning tools to help providers better understand how Florida Medicaid claims will be impacted.

   Florida Medicaid DRG Calculator: Assists providers by demonstrating how rates will be impacted due to the presence of various policy adjustors on claims. To access the DRG Calculator, visit the below link:

   DRG Simulation Results by Provider: Assists providers by projecting the financial impact of all active and participating Florida Medicaid hospitals for the 2013-2014 State fiscal year based on historical claim data. To access the Simulation Results, visit the below link:

   Examples of Priced Claims: Appendix A of the DRG Implementation presentation below contains DRG pricing examples for illustration purposes.

What grouping method is Florida using?
The Agency is implementing the APR-DRG (version 30) grouping method which has over 1,200 codes including several hundred base codes separated into four levels of severity: minor, moderate, major and extreme. APR-DRG grouping is widely used by multiple payers.

When will DRG payments begin?
DRG pricing began on July 1, 2013. DRG payments will be based on the discharge date present on the claim form. Because DRG is date of service driven, providers should anticipate a transitional period in which both payment methods, DRG and per diem, will be reflected in payments and appear on their remittance advices.
Will remittance advices and/or 835s be changed to report DRG-specific information?
Yes, if an inpatient claim is priced with DRG, the DRG code assigned to the claim will appear on the electronic (835) and paper remittance advices. In an effort to better prepare our hospital community with transition to DRG pricing, Florida Medicaid began reporting the DRG code of each claim on remittance advices (RA) as of June 1, 2013. The DRG code consists of the three-digit DRG code followed immediately by the one-digit severity of illness code. Actual DRG pricing will not occur until the discharge date of a claim is on or after July 1, 2013. Early availability of the DRG code on the RA will enable hospitals to view the DRG assignments of Florida Medicaid current claims.

Will the current inpatient prior authorization process change?
The rules defining which inpatient stays require a prior authorization and which do not require a prior authorization remain the same with the move to DRG payment. An exception involves mother-baby claims and one-day emergency stays. Under DRG, no prior authorization is needed for the baby’s birth claim upon submission of a claim for a newborn separate from the mother’s claim even for days in which both the baby and the mother are in the hospital. Although one-day emergency stays are currently exempt from prior authorization review, if the date of admission is July 1, 2013 and after, the one-day emergency stay will require a prior authorization. Providers will need to contact eQ Health Solutions to receive a post admission authorization on all emergency admissions, including those with a one-day length of stay.

With the implementation of DRG, a prior authorization should only be billed once (one claim per one prior authorization). Interim or multiple claims containing the same prior authorization will not be reimbursable.

When a prior authorization is required, in most cases, the length of stay will no longer need to be specified. Under normal circumstances, DRG payment does not depend on length of stay, so length of stay does not need to be included in the prior authorization. Two known exceptions are listed below:

1. Recipients who have reached the 45 day benefit limit; and
2. Recipients who are undocumented non-citizens.

Note: When only emergency services are reimbursable by Medicaid, then the length of stay on the prior authorization will be used to determine the number of days in which the recipient was deemed to be in an emergency health situation. This authorized number of days will translate into the number of covered days on the claim and will cause payment to be reduced if the number of covered days is less than the length of stay.
What billing procedures are changing?

**Present on Admission Indicator**

The present on admission (POA) indicator associated with diagnosis codes will be a required field with the implementation of DRG payment. Hospitals can submit present on admission indicators today, but Medicaid is not editing against this field. Edits will be added with the implementation of DRG pricing. To clarify, POA indicators will not be required on the admission diagnosis or on external cause of injury diagnoses (“e-codes”). If a POA indicator is blank on the primary or on a secondary diagnosis code, Explanation of Benefit (EOB) code 1816, POA INDICATOR MISSING OR INVALID, will post and the claim will deny.

For primary and secondary (non-E) diagnoses, the only valid values of the POA indicator will be, Y, N, U, and W. All other values will post EOB 1816 and cause the claim to deny.

**Newborn Concurrent and Non-Concurrent Claims**

The concept of concurrent and non-concurrent newborn claims goes away with DRG pricing. With DRG pricing, separate claims must be submitted for the mother (the delivery) and the baby (the birth) in all cases. The delivery claim should include only services provided to the mother. The birth claim should include only services provided to the baby and should include all dates of service, starting with the date of birth (assuming the baby was born at the billing hospital). In addition the birth claim must include the baby’s Medicaid Recipient ID. Separate DRG payments will be made for the delivery and for the birth.

**Interim Claims**

Interim claims will no longer be accepted once DRG pricing is implemented. The hospital must wait until the patient is discharged before submitting a claim. Claims with a frequency (last character of the bill type) equal to 2, 3, or 4 will be denied. In addition, claims with a patient discharge status equal to 30, indicating the patient is still in the hospital, will be denied.

**Medicare Part A Exhausted Claims**

If a recipient is dually eligible for Medicare and Medicaid and his/her Medicare Part A benefits are fully consumed during a hospital stay, then the hospital can bill Medicaid for the portion of the stay not covered by Medicare. This is done using a straight Medicaid paper claim, not a Medicare crossover claim. On the Medicaid claim, the hospital should include the full length of stay and all the charges associated with the admission. Medicaid will calculate a DRG payment for the full stay, including any applicable outlier payments, and then will reduce the payment down to cover only those days reimbursable by Medicaid. On the Medicaid claim, occurrence code “A3” should be included along with the date in which Medicare Part A benefits were exhausted. Providers should continue to send this type of claim to their local Area Offices for review and override of the Medicare -present edit.
Medically Needy Recipients
If a recipient obtains Medicaid eligibility because his/her share of cost is met during an inpatient stay, then the hospital should submit a Medicaid claim which includes the full length of stay and all charges and services associated with the admission. Medicaid will calculate a DRG payment for the full stay, including any applicable outlier payments, and then will reduce the payment down to cover only those days for which the recipient was Medicaid eligible.

How will DRG payment affect Medicaid managed care?
The move to DRG payment is being implemented only for Medicaid fee-for-service recipients. Some managed care organizations may choose to follow the fee-for-service model and move from per diem payment to DRG payment. However, the Agency is not requiring the managed care organizations to change their inpatient reimbursement method.

How will DRG payment affect the annual cost settlement process?
DRG payment will be a prospective payment for inpatient stays and is intended to be payment in full, without a need for subsequent cost settlement. Post-payment cost settlement of inpatient claims will be phased out over the next few years for hospitals reimbursed via the DRG payment method. However, the requirement for hospitals to file cost reports to the Medicaid agency will continue as they are used to determine inpatient cost-to-charge ratios which are used in the calculation of outlier payments.

Will payment adjustments for health care acquired conditions change with DRG reimbursement?
Yes, with the implementation of DRG reimbursement, Medicaid will adjust payment for health care acquired conditions (HCACs) in a way similar to that used by Medicare. Two DRGs will be assigned to each claim; one determined using all diagnosis and procedure codes on the claim and a second determined while ignoring diagnoses and procedure codes associated with HCACs. HCACs are very rare, so in most cases these two DRGs will be the same. But in cases where they are different, the DRG with the lower relative weight will be used to calculate payment.

Does the recipient’s 45 day inpatient benefit limit still apply with the transition to DRG?
Yes, recipients aged 21 and over, will continue to have a maximum of 45 covered inpatient days per fiscal year. With DRG pricing logic, a comparison will be made between the covered days calculated on the claim versus the DRG average length of stay. The lesser of those two values will be used to contribute to the recipient’s 45 day cap.

Will BBA claim requirements change with the implementation of DRG?
Effective with DRG pricing, a Balanced Budget Act (BBA) claim is required only if the recipient has zero days available within their 45-benefit limit. If the recipient has at least one day remaining within their benefit limit at
the time of admission, or gains a new 45-days when crossing state fiscal years during an admission, then full DRG payment will apply.

If neither of these is true, then a BBA claim is required, including authorization of the covered portion of the stay. Florida Medicaid payment for BBA claims will be prorated downward based on a comparison of the covered days to the full length of stay.

**Will the rules related to recipient copayments change with DRG reimbursement?**

No, these rules will remain the same.

**Will Florida Medicaid handbooks be updated to reflect DRG changes?**

Revisions to the Provider General, UB 04 Reimbursement, and Hospital Coverage and Limitations manuals are currently underway. Until posted handbook updates occur, providers are strongly encouraged to monitor their e-mail for important, DRG-related provider alerts. For more information on e-mail alerts, please visit the Florida Medicaid’s Health Care Alerts page at [http://ahca.myflorida.com/Medicaid/alerts/alerts.shtml](http://ahca.myflorida.com/Medicaid/alerts/alerts.shtml).

Additionally, providers can access all posted alerts by accessing the Florida Web Portal Public Information for Providers Provider Support Provider Alerts.

**What training is available for providers?**

To better prepare our hospital community, the Agency, its consultant, Navigant Healthcare, and DXC invite our provider communities and partners to participate in a series of DRG webinars. The series consists of three main topics:

1. **DRG Provider Training Presentation and Resources Review**
   Designed for providers that have not reviewed the published content within the PowerPoint, Quick Reference Guide, and FAQ document. The focus of the session will be explaining billing changes and the impact of the DRG transition.

2. **DRG Calculator Demonstration, Resources Review, and Q & A Session**
   Designed for providers that have reviewed the published content within the PowerPoint, Quick Reference Guide, and FAQ document. The focus of the session will be a detailed discussion of the DRG pricing logic, review of resources, and a question and answer session.

3. **Prior Authorization and Q & A Session**
   Designed for providers aware of billing changes and other impacts of DRG. The focus of the session will be a discussion of which specific prior authorization requirements will be changing and impact of those changes. Remaining time will used for questions and answers.
On-line registration details are posted to the DRG Pricing webpage on the Public Web Portal, mymedicaid-florida.com.

Members of the Agency, Navigant, and DXC Provider Relations will also communicate DRG activities and resources through the Florida Hospital Association quarterly meetings.

Please check the DRG Pricing page located under the Agency Initiative menu often for additional training, links to helpful resources, and other important DRG-related documents.

For More Information

Agency

For more information regarding DRG and related policies, visit the Agency website at http://ahca.myflorida.com/Medicaid/cost_reim/drg.shtml.

DXC