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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

Effective with dates of admission on or after July 1, 2008, the Office of Vermont Health Access (OVHA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

I. Participating Hospitals

All in-state and out-of-state hospitals will be included in this payment methodology, regardless of any designation provided by Medicare. Hospitals may be eligible for special payment provisions in addition to payments made under this methodology as discussed in Section IV below.

II. Data Sources and Preparation of Data for Computation of Prospective Rates

A. Introduction

The calculation of prospective rates requires the use of claims data and cost report data. The historical claims data is obtained from a chosen base period and the cost for these claims is derived from Medicare cost report data for the corresponding period. Claim costs are adjusted to the year in which the rates are in effect to account for inflation. Claims are grouped together into a diagnostic related group (DRG) based upon the diagnoses present on the claim.

B. Data Sources- Initial Period

For the rate setting period effective July 1, 2008, hospital cost report data from all in-state Medicaid providers plus Dartmouth-Hitchcock Medical Center for the fiscal years ending September 30, 2004 and September 30, 2005 were used to assign cost values to claims used in the rate development process. All hospitals included in the analysis have a fiscal year end of September 30. The claims used to assign relative weight values and to develop base rates were from the same hospitals for which cost data was collected and were from the same period as the hospital cost reports.

C. Data Sources- Subsequent Periods

More recent cost report and claims data will be used to develop new base rates and relative weights no less than once every four fiscal years.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT  
HOSPITAL SERVICES (CONTINUED)

III. Payment for Inpatient Hospital Services

A. Payment Formulas

1. Non-Outlier DRG Payment Per Case = (Base Rate Assigned to Hospital x DRG Relative Weight)

2. Outlier DRG Payment Per Case = (Cost of Case – Outlier Threshold) x Outlier Payment Percentage

where

Cost of Case = Allowable Charges x Hospital-specific Cost to Charge Ratio and  
Outlier Threshold = (Base Rate x DRG Relative Weight) + Fixed Outlier Value

3. Psychiatric DRG Payment Per Case = (Base Per Diem Rate Assigned to Hospital x DRG Relative Weight x Factor Representing Length of Stay)

where

Factor Representing Length of Stay = The factors assigned by the Medicare Inpatient Psychiatric Facilities Prospective Payment System effective October 1, 2007

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT  
HOSPITAL SERVICES (CONTINUED)

III. Payments Inpatient Hospital Services (Continued)

A. Discussion of Payment Components

1. Base Rates

The in-state Base Rate effective July 1, 2008 is based on claims with dates of service from October 1, 2003 to September 30, 2005 from all in-state hospitals plus Dartmouth-Hitchcock Medical Center. The cost values were assigned to each hospital claim on a claim-by-claim basis using data from each hospital's Medicare Cost Report for the hospital year ending September 30, 2004 or September 30, 2005. The cost report used for each claim was based on the ending date of service of the claim.

Allowed charges on each detail line of the inpatient claim were multiplied by a hospital-specific cost to charge ratio (CCR). The CCR assigned to each detail line is based on the revenue code billed for the detail line. The mapping of revenue codes to CCRs followed the principles that were described in the Medicare Inpatient Prospective Payment System Final Rule for 2007 published in the Federal Register on August 18, 2006.

The cost value of the claim is adjusted for inflation using Global Insight's Health Care Cost Review New CMS Hospital Prospective Reimbursement Market Basket moving average factors. Claim costs are inflated to the mid-point of the rate year.

The in-state base rate was derived by computing the average inflated cost per case across all claims in the base period (full-cost base rate). Because of funding limits imposed by the Vermont Legislature, the in-state Base Rate effective July 1, 2008 was reduced by 22.37% (base rate reduction factor).

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III. Payments Inpatient Hospital Services (Continued)

B. Relative Weights

Relative weights were assigned to each DRG in the CMS Medicare Grouper Version 24.0 based on Vermont hospital costs. The relative weight is the average cost of the claims grouped into the DRG divided by the average cost of all claims in the base period.

Before calculating the relative weight for a DRG, tests were conducted to ensure that there was sufficient volume and conformity among the cases in the DRG to set a stable relative weight. A DRG was found to have sufficient sample size to compute a relative weight if: (a) There was a minimum of 10 claims across the two years of data; and (b) There were sufficient claims to pass this statistical test: The standard error of the claims' costs is within 25% of the mean with a 90% level of confidence.

Before running the statistical test, low-cost and high-cost outliers were removed from each DRG, which are defined as any claim that was outside +/- two standard deviations from the geometric mean cost of the DRG.

This test yielded 172 stable DRGs and 364 unstable DRGs. The 364 unstable DRGs were then collapsed into nine tier groups based on the Medicare relative weight for each DRG. After the claims were collapsed into these categories, a new average cost was computed for the claims in each tier and a relative weight was set.

Effective with dates of admission on or after July 1, 2008, all DRGs that were collapsed into a tier will share the same relative weight.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT  
HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions

A. Rehabilitation DRG

In-state hospitals with a claim that groups into the Rehabilitation DRG (DRG 462 in Grouper Version 24.0) will be paid an additional \$300 per diem for the entire length of the patient's stay for the single episode of care. This payment is in addition to the Non-Outlier and Outlier DRG Payments Per Case.

B. Neonate DRGs

In-state hospitals that do not serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional \$100 per diem for the entire length of the patient's stay for the single episode of care. This payment is in addition to the Non-Outlier and Outlier DRG Payments Per Case.

In-state hospitals that do serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional \$200 per diem for the entire length of the patient's stay for the single episode of care. This payment is in addition to the Non-Outlier and Outlier DRG Payments Per Case. A hospital with a disproportionate share of neonate cases is a hospital that had more than 50% of all of the neonate DRG cases in the rate setting claims period.

The Neonate DRGs paid under this methodology are those Neonate DRGs as assigned by the Grouper being utilized by OVHA. Effective July 1, 2008, this included the following DRGs:

- DRG 385: Neonates, Died or Transferred to Another Acute Care Facility
- DRG 386: Extreme Immaturity or Respiratory Distress Syndrome, Neonate
- DRG 387: Prematurity with Major Problems
- DRG 388: Prematurity without Major Problems
- DRG 389: Full Term Neonate with Major Problems
- DRG 390: Neonate with Other Significant Problems

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT  
HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

C. Psychiatric DRG Cases for High-Volume Psychiatric Case Hospitals

In-state hospitals that had more than 10% of the Psychiatric DRG cases paid by OVHA in 2006 or who had a distinct part psychiatric unit in place prior to July 1, 2008 will be paid for psychiatric cases under a DRG per diem methodology instead of a DRG per case methodology using the formula shown in III.A above.

The Psychiatric DRGs paid under this methodology are those Psychiatric DRGs as assigned by the Grouper being utilized by OVHA. Effective July 1, 2008, this included the following DRGs:

- DRG 12: Degenerative Nervous System Disorders
- DRG 23: Nontraumatic Stupor and Coma
- DRG 424: O.R. Procedure with Principal Diagnosis of Mental Illness
- DRG 425: Acute Adjustment Reaction & Psychosocial Dysfunction
- DRG 426: Depressive Neuroses
- DRG 427: Neuroses Except Depressive
- DRG 428: Disorders of Personality & Impulse Control
- DRG 429: Organic Disturbances & Mental Retardation
- DRG 430: Psychoses
- DRG 431: Childhood Mental Disorders
- DRG 432: Other Mental Disorder Diagnoses
- DRG 433: Alcohol/Drug Abuse or Dependence, Left AMA
- DRG 521: Alcohol/Drug Abuse or Dependence with CC
- DRG 522: Alcohol/Drug Abuse or Depend. with Rehabilitation Therapy w/o CC
- DRG 533: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w/o CC

On an ongoing basis, the factors applied representing the length of stay will be the same as those utilized by Medicare in its Inpatient Psychiatric Prospective Payment System. The factors applied are additive by length of stay.

Psychiatric base per diem rates were set to ensure that the payments for psychiatric cases in the new payment system were the same or better than those under the previous payment system. Effective July 1, 2008, the Base Per Diem Rates are as follows:

For Institutions of Mental Disease (IMD): \$885 per diem  
For all other eligible hospitals: \$825 per diem

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HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

D. One-Day Stays

Claims for patients admitted as an inpatient but for which the length of stay is not overnight are paid as the lesser of the cost of the case or the Non-Outlier DRG Payment Per Case. The exception is if the patient is classified as a Normal Newborn (DRG 391). In this case, payment will always be the Non-Outlier DRG Payment.

E. Transfer Cases

For claims in which the patient is transferred from one inpatient general acute care facility to another, the payment to the transferring hospital is the lesser of the cost of the case or the DRG Payment Per Case, including any outlier payment or Rehabilitation DRG Add-on payment, if applicable. Payment to the receiving hospital will follow the payment guidelines of non-transfer cases.

F. Sub-acute Care

Swing bed, waiting placement and inappropriate level of care days are reimbursed at a per diem rate established by the Division of Rate Setting equal to the average statewide rate per patient day paid for services furnished in nursing facilities during the previous calendar year.

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HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

G. Out of State Facilities

Out-of-state facilities will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. However, the values of components of the formulas may differ from those used to pay in-state hospitals.

For payments on or after July 1, 2008, the following values will be applied.

1. A Base Rate will be assigned to each participating out-of-state hospital based upon its peer group.
  - a. Border Teaching Hospitals: Defined as hospitals within 10 miles of the Vermont border that operate post-graduate training programs. Base rate will equal 58.0% of the in-state base rate.
  - b. Non-Border Teaching Hospitals: Defined as hospitals greater than 10 miles of the Vermont border that operate post-graduate training programs. Base rate will equal 54.4% of the in-state base rate.
  - c. Other Out-of-State Hospitals: Defined as hospitals not meeting the criteria of G.1.a or G.1.b. Base rate will equal 50.7% of the in-state base rate.
2. A Fixed Outlier Value will be assigned to each participating out-of-state hospital based upon its peer group.
3. An Outlier Percentage will be assigned to each participating out-of-state hospital based upon its peer group.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT  
HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

4. The Cost to Charge Ratio (CCR) to be applied for calculating the outlier cost of the case will be assigned to each participating out-of-state hospital based upon its peer group.
  - a. Border Teaching Hospitals: The CCR to apply will be calculated from the most recent available Medicare Cost Report for each hospital in the peer group.
  - b. Non-Border Teaching Hospitals: The CCR to apply will be the average CCR of all in-state hospitals.
  - c. Other Out-of-State Hospitals: The CCR to apply will be the average CCR of all in-state hospitals.
  
5. In order to ensure access to non-Vermont hospitals providing unusual and highly complex services, the State has the authority to establish rates on a case by case basis or by hospital.

H. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. If the new facility is an in-state hospital, it will receive the same base rate as other in-state hospitals and all other payment policies for in-state hospitals will apply. If it is an out-of-state hospital, it will receive a base rate based upon the out-of-state peer group it is assigned to. All other payment provisions will follow the policies for the out-of-state hospital peer group to which it is assigned or the authority as outlined in G.5 above.

I. New Medicaid Providers

Prospective payment rates for established facilities which had not been an OVHA participating provider prior to July 1, 2008 will receive payments based on the same provisions that apply to new facilities as described in IV.H.

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