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

III. Payments Inpatient Hospital Services (Continued)

B. Discussion of Payment Components

1. Base Rates

The in-state Base Rate effective October 3, 2008 is based on claims with dates of service from October 3, 2003 to September 30, 2007 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. The cost report used to assign the cost 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 first computing the average inflated cost per case across all claims in the base period. This value is \$6,870. Because of funding limits imposed by the Vermont Legislature, the in-state Base Rate effective October 3, 2008 was reduced by 24.48% to \$5,093.

(Continued)

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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 October 3, 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 October 3, 2008, this included the following DRGs:

- DRG 56: Degenerative Nervous System Disorders w MCC
- DRG 57: Degenerative Nervous System Disorders w/o MCC
- DRG 80: Nontraumatic Stupor and Coma w MCC
- DRG 81: Nontraumatic Stupor and Coma w/o MCC
- DRG 876: O.R. Procedure with Principal Diagnosis of Mental Illness
- DRG 877: Acute Adjustment Reaction & Psychosocial Dysfunction
- DRG 881: Depressive Neuroses
- DRG 882: Neuroses Except Depressive
- DRG 883: Disorders of Personality & Impulse Control
- DRG 884: Organic Disturbances & Mental Retardation
- DRG 885: Psychoses
- DRG 886: Behavioral & Developmental Disorders
- DRG 887: Other Mental Disorder Diagnoses
- DRG 894: Alcohol/Drug Abuse or Dependence, Left AMA
- DRG 895: Alcohol/Drug Abuse or Depend. with Rehabilitation Therapy
- DRG 896: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w MCC
- DRG 897: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w/o MCC

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 comparable to the previous payment system. Effective October 3, 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