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 Base Rates effective January 1, 2025 ~~November 1, 2020~~ are based on claims with dates of discharge from October 1, 2020 to September 30, 2023 ~~October 1, 2015 to September 30, 2019~~ from all in-state hospitals plus Dartmouth-Hitchcock Medical Center and Albany 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 (MCR). The cost report used to assign the cost for each claim was based on the discharge date of the claim. Claims with dates of discharge from October 1, 2020, to September 30, 2023, ~~October 1, 2015 to September 30, 2019~~ were assigned costs using the hospital's fiscal year end MCR that matches the month of the discharge within the fiscal year end MCR.

Accommodation days were identified on each claim and assigned a cost per day using the hospital-specific MCR's cost per diem based on the unit in the hospital, such as semi-private room, nursery, or ICU. Allowed charges on each ancillary service 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 (IPPS) Final Rule for 2014 published in the Federal Register with the following exceptions: The Medicare IPPS group for Routine Days was split into two groups—Adults & Pediatrics and Nursery. The Medicare IPPS group for Intensive Days was split into three groups—ICU, Surgical ICU and Neonatal ICU.

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

The in-state base rates were derived by first computing the average inflated cost per case across all non-outlier claims in the base period. ~~This value is between $12,862 and $13,488. Because of funding limits imposed by the Vermont Legislature,~~ The ~~the~~ in-state Base Rates effective January 1, 2025 ~~November 1, 2020~~ for non-psychiatric DRGs is $10,900 ~~$9,488.32~~ for Critical Access Hospitals, $9,755 ~~$8,355.03~~for in-state and Border Teaching Hospitals, and $10,100 ~~$9,159.71~~for all other Prospective Payment System Hospitals~~. and Institutions of Mental Diseases.~~

(Continued)

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