Cost Estimation Process:

Cost was estimated for each claim using data from the hospital's 2009 FYE submitted cost report. Each revenue code was crosswalked to a cost center on the cost report and the appropriate cost per diem (per diem) or cost to charge ratio (CCR) was assigned. The preliminary crosswalk was sent to each provider for review. Based on feedback from providers, crosswalks were revised to assign cost for specific revenue codes to cost centers that were not shown on the initial crosswalk developed, except where providers attempted to reassign revenue codes that the state had determined would be non-costed for the purposes of weight setting. These changes are shown on the included exhibit "Master Provider Crosswalk." The CR Line Source for revenue codes that were requested to be revised is listed as "Provider."

Although hospital-specific revenue code crosswalks were used whenever possible, the state created a statewide default crosswalk that was used whenever a hospital-specific revenue code assignment was not present or led to a cost center that was not present on the 2009 FYE cost report. This default crosswalk also contained two additional payment codes, IR (in routine) and NC (non-covered). IR is used for revenue codes that the state determined were usually assigned to the routine cost center (line 25). If a hospital-specific crosswalk assigned this cost to a different cost center, the hospital-specific crosswalk was utilized. If no hospital-specific crosswalk was available, a CCR of 0 was assigned as all cost from these lines was considered to be included in the per diem cost. Revenue codes assigned a flag of NC were determined by the state to represent services that were not part of an inpatient stay or would not be considered allowable cost for the claim. These revenue codes are always assigned a per diem or CCR of 0.

Using the final revenue code crosswalk, a cost is estimated for each line item on a claim. For routine line items, the number of units on the line is multiplied by the per diem cost. For ancillary line items, the charges on each line are multiplied by the appropriate cost to charge ratio. The unadjusted cost for the line is inflated to 2012 using the CMS Hospital Prospective Reimbursement Market Basket from quarter 2 of 2011. Ancillary costs, which are based on charges present on the claim, are inflated from the discharge date to the midpoint of 2012. Routine costs, which are based on the average cost per day of the hospital's 2009 fiscal year period, are inflated from midpoint of the hospital's fiscal year to the midpoint of 2012. In each case, an inflation begin index and an inflation end index are determined by interpolating between the appropriate quarter's begin and end indices from the inflation table listed above. These computed indices are used to create an inflation factor which is unique to that specific claim and line. The inflation used for each hospital fiscal year and all discharge dates present in the claim set are shown in the exhibit "Costing Estimation Inflation Table."

This unadjusted cost and the inflated cost for each line is summed to create the unadjusted cost and inflated cost for each claim. The 2012 inflated cost is also adjusted to remove the IME cost using the IME factors shown in the exhibit "Medical Education Factors," creating the 2012 IME-removed cost, which is used for determining DRG weights.