Rate Setting Process:

The 2008 budgeted payments included in the DRG rate reimbursement model are based on the payments from the 2006 Medicaid paid claims that are inflated to 2008 dollars using applicable TEFRA inflation factors. The “2008 Inflated Payments” were adjusted to remove $3.7 million in payments related to Utilization Review activities that were included in the DRG rates under the current system. The 2008 budgeted amount was further adjusted by $5.1 million to remove hospital-based physician payments through use of the hospital-specific Physician Factors that are included in the current DRG rates. The total statewide 2008 budgeted payments for the revised DRG system are $397,814,529.

The statewide hospital base rate was calculated as follows: A payment amount of $33,011,491 was calculated for projected outliers under the revised outlier system, as well as payments of $109,792 for Alternate Level of Care days for patients waiting placement to non-acute care facilities. The 2008 budgeted amount also includes an adjustment for the effect on Medicaid payments for Medicare crossover and third party claims. A separate narrative (Exhibit 13) is included describing the modeling of crossover and third party payments. Myers and Stauffer modeled claims under the current and revised DRG systems and determined that the rebasing would result in a reduction of $6,952,632 in crossover and TPL payments. This amount was added to the total DRG statewide budgeted payments.

The resulting 2008 budget for inlier payments is $371,645,878. To determine the statewide base rate, claims were modeled for payment under the revised system and the amount required to completely utilize the inlier budget was determined, using the hospital’s claim volume, case mix index and rate add-ons. The final statewide base rate was set at $4,323. If a hospital qualifies, additional percentage add-ons up to a maximum of 30% to this rate apply for Critical Service Providers and Critical Access Providers, resulting in a final hospital rate, which will be used in calculating fee-for-service payments to hospitals for providing services to Medicaid inpatient patients.

Exhibit 21 (Final Rate Model) shows the modeled base rate and hospital payments for each provider.