Cost Estimation Process:

Cost was estimated for each claim using data from the hospital's 2003 FYE audited 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, some crosswalks were revised to assign cost for specific review codes to cost centers that were not shown on the initial crosswalk received from Riverbend. These changes are highlighted in red on the included exhibit "Master Provider Crosswalk." There were also additions made to the crosswalk of revenue codes that were not present in the initial data set but were needed to estimate cost for additional claims or the charity care claim set that was used in the weight setting process. Any revenue codes that were not present on the original crosswalks sent to providers are also highlighted on this exhibit.

Although hospital-specific revenue code crosswalks were used whenever possible, the state determined a statewide default crosswalk that was whenever a hospital-specific revenue code assignment was not present or led to a cost center that was not present on the 2003 FYE cost report. This default crosswalk also contained two additional codes, IR (included in routine) and NC (non-covered). IR is used for revenue codes that the state has determined were inclusive of the routine per diems (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 .000000 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 2008 using the CMS Hospital Prospective Reimbursement Market Basket from quarter 2 of 2007. Ancillary costs, which are based on charges present on the claim, are inflated from the discharge date to the midpoint of 2008. Routine costs, which are based on the average cost per day of the hospital's 2003 fiscal year period, are inflated from midpoint of the hospital's fiscal year to the midpoint of 2008. In each case, an inflation begin index and an inflation end index are determined by interpolating between the appropriate quarter's begin and end indexes from the inflation table listed above. These computed indexes 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 2008 inflated cost is also adjusted to remove the IME cost using the IME factors shown in the exhibit "Medical Education Factors," creating the 2008 IME-removed cost, which is used for determining DRG weights. The unadjusted cost is also summed by hospital, along with the charges from acute care services, and the total cost is divided by the total acute charges to determine the hospital's cost to charge ratio. This CCR was used in the modeling of outlier payments during the rate-setting process.