

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 422 TEMP

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 9-23
DATE FOR REVIEW
DATE DUE 9-30

Adopted w/a hearing
Adopted w/o hearing
Temporary rule ✓

Approved 9-30-83 mjc Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State 10/5/83 Revisor approved 9/26/83 disapproved

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✓ Rule as Adopted

✓ Rule as Proposed see SR

✓ Order Adopting 9.19.83 Date

Notice of Intent to Solicit Outside Opinion

✓ Order for rulemaking
N/A date of Hearing

N/A Certificate of Board's Authorizing Resolution

Notice of rulemaking
Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
7.26./7.27.83 At least ~~30~~ 20 days prior to ~~hearing~~/adoption

✓ Mailing list Certificate

✓ Publication in State Register
8.1.83 At least ~~30~~/20 days prior to ~~hearing~~/adoption

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
Approving H.E.'s Report
Approving agency action

✓ Agency's Findings of Fact

N/A LCRAR Report or agency Affidavit

Certificate of Board's Resolution Adopting Rules

Order Approving Incorporation by Reference

Statement of Need and Reasonableness

Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

N/A Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : Leonard W. Levine, Commissioner

DATE: 9/30/83

Attn: JOHN BURMAN, Special Assistant Attorney General

FROM : MARTHA J. CASSERLY MJC
Special Assistant
Attorney General

PHONE: 296-4347

SUBJECT: In the Matter of Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided Under the Medical Assistance and General Assistance Medicare Care Programs. (12 MCAR §§ 2.05401 - 2.05403 Temporary)

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.
MJC/ls
cc: Ms. Kathy Burek
Mr. Duane Harves

Department of Public Welfare
Income Maintenance Bureau
Adopted Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided under the Medical Assistance and General Assistance Medical Care Programs
Temporary Rules as Adopted

12 MCAR S 2.05401 [Temporary] General provisions on reimbursement methodology for hospital inpatient care provided under the ~~medicare~~ medical assistance and general assistance medical care programs.

A. Statutory authority, purpose, and applicability.

1. Authority. 12 MCAR SS 2.05401-2.05403 [Temporary] are enacted under the authority granted the commissioner of public welfare by Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39. The provisions of 12 MCAR SS 2.05401-2.05403 [Temporary] are to be read in conjunction with code of Federal Regulations, titles XVIII and XIX and Minnesota Statutes, chapters 256, 256B, and 256D. ~~Any provision of 12 MCAR SS 2.05401-2.05403 [Temporary] that is inconsistent with any of the provisions of those laws and/or regulations is superseded thereby~~. The Minnesota Department of Public Welfare, as the state agency responsible for the administration of the medical assistance and general assistance medical care programs may issue instructional bulletins, manual materials, and forms, as necessary, to assist in compliance with these rules.

2. Purpose and applicability. 12 MCAR SS 2.05401-2.05403 [Temporary] establish a prospective inpatient hospital reimbursement methodology for all hospitals which participate in the medical assistance and/or general assistance medical care programs. ~~This rate methodology promotes cost containment through efficient and economical hospital operation by offering financial incentives without negative effects on patient care~~.

Rules 12 MCAR SS 2.05401-2.05403 [Temporary] also prescribe a method for implementing the statutory limitation in the growth of rates paid for inpatient hospital care, as found in Minnesota Statutes, section 256.966, as amended by Laws of Minnesota 1983,

chapter 312, article 5, sections 6 and 39, as those limits apply to hospitals not yet subject to the prospective rate determination system.

B. Definitions.

1. Applicability. As used in 12 MCAR SS 2.05401-2.05403 [Temporary], the following terms have the meanings given them.

2. Adjusted base year costs. "Adjusted base year costs" means allowable base year costs cumulatively adjusted by the annual hospital cost index for years prior to the budget year, and adjustments resulting from exceptions and/or appeals, if applicable.

3. Allowable base year costs. "Allowable base year costs" means a hospital's total program reimbursable cost as identified in the hospital's base year medicare/medicaid cost report with the following adjustments:

a. deduct hospital malpractice insurance costs that have been apportioned to the program as identified in the base year cost report;

b. deduct pass-through capital costs (pass-through costs other than malpractice insurance costs) apportioned to the program based on the ratio of reimbursable program costs to total reimbursable costs as identified in the base year cost report;

c. add costs disallowed on the medicare/medicaid cost report due to Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233, lower of cost or charge limitation; and

d. using the hospital cost index revise program reimbursable costs, as identified in the medicare/medicaid cost report, adjusted by a., b., and c. for the period between the base year fiscal year end and the first day of the hospital's first fiscal year beginning on or after July 1, 1983.

4. Base year. "Base year" means each hospital's fiscal year ending during calendar year 1981.

5. Budget year. "Budget year" means each hospital's most immediate upcoming fiscal year.

6. Commissioner. "Commissioner" means the commissioner of public welfare.

7. Current year. "Current year" means each hospital's current fiscal year.

8. Department. "Department" means the Department of Public Welfare.

9. Hospital cost index. "Hospital cost index (HCI)" means a single percentage factor applied annually to allowable base year costs, or, subsequent to the initial year, to the adjusted base year costs, to adjust costs for inflation and technology.

10. Out-of-area hospital. "Out-of-area hospital" means any hospital outside of Minnesota which had fewer than 20 inpatient admissions of program eligibles in the year before a given rate year. Any hospital outside of Minnesota with 20 or more program admissions will receive reimbursement on the same basis as a hospital in Minnesota.

11. Minimal participation. "Minimal participation" means a hospital with fewer than 100 program admissions in any given rate year.

12. Pass-through costs. "Pass-through costs" means those hospital cost categories which are not subject to the HCI. Pass-through costs are limited to the following categories as defined by medicare:

a. depreciation;

b. rents and leases;

c. property taxes and license fees;

d. interest; and

e. malpractice insurance.

No pass-through costs will be allowable if they are derived from capital projects requiring a certificate of need for which any applicable certificate of need was not granted.

13. Prior year. "Prior year" means each hospital's most recently concluded fiscal year.

14. Program. "Program" means the medical assistance ("medicaid" or "M.A.") program established under Minnesota

Statutes, section 256B and the provisions of the Social Security Act, title XIX. The term includes or may alternatively mean the general assistance medical care program established under Minnesota Statutes, section 256D, as the context may require.

15. Prospective reimbursement system. "Prospective reimbursement system" means a method of paying hospital inpatient care on the basis of a rate per admission or rate per day, or some combination thereof, determined in advance of the delivery of care, rather than by the traditional systems of paying for care on the basis of customary charges or audited prorated costs.

16. Rate per admission. "Rate per admission" means ~~the allowable-base-year-costs-per-program-admission,-or,-subsequent to-the-initial-year,~~ the adjusted base year costs, times the budget year hospital cost index plus budget year pass-through costs per program admission.

17. Rate per day. "Rate per day" means the allowable payment per day of care when payment is not based on a rate per admission.

C. Determination of allowable base year costs for ~~period beginning-July-1,-1983,-through-July-30,-1987~~ hospital fiscal years beginning on or after July 1, 1983.

1. Each hospital participating in medicaid must submit its medicaid/medicare cost report for the base year. Final allowable base year costs will be calculated from the submitted cost report.

2. Allowable base year costs will be calculated as follows, using data from the Health Care Financing Administrator (HCFA) Form 2552 Worksheet, 1981 revision:

(1) Total reimbursable program costs: (Worksheet E-5, Part 1, Line 17) _____

(2) Reimbursable malpractice insurance costs (Worksheet E-5, Part 1, Line 5) _____

(3) Net reimbursable program costs (Line 1 minus Line 2) _____

(4) Total costs (Worksheet A, Column 3, Line 84) _____

(5) Malpractice insurance costs _____

(Worksheet A, Column 5, Line 71)

(6) Net total costs (Line 4 minus Line 5) _____

(7) Overall program utilization (Line 3 divided by Line 6) _____

(8) Total pass-through capital costs (Worksheet A, Column 7, Lines 2 and 3) _____

(9) Calculated program pass-through capital costs (Line 7 times Line 8) _____

(10) Program routine service costs before limitation (Worksheet D-1, Line 57) _____

(11) Program reimbursable routine service costs (Worksheet D-1, Line 61) _____

(12) Program reimbursable routine service costs subject to limitation (Line 10 minus Line 11) _____

(13) Program adjusted reimbursable costs ~~(Line 3 plus Line 12, minus Line 7)~~ (Line 3 minus Line 9 plus Line 12) _____

(14) Program admissions for persons not enrolled in medicare, Part A _____

(15) Program adjusted reimbursable costs per admission (Line 13 divided by Line 14) _____

(16) Applicable hospital cost index(es) _____

(17) Final base year costs per admission (Line 15 times Line 16) _____

D. Determination of annual hospital cost index.

1. The department shall publish 30 days prior to the start of each calendar quarter the hospital cost index to be used for the succeeding fiscal year. Each hospital whose fiscal year starts during a given calendar quarter will be subject to the HCI published 30 days prior to the start of that quarter. During the quarter beginning July 1, 1983, an HCI will not be published, but each hospital affected by that HCI shall be notified in writing of the HCI when it is determined.

2. The department shall obtain, from an independent source, inflation estimates to be used in the calculation of the hospital cost index. The hospital cost index will represent a weighted average of inflation estimates determined for the expense categories described below plus an additional one percent to reflect changes in technology. To the extent possible, the HCI shall reflect regional differences in the expenses constituting the HCI. The HCI shall include the

following factors:

a. salaries;

b. employee benefits;

c. medical fees;

d. raw food;

e. medical supplies;

f. pharmaceuticals;

g. utilities;

h. repairs and maintenance;

i. insurance (other than malpractice); and

j. other operating expenses approved by the commissioner.

3. The department shall weight the expense of the categories to approximate the proportionate weight found in the aggregate of the hospitals in Minnesota.

4. Subsequent to the initial year, a factor to adjust for the difference between estimated and actual inflation for the prior year will be calculated into the HCI.

5. ~~The HCI is subject to legislatively imposed limitations~~.

E. Determination of the payable rate per admission and rate per day.

1. Hospital submission of financial information. For each fiscal year, each hospital must submit a report to the department containing its pass-through costs and admissions data. The report shall include actual data for the prior year and budgeted data for the current and budget years. The report is due 30 days prior to the start of the hospital's next fiscal year. The report shall include the following information:

Category	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
Depreciation			
Rents and leases			
Property taxes, license fees (and other taxes)			
Interest			
Malpractice insurance			
TOTAL PASS-THROUGH COSTS			

"Overall-Program Utilization"			
PROGRAM PASS-THROUGH COSTS			
Admissions Program PASS-THROUGH COSTS PER ADMISSION			
~~Patient-Days~~			
~~PASS-THROUGH-COSTS~~			
Patient days PASS-THROUGH COSTS PER PATIENT DAY			

2. Pass-through costs. Pass-through costs per admission for the budget year shall be calculated from the submitted hospital report.

3. Rate per admission. The rate per admission for the budget year shall be calculated as follows:

RATE = [(~~Allowable~~ Adjusted base year costs per program admission multiplied by (budget year hospital cost index), plus (budget year pass-through costs per program admission)]

~~Subsequent to the initial year, adjusted base year costs is used in the above formula instead of allowable base year costs.~~ In calculating the budget year pass-through costs per program admission, the count of total admissions and the ratio of program admissions to total admissions will be taken from the hospital's base year.

After the end of each budget year, the commissioner shall, upon request of the provider, recalculate the rate per admission and/or the rate per day and the actual ~~values~~ value for program admissions ~~and total admissions~~. The commissioner may subsequently adjust the amounts paid to the hospital. The adjustment may be either a single payment to or from a hospital or an adjustment to a hospital's subsequent year's rate(s).

4. The department shall review hospital pass-through costs and admissions data as part of the appeal process described in H.

F. Payment procedures.

1. Standard billing data required. Hospitals shall submit complete medicaid billing forms on paper or by approved

computer-tape data exchange following existing procedures, or in such modified fashion as may be prescribed by the commissioner after 120 days' written notice by program provider bulletin.

2. When billing forms may be submitted. Billing forms shall not be submitted until the patient dies, is discharged, or has been a patient for at least 30 days, whichever comes first.

3. Payments in response to billings. The department shall pay the applicable rate per day or rate per admission for eligible patients after processing the first properly submitted bill. Billings may be rejected for lack of required prior-authorizations, surgical second opinion documentation, or for other utilization-review reasons. If a billing reflects inappropriate utilization, as determined by the commissioner, a per diem debit may be made to the rate per admission.

4. Final bills. If a patient is still hospitalized when the first bill is submitted to the department, a final bill must be sent containing the type-of-bill code indicating that the bill is for information only or for documentation of the eligibility of the case for additional payments for an unusual length of stay. When a final bill or information-only continuation bill is not received within six months of the date of admission, the billing shall be deemed to be in noncompliance with this rule and any payment originally made shall be repaid to the department.

5. Medicare crossover claims shall be paid as follows:

Payment Amount = (medicare deductibles), plus
(medicare coinsurance), plus
[(Amounts covered by medicaid but not by medicare) times (raw allowable base year costs divided by total base year charges for persons not eligible for medicare Part A)]

Medicare crossover claims shall be billed to the department following existing procedures and data reporting requirements or in such other fashion as the commissioner may provide for after 120 days' written notice by program provider bulletin.

6. Payments to out-of-area hospitals. Out-of-area hospitals shall be paid their submitted customary charges

multiplied by their last available medicaid or medicare interim reimbursement rate from their home-state medicaid program or medicare intermediary. If a lesser amount would be payable by the medicaid program in a hospital's home state and can be reasonably determined, that lesser amount shall be paid.

G. Exceptions to the payment mechanism. Exceptions to the rate per admission shall be granted in the following circumstances:

1. Minimal participation. A hospital with a history of minimal participation may elect to be reimbursed on a rate per day basis in lieu of rate per admission reimbursement. The hospital must submit a written request to the commissioner at least 30 days prior to the beginning of the budget year for which rate per day reimbursement is sought. At the conclusion of the budget year, the amount paid may be adjusted according to E.3.

2. Unusual length of stay. If a hospital has an M.A. or G.A.M.C. client admission involving an unusually long length of stay, the hospital shall be entitled to a per diem payment in addition to the rate per admission. An unusually long length of stay will be defined by the appeals board in each case, as will the per diem adjustment, if any.

3. Disproportionate population. The Minnesota prospective hospital payment system will take into account the situation of hospitals which serve a disproportionate number of low income patients. Hospitals with a disproportionate number of M.A. and/or G.A.M.C. clients shall receive an adjustment to the rate per admission. If the percentage of M.A. and/or G.A.M.C. admissions exceeds 15 percent, a percentage increase to the rate per admission will be calculated as follows:

For: Percentage of total acute care admissions which are Medicaid	Increase in rate per admission
15-20%	1/4 of 1% for each percentage point above 15%
21-25%	1/2 of 1% for each percentage point above 20%
26-30%	3/4 of 1% for each percentage point above 25%
31% and above	1% for each percentage point above 30%

For example, if a hospital's ~~medicaid~~ M.A. and/or G.A.M.C. ratio was 23 percent, the rate per admission would be increased by 2.75 percent. This adjustment is made to hospital rates after the application of any statutory limits to the growth in hospital rates or unit costs.

H. Appeals.

1. Appointment of appeals board. The commissioner shall appoint an appeals board to hear and evaluate requests for changes in the rate per admission or rate per day payable for hospitals subject to the prospective hospital reimbursement system or the limits on per-admission payments governed by 12 MCAR SS 2.05401-2.05403 [Temporary].

2. Composition of appeals board. The appeals board shall consist of two representatives of the state of Minnesota, two representatives of the hospital industry, and one representative of the business or consumer community. Representatives shall serve for a period of two years. Nongovernmental representatives shall receive a per diem rate and expenses as determined by the commissioner.

3. Authority of appeals board. The appeals board shall have recommendation authority to the commissioner to adjust hospital rates.

4. Issues to be heard by appeals board. The appeals board shall hear written requests for rate redeterminations on:

a. mix changes;

b. additions of approved new services;

c. deletions of services;

d. denied applications for exceptions;

e. modifications of pass-through costs;

f. catastrophic events;

g. catastrophic patient cases; and

h. rate reduction resulting from inappropriate levels of utilization.

5. Procedures of appeals board. The appeals board shall follow the procedures of the Office of Administrative Hearings for hearings based on the Revenue Recapture Act, in 9 MCAR SS

2.501-2.519, with the following modifications:

a. Definitions. The definitions in 9 MCAR S 2.502 are modified as follows:

(1) "Agency" means the Minnesota Department of Public Welfare.

(2) "Hospital" means the hospital seeking review of a rate set by the commissioner.

(3) "Party" means the agency, the hospital, or any other person granted permission to intervene.

(4) "Service" may be accomplished by delivering a document to the business office of a hospital in person during regular business hours, or by mailing the document to the business address of the hospital, postage paid, by first class United States mail. Service is complete upon mailing.

b. Initiation of appeal. 9 MCAR S 2.503 is modified as follows:

(1) A hospital which wants to appeal a rate established by the commissioner must submit a written notice of appeal to the appeals board within 30 days of the effective date of the rate complained of or within 30 days of the change in circumstances which occassioned the appeal.

(2) Within 90 days of the receipt of a notice of appeal, the board shall issue a notice of hearing.

c. Notice of hearing. Rule 9 MCAR S 2.504 B.3. is modified as follows: a brief statement of the issues to be determined at the hearing, together with a citation to any relevant statutes and rules. Rule 9 MCAR S 2.504 B.10. is modified as follows: that failure to appear will result in dismissal of the appeal, with prejudice.

d. Default. Rule 9 MCAR S 2.505 B. is modified as follows: If the agency appears at the hearing, but the hospital does not, the appeal will be dismissed with prejudice. If the hospital appears at the hearing, but the agency does not, the allegations in the notice of appeal will be deemed true, and the appeals board shall recommend that the appeal be granted.

e. Subpoenas. Subpoenas may be issued by the

commissioner under Minnesota Statutes, section 256B.13, and 9 MCAR S 2.509, except that a request for a subpoena shall be submittted to the chief representative of the appeals board.

f. Conduct of the hearing. Hearings shall be conducted pursuant to 9 MCAR S 2.511, with the following exceptions:

(1) no hearing examiner shall be assigned to an appeal filed with the appeals board;

(2) a member of the appeals board shall open the hearing by reading the title of the case and briefly stating the issues; and

(3) the burden of proof shall be on the hospital challenging the rate established by the commissioner, and the hospital shall begin the presentation of evidence.

g. Rights of nonparties. Rule 9 MCAR S 2.513 is modified as follows: A nonparty may not testify or offer evidence without the approval of the appeals board.

h. The appeals board shall have all the rights and obligations conferred upon a hearing examiner by 9 MCAR SS 2.501-2.519. The term "appeals board" shall be substituted for the terms "hearing examiner" or "examiner" wherever those terms appear in 9 MCAR SS 2.501-2.519, except as otherwise specified by this rule.

i. Chief representative. The appeals board shall appoint one of its members to serve as the chief representative. The member may fix the time and place of hearings, and to receive and recommend action to the commissioner upon receipt of request for subpoenas.

j. Appeal rights. A hospital aggrieved by the decision of the commissioner may appeal that decision by filing a written notice of appeal with the commissioner within 30 days of the date of the decision complained of. Any such appeal shall be conducted pursuant to the contested case procedures of Minnesota Statutes, chapter 14 and the rules of the Office of Administrative Hearings.

12 MCAR S 2.05402 [Temporary] General assistance medical care

("G.A.M.C.") cases.

1. Applicability of rule. All provisions of 12 MCAR SS 2.05401-2.05403 [Temporary] shall apply equally to G.A.M.C. cases and rates, substituting the terms and data for G.A.M.C. for the terms and data referenced for medicaid, as applicable.

2. Rateable reductions. No provision in 12 MCAR S 2.05401-2.05403 [Temporary] shall be construed to increase or decrease any discount ("rateable reduction") charged against G.A.M.C. claims in determining the final payment amount.

12 MCAR S 2.05403 [Temporary] Special provisions.

A. Purpose. In accordance with Minnesota Statutes, section 256.966, the annual increase in the cost per unit paid to any vendor under medical assistance and general assistance medical care shall not exceed eight percent for admissions from January 1, 1982, through June 30, 1983.

B. Definitions.

1. Adjusted base year costs. "Adjusted base year costs" means allowable base year costs cummulatively adjusted by the annual eight percent cap factor, and adjustments resulting from appeals, if applicable.

2. Allowable base year costs. "Allowable base year costs" means each hospital's total program reimbursable costs as defined in the medicare/medicaid cost report adjusted as follows:

a. deduct hospital malpratice insurance costs that have been apportioned to the program in the base year cost report;

b. deduct pass-through captial costs (pass-through costs other than malpractice insurance costs) apportioned to the program based on the ratio of reimbursable program costs to total reimbursable costs in accordance with the medicare/medicaid cost report;

c. add costs disallowed on the medicare/medicaid cost report due to Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233, lower of cost or charge limitations;

d. using a year and inflation adjustment index, revise

program reimbursable costs, as identified in the base year the program cost report adjusted by 2.a., b., and c., for the period between the base year, fiscal year, and July 1, 1983.

3. Base year. "Base year" means each hospital's fiscal year ending during calendar year 1981.

4. Eight percent cap. "Eight percent cap" means the limit on cost increase per unit of service pursuant to state legislation.

5. Pass-through costs. "Pass-through costs" means those hospital cost categories which are not subject to the eight percent cap. Pass-through costs are limited to the following categories as defined by medicare:

a. depreciation;

b. rents and leases;

c. property taxes and license fees;

d. interest; and

e. malpractice insurance.

6. Rate per admission. "Rate per admission" means allowable base year costs per program admission, or subsequent to the initial year, adjusted base year costs, times the budget year eight percent cap, plus budget year pass-through costs per program admissions.

C. Determination of allowable base year cost per program admission for the period January 1, 1982, through June 30, 1983.

1. Each hospital participating in medical assistance will submit its medicare/medicaid cost report for the base year. Final allowable base year costs will be calculated from the audited medicare/medicaid cost report.

2. Allowable base year costs per program admission will be computed as follows, using data from the Health Care Financing Administrator (HCFA) Form 2552 Worksheet, 1981 revision:

(1) Total reimbursable M.A. program costs (Worksheet E-5, Part 1, Line 17) _____

(2) Reimbursable malpractice insurance costs (Worksheet E-5, Part 1, Line 5) _____

(3) Net reimbursable program cost (Line 1 minus _____

Line 2)

(4) Total costs (Worksheet A, Column 3, Line 84) _____

(5) Malpractice insurance costs (Worksheet A, Column 5, Line 71) _____

(6) Net total costs (Line 4 minus Line 5) _____

(7) Overall program utilization (Line 3 divided by Line 6) _____

(8) Total pass-through capital costs (Worksheet A, Column 7, Lines 2 and 3) _____

(9) Calculated program pass-through capital cost (Line 7 times Line 8) _____

(10) Program routine service costs before limitation (Worksheet D-1, Line 57) _____

(11) Program reimbursable routine service costs (Worksheet D-1, Line 61) _____

(12) Program routine service costs subject to limitation (Line 10 minus Line 11) _____

(13) Program adjusted reimbursable costs (Line 3 minus Line 9 plus Line 12) _____

(14) Program admissions for persons not enrolled in medicare Part A _____

(15) Program adjusted reimbursable costs per admission (Line 13 divided by Line 14) _____

(16) Eight percent cap applied _____

(17) Allowable base year cost per admission (Line 15 times Line 16) _____

D. Determination of rate per admission.

1. Reports for each fiscal year. Each hospital shall submit a report to the department containing pass-through costs and admission data. The report will include actual data for the prior year, and budgeted data for the current and budget years as specified in 12 MCAR S 2.05401 [Temporary] E.1.d.

2. Application of eight percent cap. The department will annually multiply the eight percent cap times the base year rate per admission. Subsequent to the initial year, adjusted base year per admission is used in place of base year rate per admission.

3. Calculation of rate per admission. The rate per admission for the budget year will be calculated as follows: allowable base year costs per program admission multiplied by budget year eight percent cap, plus budget year pass-through

costs per program admission. Subsequent to the initial year, adjusted base year costs are used in the above formula instead of allowable base year costs.

4. Payment procedures shall be as specified in 12 MCAR S 2.05401 [Temporary] F.

5. Appeals shall be pursuant to 12 MCAR S 2.05401 [Temporary] H.

6. General assistance medical care costs shall be reimbursed as specified in 12 MCAR S 2.05402 [Temporary].

E. Four percent reduction. Payment to medical assistance providers is reduced four percent for services provided January 1, 1983, through June 30, 1983, as provided in Laws of Minnesota 1983, Third special session, chapter 8, article II, subdivision 4(a)(4). The following procedure will be used to implement this four percent reduction:

1. Cost report. Each hospital must submit a special cost report covering the period January 1, 1983, through June 30, 1983.

2. Application of four percent reduction. The rate per admission for each hospital, as determined pursuant to 12 MCAR S 2.05403 [Temporary] C.2., shall be reduced by four percent for each admission during the period from January 1, 1983, through June 30, 1983.

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
OCT - 5 1983 10:00 A.M.
Joan Anderson Growe
Secretary of State

APPROVED AS TO FORM AND LEGALITY
September 30 1983
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY Martha J Cassely
~~SPECIAL ASSISTANT~~ ATTORNEY GENERAL
Legal assistant

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided Under the Medical Assistance and General Assistance Medicare Care Programs (12 MCAR §§ 2.05401 - 2.05403 Temporary)

ORDER ADOPTING TEMPORARY RULES

The above-entitled matter was published in the State Register on August 1, 1983, as a proposed temporary rule pursuant to Minnesota Statutes section 14.29 - 14.36.

After affording interested and affected persons an opportunity to submit written data and views within 20 days of the publication date, reviewing and considering the data and views, and determining that the above-captioned rules are needed and reasonable.

NOW, THEREFORE, IT IS ORDERED that these rules identified as Reimbursement Methodology for Hospital Inpatient Care Provided under the Medical Assistance and General Assistance Medicare Care Programs. (12 MCAR §§ 2.05401 - 2.05403 Temporary) are adopted this 19th day of September, 1983, pursuant to authority vested in me by Laws of Minnesota 1983, Chapter 312, Article 5, Section 9 and 39.

STATE OF MINNESOTA

LEONARD W. LEVINE
Commissioner of Public Welfare

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF A TEMPORARY RULE OF THE STATE DEPARTMENT PUBLIC WELFARE GOVERNING REIMBURSEMENT METHODOLOGY FOR HOSPITAL INPATIENT CARE PROVIDED UNDER THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS (12 MCAR §§2.05401 - 2.05403 TEMPORARY)

ORDER FOR PUBLICATION OF A TEMPORARY RULE

IT IS ORDERED this 15th day of July, 1983, that the proposed temporary rule in the above-entitled matter be published in the State Register.

STATE OF MINNESOTA

Commissioner of Public Welfare

KD1/06

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

In the Matter of Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided Under the Medical Assistance and General Assistance Medical Care Programs
(12 MCAR §§2.05401-2.05403 Temporary)

AFFIDAVIT OF MAILING

Wendy Johnson, being first duly sworn, deposes and says:

That on the 26th day of July, 1983, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Intent to Adopt Temporary Rules by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department.

Wendy Johnson

Subscribed and sworn to before me

this 27 day of July, 1983.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

In the Matter of Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Proveded Under the Medical Assistance and General Assistance Medical Care Programs
(12 MCAR §§2.05401-2.05403 Temporary)

AFFIDAVIT OF ADDITIONAL MAILING

Wendy Johnson, being first duly sworn, deposes and says:

That on the 27th day of July, 1983, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Intent to Adopt a Temporary Rule to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of the proposed adoption of rules by this Department, she also served the attached Notice by depositing in the State of Minnesota, Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following agencies:

306 Hospitals

Wendy Johnson

Subscribed and sworn to before me

this 27 day of July, 1983.

Margaret Holt

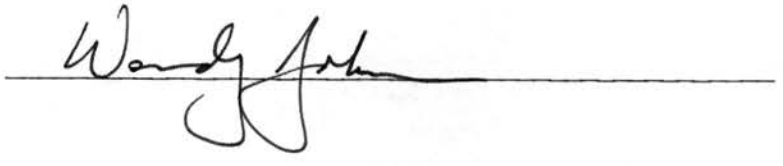
MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

In the Matter of Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided Under the Medical Assistance and General Assistance Medical Care Programs
(12 MCAR §§2.05401-2.05403 Temporary)

CERTIFICATE

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. §15.0412, subd. 4, that their names be placed on file with and maintained by the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 4:00, P.M., this 27th day of July, 1983.



public welfare by *Laws of Minnesota 1983*, chapter 312, article 5, sections 9 and 39. The provisions of 12 MCAR §§ 2.05401-2.05403 [Temporary] are to be read in conjunction with code of Federal Regulations, titles XVIII and XIX and Minnesota Statutes, chapters 256, 256B, and 256D. Any provision of 12 MCAR §§ 2.05401-2.05403 [Temporary] that is inconsistent with any of the provisions of those laws and/or regulations is superseded thereby. The Minnesota Department of Public Welfare, as the state agency responsible for the administration of the medical assistance and general assistance medical care programs may issue instructional bulletins, manual materials, and forms, as necessary, to assist in compliance with these rules.

2. Purpose and applicability. 12 MCAR §§ 2.05401-2.05403 [Temporary] establish a prospective inpatient hospital reimbursement methodology for all hospitals which participate in the medical assistance and/or general assistance medical care programs. This rate methodology promotes cost containment through efficient and economical hospital operation by offering financial incentives without negative effects on patient care.

Rules 12 MCAR §§ 2.05401-2.05403 [Temporary] also prescribe a method for implementing the statutory limitation in the growth of rates paid for inpatient hospital care, as found in Minnesota Statutes, section 256.966, as amended by *Laws of Minnesota 1983*, chapter 312, article 5, sections 6 and 39, as those limits apply to hospitals not yet subject to the prospective rate determination system.

B. Definitions.

1. Applicability. As used in 12 MCAR §§ 2.05401-2.05403 [Temporary], the following terms have the meanings given them.

2. Adjusted base year costs. "Adjusted base year costs" means allowable base year costs cumulatively adjusted by the annual hospital cost index for years prior to the budget year, and adjustments resulting from exceptions and/or appeals, if applicable.

3. Allowable base year costs. "Allowable base year costs" means a hospital's total program reimbursable cost as identified in the hospital's base year medicare/medicaid cost report with the following adjustments.

a. deduct hospital malpractice insurance costs that have been apportioned to the program as identified in the base year cost report;

b. deduct pass-through capital costs (pass-through costs other than malpractice insurance costs) apportioned to the program based on the ratio of reimbursable program costs to total reimbursable costs as identified in the base year cost report;

c. add costs disallowed on the medicare/medicaid cost report due to Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233, lower of cost or charge limitation; and

d. using the hospital cost index revise program reimbursable costs, as identified in the medicare/medicaid cost report, adjusted by a., b., and c. for the period between the base year fiscal year end and July 1, 1983.

4. Base year. "Base year" means each hospital's fiscal year ending during calendar year 1981.

5. Budget year. "Budget year" means each hospital's most immediate upcoming fiscal year.

6. Commissioner. "Commissioner" means the commissioner of public welfare.

7. Current year. "Current year" means each hospital's current fiscal year.

8. Department. "Department" means the Department of Public Welfare.

9. Hospital cost index. "Hospital cost index (HCI)" means a single percentage factor applied annually to allowable base year costs, or, subsequent to the initial year, to the adjusted base year costs, to adjust costs for inflation and technology.

10. Out-of-area hospital. "Out-of-area hospital" means any hospital outside of Minnesota which had fewer than 20 inpatient admissions of program eligibles in the year before a given rate year. Any hospital outside of Minnesota with 20 or more program admissions will receive reimbursement on the same basis as a hospital in Minnesota.

11. Minimal participation. "Minimal participation" means a hospital with fewer than 100 program admissions in any given rate year.

12. Pass-through costs. "Pass-through costs" means those hospital cost categories which are not subject to the HCI. Pass-through costs are limited to the following categories as defined by medicare:

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Rules as Proposed

Repealer. Rules 4 MCAR §§ 2.501; 2.502; 2.503; 2.504; 2.505; 2.506; 2.507; and 2.508, are repealed.

Department of Public Welfare
Income Maintenance Bureau

Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided under the Medical Assistance and General Assistance Medical Care Programs (12 MCAR §§ 2.05401-2.05403 Temporary)

Notice of Intent to Adopt Temporary Rules

The State Department of Public Welfare proposes to adopt the above-entitled temporary rules to implement *Laws of Minnesota* 1983, chapter. 312.

Persons interested in these rules have until August 22, 1983 to submit written comments. The proposed temporary rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Thomas JoliCoeur
Health Care Programs Division
Income Maintenance Bureau
Department of Public Welfare
1st Floor, Space Center
444 Lafayette Road
St. Paul, MN 55164
(612) 296-8822

Upon adoption of these temporary rules, this notice, all written comments received, and the adopted temporary rules will be delivered to the Attorney General and to the Revisor of Statutes for review as to form and legality.

The adopted temporary rules will not become effective without the Attorney General's approval and the Revisor of Statute's certification of the rules' form.

As required by the Administrative Procedures Act, Minnesota Statutes, chapter 14, these temporary rules shall be in effect for up to 180 days following their adoption and may be continued in effect for an additional 180 days if the Commissioner gives notice of continuation by publishing notice in the *State Register* and mailing the same notice to all persons registered with the Commissioner to receive notice of rulemaking proceedings. The temporary rules shall not be effective 360 days after their effective date without following the procedures in Minnesota Statutes, sections 14.13 to 14.20.

12 MCAR §§ 2.05401-2.05403 establish a prospective inpatient hospital reimbursement methodology for all hospitals which participate in the Medical Assistance and/or General Assistance Medical Care Programs. This rate methodology promotes cost containment through efficient and economical hospital operation by offering financial incentives without negative affects on patient care.

These rules also prescribe a method for implementing the statutory limitations in the growth of rates paid for inpatient hospital care, as found in Minnesota Statutes, section 256.966, with amendments in Laws of 1983, chapter 312. These rules contain provisions on definitions of terms; determination of allowable base year costs; determination of annual hospital cost index; determination of the payable rate per admission and rate per day; payment procedures; and appeals.

These temporary rules will not result in any additional state or county spending beyond the amount of funds appropriated under *Laws of Minnesota 1983*, chapter 312.

Copies of this notice and the proposed temporary rule may be obtained by contacting Sandra Searles at (612) 296-3386.

Leonard W. Levine,
Commissioner of Public Welfare

Temporary Rules as Proposed (all new material)

12 MCAR § 2.05401 [Temporary] General provisions on reimbursement methodology for hospital inpatient care provided under the medicare assistance and general medical care programs.

A. Statutory authority, purpose, and applicability.

1. Authority. 12 MCAR §§ 2.05401-2.05403 [Temporary] are enacted under the authority granted the commissioner of

a. depreciation;

b. rents and leases;

c. property taxes and license fees;

d. interest; and

e. malpractice insurance.

No pass-through costs will be allowable if they are derived from capital projects requiring a certificate of need for which any applicable certificate of need was not granted.

13. Prior year. "Prior year" means each hospital's most recently concluded fiscal year.

14. Program. "Program" means the medical assistance ("medicaid" or "M.A.") program established under Minnesota Statutes, section 256B and the provisions of the Social Security Act, title XIX. The term includes or may alternatively mean the general assistance medical care program established under Minnesota Statutes, section 256D, as the context may require.

15. Prospective reimbursement system. "Prospective reimbursement system" means a method of paying hospital inpatient care on the basis of a rate per admission or rate per day, or some combination thereof, determined in advance of the delivery of care, rather than by the traditional systems of paying for care on the basis of customary charges or audited prorated costs.

16. Rate per admission. "Rate per admission" means the allowable base year costs per program admission, or, subsequent to the initial year, the adjusted base year costs, times the budget year hospital cost index plus budget year pass-through costs per program admission.

17. Rate per day. "Rate per day" means the allowable payment per day of care when payment is not based on a rate per admission.

C. Determination of allowable base year costs for period beginning July 1, 1983, through July 30, 1987.

1. Each hospital participating in medicaid must submit its medicaid/medicare cost report for the base year. Final allowable base year costs will be calculated from the submitted cost report.

2. Allowable base year costs will be calculated as follows, using data from the Health Care Financing Administrator (HCFA) Form 2552 Worksheet, 1981 revision:

(1) Total reimbursable program costs: (Worksheet E-5, Part I, Line 17) _____

(2) Reimbursable malpractice insurance costs (Worksheet E-5, Part I, Line 5) _____

(3) Net reimbursable program costs (Line 1 minus Line 2) _____

(4) Total costs (Worksheet A, Column 3, Line 84) _____

(5) Malpractice insurance costs (Worksheet A, Column 5, Line 71) _____

(6) Net total costs (Line 4 minus Line 5) _____

(7) Overall program utilization (Line 3 divided by Line 6) _____

(8) Total pass-through capital costs (Worksheet A, Column 7, Lines 2 and 3) _____

(9) Calculated program pass-through capital costs (Line 7 times Line 8) _____

(10) Program routine service costs before limitaton (Worksheet D-1, Line 57) _____

(11) Program reimbursable routine service costs (Worksheet D-1, Line 61) _____

(12) Program reimbursable routine service costs subject to limitation (Line 10 minus Line 11) _____

(13) Program adjusted reimbursable costs (Line 3 plus Line 12, minus Line 7) _____

(14) Program admissions for persons not enrolled in medicare, Part A _____

(15) Program adjusted reimbursable costs per admission (Line 13 divided by Line 14) _____

(16) Applicable hospital cost index(es) _____

(17) Final base year costs per admission (Line 15 times Line 16) _____

D. Determination of annual hospital cost index.

1. The department shall publish 30 days prior to the start of each calendar quarter the hospital cost index to be used for the succeeding fiscal year. Each hospital whose fiscal year starts during a given calendar quarter will be subject to the HCI published 30 days prior to the start of that quarter. During the quarter beginning July 1, 1983, an HCI will not be published, but each hospital affected by that HCI shall be notified in writing of the HCI when it is determined.

2. The department shall obtain, from an independent source, inflation estimates to be used in the calculation of the hospital cost index. The hospital cost index will represent a weighted average of inflation estimates determined for the expense categories described below plus an additional one percent to reflect changes in technology. To the extent possible, the HCI shall reflect regional differences in the expenses constituting the HCI. The HCI shall include the following factors:

a. salaries;

b. employee benefits;

c. medical fees;

d. raw food;

e. medical supplies;

f. pharmaceuticals;

g. utilities;

h. repairs and maintenance;

i. insurance (other than malpractice); and

j. other operating expenses approved by the commissioner.

3. The department shall weight the expense of the categories to approximate the proportionate weight found in the aggregate of the hospitals in Minnesota.

4. Subsequent to the initial year, a factor to adjust for the difference between estimated and actual inflation for the prior year will be calculated into the HCI.

5. The HCI is subject to legislatively imposed limitations.

E. Determination of the payable rate per admission and rate per day.

1. Hospital submission of financial information. For each fiscal year, each hospital must submit a report to the department containing its pass-through costs and admissions data. The report shall include actual data for the prior year and budgeted data for the current and budget years. The report is due 30 days prior to the start of the hospital's next fiscal year. The report shall include the following information:

Category	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
Depreciation			
Rents and leases			

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Property taxes, license fees (and other taxes)	_____	_____	_____
Interest	_____	_____	_____
Malpractice insurance	_____	_____	_____
TOTAL PASS-THROUGH COSTS	_____	_____	_____
Admissions	_____	_____	_____
PASS-THROUGH COSTS PER ADMISSION	_____	_____	_____
Patient days	_____	_____	_____
PASS-THROUGH COSTS			
Patient days	_____	_____	_____
PAST-THROUGH COSTS PER PATIENT DAY	_____	_____	_____

2. Pass-through costs. Pass-through costs per admission for the budget year shall be calculated from the submitted hospital report.

3. Rate per admission. The rate per admission for the budget year shall be calculated as follows:

RATE = [(Allowable base year costs per program admission) multiplied by (budget year hospital cost index), plus (budget year pass-through costs per program admission)]

Subsequent to the initial year, adjusted base year costs is used in the above formula instead of allowable base year costs. In calculating the budget year pass-through costs per program admission, the count of total admissions and the ratio of program admissions to total admissions will be taken from the hospital's base year.

After the end of each budget year, the commissioner shall, upon request, recalculate the rate per admission and/or the rate per day and the actual values for program admissions and total admissions. The commissioner may subsequently adjust the amounts paid to the hospital. The adjustment may be either a single payment to or from a hospital or an adjustment to a hospital's subsequent year's rate(s).

4. The department shall review hospital pass-through costs and admissions data as part of the appeal process described in H.

F. Payment procedures.

1. Standard billing data required. Hospitals shall submit complete medicaid billing forms on paper or by approved computer-tape data exchange following existing procedures, or in such modified fashion as may be prescribed by the commissioner after 120 days' written notice by program provider bulletin.

2. When billing forms may be submitted. Billing forms shall not be submitted until the patient dies, is discharged, or has been a patient for at least 30 days, whichever comes first.

3. Payments in response to billings. The department shall pay the applicable rate per day or rate per admission for eligible patients after processing the first properly submitted bill. Billings may be rejected for lack of required prior-authorizations, surgical second opinion documentation, or for other utilization-review reasons. If a billing reflects inappropriate utilization, as determined by the commissioner, a per diem debit may be made to the rate per admission.

4. Final bills. If a patient is still hospitalized when the first bill is submitted to the department, a final bill must be sent containing the type-of-bill code indicating that the bill is for information only or for documentation of the eligibility of the case for additional payments for an unusual length of stay. When a final bill or information-only continuation bill is not received within six months of the date of admission, the billing shall be deemed to be in noncompliance with this rule and any payment originally made shall be repaid to the department.

5. Medicare crossover claims shall be paid as follows:

Payment Amount = (medicare deductibles), plus
(medicare coinsurance), plus
[(Amounts covered by medicaid but not by medicare) times (raw allowable base year costs divided by total base year charges for persons not eligible for medicare Part A)]

Medicare crossover claims shall be billed to the department following existing procedures and data reporting requirements or in such other fashion as the commissioner may provide for after 120 days' written notice by program provider bulletin.

6. Payments to out-of-area hospitals. Out-of-area hospitals shall be paid their submitted customary charges multiplied by

their last available medicaid or medicare interim reimbursement rate from their home-state medicaid program or medicare intermediary. If a lesser amount would be payable by the medicaid program in a hospital's home state and can be reasonably determined, that lesser amount shall be paid.

G. Exceptions to the payment mechanism. Exceptions to the rate per admission shall be granted in the following circumstances:

1. Minimal participation. A hospital with a history of minimal participation may elect to be reimbursed on a rate per day basis in lieu of rate per admission reimbursement. The hospital must submit a written request to the commissioner at least 30 days prior to the beginning of the budget year for which rate per day reimbursement is sought. At the conclusion of the budget year, the amount paid may be adjusted according to E.3.

2. Unusual length of stay. If a hospital has an M.A. or G.A.M.C. client admission involving an unusually long length of stay, the hospital shall be entitled to a per diem payment in addition to the rate per admission. An unusually long length of stay will be defined by the appeals board in each case, as will the per diem adjustment, if any.

3. Disproportionate population. The Minnesota prospective hospital payment system will take into account the situation of hospitals which serve a disproportionate number of low income patients. Hospitals with a disproportionate number of M.A. and/or G.A.M.C. clients shall receive an adjustment to the rate per admission. If the percentage of M.A. and/or G.A.M.C. admissions exceeds 15 percent, a percentage increase to the rate per admission will be calculated as follows:

For: Percentage of total acute care admissions which are Medicaid	Increase in rate per admission
15-20%	¼ of 1% for each percentage point above 15%
21-25%	½ of 1% for each percentage point above 20%
26-30%	¾ of 1% for each percentage point above 25%
31% and above	1% for each percentage point above 30%

For example, if a hospital's medicaid ratio was 23 percent, the rate per admission would be increased by 2.75 percent. This adjustment is made to hospital rates after the application of any statutory limits to the growth in hospital rates or unit costs.

H. Appeals.

1. Appointment of appeals board. The commissioner shall appoint an appeals board to hear and evaluate requests for changes in the rate per admission or rate per day payable for hospitals subject to the prospective hospital reimbursement system or the limits on per-admission payments governed by 12 MCAR §§ 2.05401-2.05403 [Temporary].

2. Composition of appeals board. The appeals board shall consist of two representatives of the state of Minnesota, two representatives of the hospital industry, and one representative of the business or consumer community. Representatives shall serve for a period of two years. Nongovernmental representatives shall receive a per diem rate and expenses as determined by the commissioner.

3. Authority of appeals board. The appeals board shall have recommendation authority to the commissioner to adjust hospital rates.

4. Issues to be heard by appeals board. The appeals board shall hear written requests for rate redeterminations on:

a. mix changes;

b. additions of approved new services;

c. deletions of services;

d. denied applications for exceptions;

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e. modificatons of pass-through costs;

f. catastrophic events;

g. catastrophic patient cases; and

h. rate reduction resulting from inappropriate levels of utilization.

5. Procedures of appeals board. The appeals board shall follow the procedures of the Office of Administrative Hearings for hearings based on the Revenue Recapture Act, in 9 MCAR §§ 2.501-2.519, with the following modifications:

a. Definitions. The definitions in 9 MCAR § 2.502 are modified as follows:

(1) "Agency" means the Minnesota Department of Public Welfare.

(2) "Hospital" means the hospital seeking review of a rate set by the commissioner.

(3) "Party" means the agency, the hospital, or any other person granted permission to intervene.

(4) "Service" may be accomplished by delivering a document to the business office of a hospital in person during regular business hours, or by mailing the document to the business address of the hospital, postage paid, by first class United States mail. Service is complete upon mailing.

b. Initiation of appeal. 9 MCAR § 2.503 is modified as follows:

(1) A hospital which wants to appeal a rate established by the commissioner must submit a written notice of appeal to the appeals board within 30 days of the effective date of the rate complained of or within 30 days of the change in circumstances which occassioned the appeal.

(2) Within 90 days of the receipt of a notice of appeal, the board shall issue a notice of hearing.

c. Notice of hearing. Rule 9 MCAR § 2.504 B.3. is modified as follows: a brief statement of the issues to be determined at the hearing, together with a citation to any relevant statutes and rules. Rule 9 MCAR § 2.504 B.10. is modified as follows: that failure to appear will result in dismissal of the appeal, with prejudice.

d. Default. Rule 9 MCAR § 2.505 B. is modified as follows: If the agency appears at the hearing, but the hospital does not, the appeal will be dismissed with prejudice. If the hospital appears at the hearing, but the agency does not, the allegations in the notice of appeal will be deemed true, and the appeals board shall recommend that the appeal be granted.

e. Subpoenas. Subpoenas may be issued by the commissioner under Minnesota Statutes, section 256B.13, and 9 MCAR § 2.509, except that a request for a subpoena shall be submitted to the chief representative of the appeals board.

f. Conduct of the hearing. Hearings shall be conducted pursuant to 9 MCAR § 2.511, with the following exceptions:

(1) no hearing examiner shall be assigned to an appeal filed with the appeals board;

(2) a member of the appeals board shall open the hearing by reading the title of the case and briefly stating the issues; and

(3) the burden of proof shall be on the hospital challenging the rate established by the commissioner, and the hospital shall begin the presentation of evidence.

g. Rights of nonparties. Rule 9 MCAR § 2.513 is modified as follows: A nonparty may not testify or offer evidence without the approval of the appeals board.

h. The appeals board shall have all the rights and obligations conferred upon a hearing examiner by 9 MCAR §§ 2.501-2.519. The term "appeals board" shall be substituted for the terms "hearing examiner" or "examiner" wherever those terms appear in 9 MCAR §§ 2.501-2.519, except as otherwise specified by this rule.

i. Chief representative. The appeals board shall appoint one of its members to serve as the chief representative. The member may fix the time and place of hearings, and to receive and recommend action to the commissioner upon receipt of request for subpoenas.

j. Appeal rights. A hospital aggrieved by the decision of the commissioner may appeal that decision by filing a written notice of appeal with the commissioner within 30 days of the date of the decision complained of. Any such appeal shall be conducted pursuant to the contested case procedures of Minnesota Statutes, chapter 14 and the rules of the Office of Administrative Hearings.

12 MCAR § 2.05402 [Temporary] General assistance medical care ("G.A.M.C.") cases.

1. Applicability of rule. All provisions of 12 MCAR §§ 2.05401-2.05403 [Temporary] shall apply equally to G.A.M.C. cases and rates, substituting the terms and data for G.A.M.C. for the terms and data referenced for medicaid, as applicable.

2. Rateable reductions. No provision in 12 MCAR §§ 2.05401-2.05403 [Temporary] shall be construed to increase or decrease any discount ("rateable reduction") charged against G.A.M.C. claims in determing the final payment amount.

12 MCAR § 2.05403 [Temporary] Special provisions.

A. Purpose. In accordance with Minnesota Statutes, section 256.966, the annual increase in the cost per unit paid to any vendor under medical assistance and general assistance medical care shall not exceed eight percent for admissions from January 1, 1982, through June 30, 1983.

B. Definitions.

1. Adjusted base year costs. "Adjusted base year costs" means allowable base year costs cummulatively adjusted by the annual eight percent cap factor, and adjustments resulting from appeals, if applicable.

2. Allowable base year costs. "Allowable base year costs" means each hospital's total program reimbursable costs as defined in the medicare/medicaid cost report adjusted as follows:

a. deduct hospital malpractice insurance costs that have been apportioned to the program in the base year cost report;

b. deduct pass-through capital costs (pass-through costs other than malpractice insurance costs) apportioned to the program based on the ratio of reimbursable program costs to total reimbursable costs in accordance with the medicare/medicaid cost report;

c. add costs disallowed on the medicare/medicaid cost report due to Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233, lower of cost or charge limitations;

d. using a year and inflation adjustment index, revise program reimbursable costs, as identified in the base year the program cost report adjusted by 2. a., b., and c., for the period between the base year, fiscal year, and July 1, 1983.

3. Base year. "Base year" means each hospital's fiscal year ending during calendar year 1981.

4. Eight percent cap. "Eight percent cap" means the limit on cost increase per unit of service pursuant to state legislation.

5. Pass-through costs. "Pass-through costs" means those hospital cost categories which are not subject to the eight percent cap. Pass-through costs are limited to the following categories as defined by medicare:

a. depreciation;

b. rents and leases;

c. property taxes and license fees;

d. interest; and

e. malpractice insurance.

6. Rate per admission. "Rate per admission" means allowable base year costs per program admission, or subsequent to the initial year, adjusted base year costs, times the budget year eight percent cap, plus budget year pass-through costs per program admissions.

C. Determination of allowable base year cost per program admission for the period January 1, 1982, through June 30, 1983.

1. Each hospital participating in medical assistance will submit its medicare/medicaid cost report for the base year. Final allowable base year costs will be calculated from the audited medicare/medicaid cost report.

2. Allowable base year costs per program admission will be computed as follows, using data from the Health Care Financing Administrator (HCFA) Form 2552 Worksheet, 1981 revision:

(1) Total reimbursable M.A. program costs (Worksheet E-5, Part 1, Line 17) _____

(2) Reimbursable malpractice insurance costs (Worksheet E-5, Part 1, Line 5) _____

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

(3) Net reimbursable program cost (Line 1 minus Line 2) _____

(4) Total costs (Worksheet A, Column 3, Line 84) _____

(5) Malpractice insurance costs (Worksheet A, Column 5, Line 71) _____

(6) Net total costs (Line 4 minus Line 5) _____

(7) Overall program utilization (Line 3 divided by Line 6) _____

(8) Total pass-through capital costs (Worksheet A, Column 7, Lines 2 and 3) _____

(9) Calculated program pass-through capital cost (Line 7 times Line 8) _____

(10) Program routine service costs before limitation (Worksheet D-1, Line 57) _____

(11) Program reimbursable routine service costs (Worksheet D-1, Line 61) _____

(12) Program routine service costs subject to limitation (Line 10 minus Line 11) _____

(13) Program adjusted reimbursable costs (Line 3 minus Line 9 plus Line 12) _____

(14) Program admissions for persons not enrolled in medicare Part A _____

(15) Program adjusted reimbursable costs per admission (Line 13 divided by Line 14) _____

(16) Eight percent cap applied _____

(17) Allowable base year cost per admission (Line 15 times Line 16) _____

D. Determination of rate per admission.

1. Reports for each fiscal year. Each hospital shall submit a report to the department containing pass-through costs and admission data. The report will include actual data for the prior year, and budgeted data for the current and budget years as specified in 12 MCAR § 2.05401 [Temporary] E.1.d.

2. Application of eight percent cap. The department will annually multiply the eight percent cap times the base year rate per admission. Subsequent to the initial year, adjusted base year per admission is used in place of base year rate per admission.

3. Calculation of rate per admission. The rate per admission for the budget year will be calculated as follows: allowable base year costs per program admission multiplied by budget year eight percent cap, plus budget year pass-through costs per program admission. Subsequent to the initial year, adjusted base year costs are used in the above formula instead of allowable base year costs.

4. Payment procedures shall be as specified in 12 MCAR § 2.05401 [Temporary] F.

5. Appeals shall be pursuant to 12 MCAR § 2.05401 [Temporary] H.

6. General assistance medical care costs shall be reimbursed as specified in 12 MCAR § 2.05402 [Temporary].

E. Four percent reduction. Payment to medical assistance providers is reduced four percent for services provided January 1, 1983, through June 30, 1983, as provided in Laws of Minnesota 1983, Third special session, chapter 8, article II, subdivision 4(a)(4). The following procedure will be used to implement this four percent reduction:

1. Cost report. Each hospital must submit a special cost report covering the period January 1, 1983, through June 30, 1983.

2. Application of four percent reduction. The rate per admission for each hospital, as determined pursuant to 12 MCAR § 2.05403 [Temporary] C.2., shall be reduced by four percent for each admission during the period from January 1, 1983, through June 30, 1983.

Department of Public Welfare
Bureau of Social Services

Proposed Temporary Rule Governing Child Day Care Sliding Fees (12 MCAR § 2.164 Temporary)

Notice of Intent to Adopt Temporary Rule

The State Department of Public Welfare proposes to adopt the above-entitled temporary rule to implement *Laws of Minnesota 1983*, chapter 312, article 2.

Persons interested in this rule have until August 22, 1983 to submit written comments. The proposed temporary rule may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Jerry Ferguson
Social Services Bureau
Department of Public Welfare
4th Floor, Centennial Building
St. Paul, MN 55155
(612) 297-3635

Upon adoption of this temporary rule, this notice, all written comments received, and the adopted temporary rule will be delivered to the Attorney General and to the Revisor of Statutes for review as to form and legality.

The adopted temporary rule will not become effective without the Attorney General's approval and the Revisor of Statute's certification of the rule's form.

As required by the Administrative Procedures Act, Minnesota Statutes, chapter 14, this temporary rule shall be in effect for up to 180 days following its adoption and may be continued in effect for an additional 180 days if the Commissioner gives notice of continuation by publishing notice in the *State Register* and mailing the same notice to all persons registered with the Commissioner to receive notice of rulemaking proceedings. The temporary rule shall not be effective 360 days after its effective date without following the procedures in Minnesota Statutes, sections 14.13 to 14.20.

Under Minnesota Statutes, sections 245.83-245.87, as amended, 12 MCAR § 2.164 (Temporary) governs the administration of the Child Day Care Sliding Fee Program for reducing, according to a sliding fee, the cost of child care for eligible families. To be eligible for this program, a family's income must be between the income level established for eligibility for the Aid to Families with Dependent Children Program to 90 percent of the state median income. This temporary rule contains provisions on the allocation appropriations of child day care monies to local social service agencies and on family eligibility for funding assistance.

This temporary rule will not result in any additional state spending beyond the amount of funds appropriated under *Laws of Minnesota 1983*, chapter 312 or additional county spending beyond the amount currently required by Minnesota Statutes, section 245.84, subdivision 2.

Copies of this notice and the proposed temporary rules may be obtained by contacting Jerry Ferguson at (612) 297-3635.

Leonard W. Levine,
Commissioner of Public Welfare

Temporary Rule as Proposed (all new material)

12 MCAR § 2.164 [Temporary] Child day care sliding fee program.

A. Introduction. Under Minnesota Statutes, sections 245.83 to 245.87, this rule governs the administration of the child day care sliding fee program for reducing, according to a sliding fee schedule, the cost of child care for eligible families.

B. County allocation.

1. The recipient of a child day care sliding fee program allocation shall be a county or a group of counties. The county may designate any public or nonpublic agency to administer the program.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of Proposed Temporary Rules Governing Reimbursement Methodology for Hospital Inpatient Care Provided Under the Medical Assistance and General Assistance Medicare Care Programs (12 MCAR §§ 2.05401 - 2.05403 Temporary)

FINDINGS OF FACT AND CONCLUSIONS

Notice of the Commissioner's intent to adopt the above-entitled temporary rules and the proposed rules were published in the State Register on August 1, 1983, and were sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes section 14.14, subdivision 1 on July 26, 1983. After affording interested and affected persons an opportunity to submit comments for 20 days after publication, reviewing and considering the comments, and having determined that the above-captioned rule is needed and reasonable, I find the following:

1. Because of typographical errors, it is necessary on page 1, line 9 to delete "medicare" and replace it with "medical" and insert the word "assistance" between general and medical.

2. On page 2, line 30 the words "July 1, 1983" must be deleted and replace with the following phrase:

   "the first day of the hospital's first fiscal year beginning on or after July 1, 1983"

The Commissioner finds the change to be necessary in order to comply with Laws of Minnesota 1983, Chapter 312, Article 5, Section 9. That section states that rates paid to hospitals will become effective on the rate year which is the hospitals fiscal year.

3. In a number of areas under 12 MCAR §§ 2.05401 (Temporary) it indicates that in the calculation of the rate per admission for the initial year, the allowable base year costs per program admission are to be used. The allowable base year costs relate to the hospital's fiscal year ending during calendar year 1981. Because 12 MCAR §§ 2.0501 (Temporary) is applicable to the rates beginning in 1983, adjusted base year costs must be used. Therefore, the Commissioner finds it necessary to make the following corrections:

   a. Delete on page 4, lines 10,11 and 12 "the allowable base year costs per program admission, or, subsequent to the initial year".

   b. On page 7, line 11 the word "Allowable" should be deleted and "Adjusted" used in its place.

   c. On page 7, lines 15 and 16 should be deleted: "Subsequent to the initial year, adjusted base year costs is used in the above formula instead of allowable base year costs"

4. Page 4, lines 18 and 19 should be changed to delete "period beginning July 1, 1983 thourgh July 30, 1987" with "for hospital fiscal years beginning on or after July 1, 1983." The Commissioner finds this adjustment necessary for the same reasons as in comment #2. Also, the "July 30, 1987" date on line 14 was a typographical error.

5. Page 5, Line 19 is amended due to a typographical error to read: (Line 3 minus Line 9 plus Line 12). This amendment is consistent with the formula stated under 12 MCAR §§2.05403 (Temporary) C.2. on page 15, Line 15. A comment from Mr. Feinwachs was received concerning this error.

6. A comment was received from Kenneth Peterson, controller of Hennepin County Medical Center relative to the inconsistency of how pass-through capital costs are determined under 12 MCAR §§2.05401 (Temporary) E.1. on page 6 and how they are determined under 12 MCAR §§ 2.05401 (Temporary) B.3.b. in the calculation of allowable base year costs. Under 12 MCAR §§2.05401 (Temporary) B.3.b. on page 2, pass-through capital costs are determined based on the ratio of program costs to total reimburseable costs. Under 12 MCAR §§2.05401 (Temporary) E.1. the pass-thorugh capital costs are calculated based on the hospital's admissions. However, this method would not be appropriate for hospitals with attached nursing home facilities. Because of the extremely long length of stay for nursing home residents, a skewing of the costs per admission could occur. The Commissioner finds that it is necessary to comply with this request for consistency and equity reasons. Therefore, the following amendments are made under 12 MCAR §§2.05401 (Temporary) E.1. on page 6 as follows:

   a. Delete "Admissions" on line 40 and replace with "Overall Program Utilization"

   b. On lines 41 and 42 delete "PASS THROUGH COSTS PER ADMISSIONS" and replace with "PROGRAM PASS-THORUGH COSTS"

   c. On line 43 insert "Program Admissions"

   d. On line 44 delete "Patient days" and replace on lines 44 and 45 with "PASS-THROUGH COSTS PER ADMISSION"

   e. On line 45 delete "PASS-THROUGH COSTS"

   f. On line 46 insert "Patient Days"

   g. Delete on line 1 "Patient days" and on lines 2 and 3 "PASS-THROUGH COSTS PER PATIENT DAY"

   h. On lines 1 and 2 insert "PASS-THROUGH COSTS PER PATIENT DAY"

Also for consistency purposes, this change would require that page 7, lines 23 and 24 be adjusted to delete: "and total admissions" and change "values" on line 23 to "value".

7. A comment was received from Mr. Feinwachs regarding 12 MCAR §§2.05401, (Temporary) E.3. This provision requires the Commissioner to recalculate rates after the end of each budget year based on the actual value for program admissions upon request.

Mr. Feinwachs requests that page 7, line 22 should be changed to insert after request "of the provider". This clarifies the provision to allow only for the provider to request such a recalculation and removes any potential ambiguity concerning the ability of the general public to make such a request. The Commissioner finds this request reasonable and necessary and within the intent of the rule.

8. On page 9, line 37 under 12 MCAR §§ 2. 05401 (Temporary) G.3. and the word "medicaid" should be deleted and replaced with: "M.A. and/or G.A.M.C." The Commissioner finds this necessary to be consistent with page 9, line 37 under the same section so that it is clear that both programs can be counted in the calculation of the disproportionate population percentage.

All comments concerning the proposed temporary rules received within the period allowed by law were considered by the Department.

The changes made to the proposed temporary rule are not substantial changes.

CONCLUSIONS

I hereby conclude that:

1. The Commissioner has statutory authority to promulgate these rules.
2. Proper notice of the Department's intent to adopt the proposed captioned temporary rules was given as required by law, and all interested persons were afforded an opportunity to submit data and views on the proposed temporary rules.
3. All modifications made to the proposed temporary rule are either supported by the data and views submitted to the Department, necessary to correct errors, or to achieve internal consistency, and are not substantial changes.
4. The temporary rules, as modified are necessary and reasonable.
5. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning and effect.
6. The Department has complied with all applicable provisions of law and rule in the promulgation of these rules.
7. If any finding or part of a finding, above, is properly characterized as a conclusion, it is adopted as a conclusion.

9-19-83
Date

STATE OF MINNESOTA

LEONARD W. LEVINE
Commissioner of Public Welfare

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF PROPOSED TEMPORARY RULES GOVERNING REIMBURSEMENT METHODOLOGY FOR HOSPITAL IMPATIENT CARE PROVIDED UNDER THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS (12 MCAR §§2.05401 - 2.05403 TEMPORARY)

STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General John Burman, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedure Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Special Assistant Attorney General

Dated: February 23, 1983