

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

RULE REVIEW CHECKLIST

File No. 1348 Docket No. 05.0009.0866

DATE RECEIVED 2/13/87
REVIEW DATE 2/22/87
DUE DATE 2/27/87

APPROVED 2/23/87
DISAPPROVED
WITHDRAWN

ADOPTED W/O HEARING ✓
EMERGENCY RULE

REVISOR APPROVED
REVISOR DISAPPROVED
FILED W/SEC. STATE
RETURNED TO AGENCY

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion
2/17/86 Date published in State Register
Comments

~~Petition for Adoption of~~ a Rule

~~Board's Authorizing Resolution~~

✓ Proposed rule
Yes Revisor's Certificate

✓ Notice of Intent to Adopt Rule
256.969 + Laws of MN, 1986 chapter 420 s. 6. Statutory Authority
no Small business statement
Yes Expenditure of public money statement
Yes Signature

✓ Statement of Need and Reasonableness

✓ Affidavit of Mailing Notice of Intent to Adopt Rule
11/25/86 Date (30)/25 days before adoption

✓ Publication in State Register
12/1/86 Date (30)/25 days before adoption

~~Resolution Adopting~~

✓ Findings of Fact, Conclusions & Order Adopting
2/13/87 Date

✓ Written requests, submissions or comments

✓ Declaration of attorney
Gail Olson Name of SAAG representing agency

✓ Certificate ~~Notice of Submission to Attorney General~~

~~Affidavit of Mailing Notice to Attorney General~~

SF-00006-03

STATE OF MINNESOTA

DEPARTMENT

Office Memorandum

ATTORNEY GENERAL

TO:

DATE:

MIKE DEAN
Department of Human Services
444 Lafayette Road

2/24/87

FROM:

PHONE:

J. MICHAEL MILES
Assistant Attorney General

6-6555

SUBJECT:

In the Matter of the Proposed Adoption of Rules of the Department of Human Services Governing Hospital Medical Assistance and General Assistance Medical Care Reimbursement, parts 9500.1090 to 9500.1155.

The above-referenced rule has been approved as to its legality by the Attorney General on February 23, 1987.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

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

JMM:nah

Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Adminsitrative Rules

Duane Harves
Chief Administrative Law Judge
Office of Administrative Hearings

Department of Human Services

Adopted Rules Relating to Hospital Medical Assistance and General Assistance Medical Care Reimbursement

Rules as Adopted

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for ~~the hospitals that participate in and are reimbursed by~~ inpatient hospital services provided under medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 5, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

9500.1100 DEFINITIONS.

Subpart 1. to 3. [Unchanged.]

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy

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families with dependent children.

Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission that is adjusted for case mix, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. [Unchanged.]

Subp. 7. **Appeals board.** "Appeals board" means the board that advises the commissioner on a hospital's request for adjustments to reimbursements made under the prospective reimbursement system.

Subp. 8. [Unchanged.]

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. to 11. [Unchanged.]

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the [(adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (DRGs) under medicare with adjustments as follows:

Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A. to JJ. [Unchanged.]	

Subp. 21. [Unchanged.]

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards

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of practice accepted by the medical community.

Subp. 22. to 24. [Unchanged.]

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. to 29. [Unchanged.]

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. [Unchanged.]

Subp. 32. **Medicare crossover claims.** "Medicare crossover claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for medicare eligible inpatient hospital services provided to a recipient who is also eligible for medicare.

Subp. 33. [Unchanged.]

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. to 38. [Unchanged.]

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to 9505.5030 and 9505.5105.

Subp. 40. [Unchanged.]

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per

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admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission that occurs within seven days of a discharge of the same recipient.

Subp. 43. [Unchanged.]

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. [Unchanged.]

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all the diagnostic categories on a statewide basis.

Subp. 46. [Unchanged.]

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. [Unchanged.]

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing

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Administration (HCFA) Form 2552, 1981 revision, Worksheet A, column 7, line 84. The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. [Unchanged.]

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. to C. [Unchanged.]

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio from the base year medicare/medical assistance cost report, using data from

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HCFA Form 2552, 1981 revision, Worksheet C,

(3) and (4) [Unchanged.]

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using a version of the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all ~~computations~~ determinations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. and G. [Unchanged.]

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's ~~diagnostic-category-day-outlier~~ trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the ~~diagnostic category-day-outlier~~ trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital costs for all admissions less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions including outliers;

K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic

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category less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category including outliers; and

L. determine the relative value for each diagnostic category by dividing item K by item J.

Subp. 2. and 3. [Unchanged.]

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. [Unchanged.]

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital including outliers;

D. adjust item C for case mix as follows:

(1) [Unchanged.]

(2) multiply the hospital's number of base year admissions within each diagnostic category including outliers by the relative value of that diagnostic category,

(3) [Unchanged.]

(4) divide the sum from subitem (3) by the number of base year admissions including outliers, and

(5) [Unchanged.]

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's

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budget year, the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total ~~Medical Assistance non-AFDC~~ general assistance admissions. A pass-through cost report for a hospital budget year that begins on or after July 1, 1987, must separate medical assistance admissions data into AFDC or non-AFDC admissions data. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days before the start of each hospital's budget year and must include the following information:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
(1)	Depreciation	_____	_____	_____
(2)	Rents and leases	_____	_____	_____
(3)	Property taxes	_____	_____	_____
(4)	Property insurance	_____	_____	_____
(5)	Interest	_____	_____	_____
(6)	Malpractice insurance	_____	_____	_____
(7)	Total Pass-Through Costs (Subitems (1) to (7))	_____	_____	_____
B.	Total charges billed to all payers for inpatient hospital services	_____	_____	_____
C.	Total admissions for all payers	_____	_____	_____
D.	Total days of inpatient hospital services for all payers	_____	_____	_____
E.	Total MA AFDC admissions	_____	_____	_____
F.	Total MA non-AFDC admissions	_____	_____	_____
G.	Total GAMC admissions	_____	_____	_____

Pass-through costs are limited to item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to ~~medicare~~ medical assistance. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department

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within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/~~medicaid~~ medical assistance cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. **Determination of budget year pass-through cost per admission.** The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A. Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs	_____	_____	_____
B. Pass-through costs as specified in subpart 1, item A, subitem (7), multiplied by item A	_____	_____	_____
C. Number of Medical Assistance admissions including outliers	_____	_____	_____
D. Pass-through cost per admission (item B divided by item C)	_____	_____	_____

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category), plus the budget year pass-through cost per admission]

Subp. 4. **Pass-through cost adjustment.** After the end of each budget year, the commissioner shall redetermine the budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

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A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This ~~computation~~ determination produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as ~~computed~~ determined in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. ~~Compute~~ Determine the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs ~~computed~~ determined in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted ~~per-admission~~ pass-through cost per-admission used in paying claims for inpatient hospital services during the year for which

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the adjustment is being calculated. ~~This computation produces the actual value of the pass through cost payments made during the year.~~

G. Subtract the ~~actual value of the medical assistance pass through cost payments during the completed year (computed~~ amount determined at item F~~)~~ from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be ~~payed~~ paid by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the ~~61st~~ 66th day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [See Repealer.]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

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Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. [Unchanged.]

Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.** The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. **Adjustment to reimbursement.** Reimbursements shall be adjusted by the department for the reasons specified in

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subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be by debit.

Subp. 5. [Unchanged.]

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	Medicare deductibles, plus Medicare coinsurance less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[{(The product of the adjusted base year cost per admission ~~multiplied by~~ and the budget year HCI ~~and~~ multiplied by the relative value of the appropriate diagnostic category, divided by the arithmetic mean length of stay of the diagnostic category) and multiplied by the number of days of inpatient hospital services}, plus the budget year pass-through cost per admission]

In no case of a transfer may a hospital receive a reimbursement that exceeds the applicable categorical rate per admission, or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for

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outlier reimbursements under subpart 9.

A hospital that admits a ~~transferred~~ transfer recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to ~~the other~~ another hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if eligible. The combined stay of the admission and readmission shall be used to determine ~~qualification~~ eligibility for outlier ~~payment~~ reimbursement. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer

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reimbursement; or rate per admission. An admission and subsequent readmission to a different hospital shall be reimbursed as specified under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the arithmetic mean length of stay for the diagnostic category;

(3) [Unchanged.]

(4) subtract the day outlier trim point for the appropriate diagnostic category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) [Unchanged.]

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year

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cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) [Unchanged.]

(3) subtract the cost at three standard deviations for diagnostic category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item ~~G~~ H from the adjusted cost from subitem (2); and

(4) multiply the ~~amount~~ difference determined in subitem (3) by 60 percent for diagnostic category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse an out-of-area ~~hospitals~~ hospital for an admission based on the lesser of billed charges for the admission or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each hospital statewide by that hospital's HCI and by the number of admissions in that hospital's base year, including outliers;

B. sum the products in item A;

C. divide the sum from item B by the sum of all admissions for all hospitals statewide, including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base

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year, including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission	=	[(statewide budget year adjusted base year cost per admission multiplied by the relative value of the appropriate diagnostic category), plus statewide budget year pass-through cost per admission]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

A. Multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of the admissions for all MSA hospitals statewide, including outliers, to determine the statewide allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission must be determined according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per Admission for MSA Hospitals Statewide	=	[(adjusted base year cost per admission for MSA hospitals statewide multiplied by the budget year HCI and

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That Do Not Have Admissions In The Base Year	multiplied by the relative value of the appropriate diagnostic category) plus budget year pass-through cost per admission]

F. [Unchanged.]

Subp. 12. [Unchanged.]

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Determination of disproportionate population adjustment.** The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions ~~according to the schedule below~~.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are MA and GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate

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population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. [Unchanged.]

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

Subpart 1. to 4. [Unchanged.]

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. to 5. [Unchanged.]

Subp. 5a. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of

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that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. [Unchanged.]

REPEALER. Minnesota Rules, part 9500.1125, subpart 5 is repealed.

Approved by Revisor _____

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
FEB 24 1987
Joan Anderson Growe
Secretary of State
3:15 PM

APPROVED AS TO FORM AND LEGALITY

2/23 1987

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY _____
ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to the Rule of the State Department of Human Services Governing Inpatient Hospital Reimbursement, Minnesota Rules, parts 9500.1090 to 9500.1155.

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE WITHOUT A PUBLIC HEARING.

Notice of the Commissioner's intent to adopt the above-entitled rule was published in the State Register on Monday, December 1, 1986 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22, on Tuesday, November 25, 1986. The statement of need and reasonableness was prepared before the notice of intent to adopt a rule without a public hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

All persons were given the opportunity to submit comment on the rule for 30 days after notice of proposed rulemaking. The department did not consider comments received after the 30 days following notice of proposed rulemaking. No requests for a public hearing on the rule were received by the agency. Therefore a public hearing was not held. No requests for notice of submission to the attorney general were received by the agency.

Based on the comments and evidence in the record before the agency, I find the following:

I. CHANGES IN RESPONSE TO COMMENTS. The commissioner accepts suggestions from commentators to make the changes discussed below. These changes are for clarification purposes only and are not substantial.

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL

Subpart 1, Pass-through cost reports, (page 7 of adopted rule).

Commentators: University Hospitals and Clinics (UHC); Minnesota Hospital Association (MHA);

The commentators suggested that new rule language be inserted to clarify when hospitals must begin to submit admissions data that is "broken down" into AFDC admissions and non-AFDC admissions. They said that hospitals have not been gathering admissions data that is broken into the two categories and that hospitals would need advance notice to do so. The department agrees with the comments and proposes the following changes on page 7, lines 32 and 33 to address the issue:

. . . payers, total Medical Assistance ~~AFDC~~ admissions, ~~and total Medical Assistance non-AFDC admissions~~ and total general

assistance admissions. A pass-through cost report for a hospital budget year that begins on or after July 1, 1987 must separate Medical Assistance admissions data into AFDC or non-AFDC admissions data.

Additionally, the department makes the following changes under subpart 1 to correct an inadvertent misuse of similar terms:

Page 8, line 36, replace "medicare" with "medical assistance"; line 40, replace "medicaid" with "medical assistance".

Subpart 4, Pass-through cost adjustment, item D (page 10 of the adopted rule).

Commentator: MHA; UHC;

MHA commented that, and UHC agreed that, "the determination of allowable medical malpractice insurance cost will be understated using the section quoted in the rule" and that it "is difficult to identify the specific sections within the worksheet" that must be used. To clarify which section must be used MHA suggested the following addition to item D:

D. Determine the allowable medical assistance share of malpractice insurance cost, using the current method identified in HCFA Form 2552, worksheet D-8; . . .

The idea that "malpractice insurance cost will be understated " as expressed by the commentators, means that currently HCFA form 2552, worksheet D-8 excludes some malpractice insurance costs that the hospital industry feels should be included. The hospital industry has brought a lawsuit against Medicare to require Medicare to include more malpractice insurance costs in HCFA form 2552, worksheet D-8. The commentators have suggested the above amendment to provide the flexibility needed to "determine the allowable medical assistance share of malpractice insurance cost" as required by item D above, if the method identified in HCFA Form 2552, worksheet D-8 changes as a result of the lawsuit.

The department agrees that the language "the current method identified in" suggested by the commentators helps identify the specific sections within the worksheet that must be used and that it provides the flexibility in item D that will be needed in case the requirements of HCFA form 2552, worksheet D-8 change. The department will incorporate the suggested language into the rule.

Additionally, the department makes the following non-substantial changes:

Delete the last sentence under item F that begins on line 22 and ends on line 24, page 10. This change clarifies the item by removing unnecessary language that might be confusing to a reader of the rule.

Under item H, (page 11, line 7), change "61st" to "66th". This change is necessary to allow enough days for mailing.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 4. Adjustment to reimbursement, (page 12 of adopted rule).

Parts 9505.1910 to 9505.2020 specify when reimbursements shall be adjusted because of inappropriate utilization. However, it is possible that other regulations or statutes may affect this adjustment. Therefore, it is necessary and reasonable to revise this subpart to allow for this possibility. Thus, the following insertion (underlined) clarifies that other laws also apply to this subpart:

> Subp. 4. Adjustment to reimbursement. Reimbursements shall be adjusted by the department for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be by debit.

Subpart 6, Medicare crossover claims, (page 12 of adopted rule)

Commentators: MHA and Ramsey

The commentators requested that language deleted in the rule as proposed be inserted back into the rule as follows:

Medicare crossover reimbursement	=	Medicare deductibles plus Medicare coinsurance plus amounts for services covered by medical assistance but not by Medicare less recipient resources and amounts owed by third parties.

The department does not agree that the above (underlined) language should be inserted back into the rule because the purpose of medical assistance is to be a coinsurer for covered individuals. It is the department's intent to pay the difference between Medicare's payment and the amount a hospital would have received if Medicare paid in full. Medicare reimbursement for treatment of an illness episode under a diagnostic-related-group is considered complete payment for that illness episode. The department must ensure that medical assistance reimbursements do not exceed Medicare upper payment limits under the Code of Federal Regulations, title 42, section 447.271.

A hospital could receive reimbursement for a Medicare/Medical Assistance recipient's inpatient hospital stay not covered by Medicare by billing Medical Assistance directly provided all required second surgical opinions, admission certification, and prior authorizations were obtained.

The department believes that the commentator's concerns should be addressed with a technical amendment to part 9500.1100, subpart 32 (page 3 of the adopted rule). Therefore the commissioner proposes the

following amendment:

Subp. 32. Medicare crossover claims. "Medicare crossover claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for medicare eligible inpatient hospital services provided to a recipient who is also eligible for medicare.

II. GRAMMATICAL AND TECHNICAL CHANGES SUGGESTED BY THE DEPARTMENT. The commissioner finds that a number of changes are needed to correct grammatical and technical problems. These changes are for clarification purposes only and are not substantial. The changes are as follows:

9500.1090 PURPOSE AND SCOPE (page 1, lines 8 to 10)

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for inpatient hospital services ~~the hospitals that participate in and are~~ provided under ~~reimbursed by~~ medical assistance.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1, Determination of relative values, item E, (page 5, line 31) insert "a version of" between "using" and "the", (page 6, line 2), replace "computations" with "determinations"; Item I (page 6, line 10), delete "diagnostic category day outlier", (lines 17 and 18), delete "diagnostic category day outlier".

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 3,Categorical rate per admission, (page 9, line 26), insert "the" between "by" and "budget"; (page 9, line 29), insert "the" between "plus" and "budget".

Subpart 4, Pass-through cost adjustment, Item A (page 9, line 40), item B (page 9, lines 44 and 47), item C (page 10, lines 1 and 7), item E (line 15), replace "compute" with "determine" and replace "computation" with "determination";

Item F (page 10, line 20), change "per-admission pass-through cost" to "pass-through cost per-admission"; .

Item G, (page 10, lines 25, 26, and 27), change as follows:

G. Subtract the amount ~~actual value of the medical assistance pass-through cost payments during the completed year (computed~~ determined at item F~~)~~ from the medical assistance share of allowable pass-through costs for the completed year.

Item G, (page 10, line 33), change "payed" to "paid".

9500.1130 REIMBURSEMENT PROCEDURES

Subpart 7, Reimbursement for transfers, Item A, (page 12, line 37), replace "mulitiplied by" with "and"; (page 12, line 38), delete "and" - the changes on lines 37 and 38 clarify that in the right side of the equation the term "product" on line 35 refers to the multiplication of the adjusted base year cost per admission by the budget year HCI. Page 13, line 4, insert "the" between "plus" and "budget"; (page 13, line 19) change "transferred" to "transfer".

Item B, subitem 2, (page 13, line 36), replace "the other" with "another".

Subpart 8, Reimbursement for readmissions, (page 14, line 7), replace "qualification" with "eligibility" and "payment" with "reimbursement"; (page 14, lines 12 and 22), insert ", out of area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission" between "admission" and the ".". The changes under this subpart are reasonable because they are consistent with the way the department has been administrating the rule and with how the department and the industry have been interpreting the rule since the effective date of the rule in August of 1985.

Subpart 9, Reimbursement for outliers, Item B, subitem (3), (page 15, line 17), change "G" to "H"; Item B, subitem (4) (page 15, line 19), replace "amount" with "difference".

Subpart 10, Reimbursement to an out-of-area hospital, (page 15, lines 25 to 27), change lines 25 to 27 to read as follows: "The department shall reimburse an out-of-area hospitals for an admission based on the lesser of billed charges for the admission or either the out-of-area hospital . . ."

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT

Subpart 1, Determination of disproportionate population adjustment, (page 17, line 25), delete "according to the schedule below".

III. ADDITIONAL COMMENTS ADDRESSED. The commissioner does not accept the suggestions from commentators to make the changes discussed below.

9500.1100 DEFINITIONS

Subpart 21a, Foreseeable complication, (page 2 of adopted rule)

Commentators: Minnesota Hospital Association (MHA); St. Paul-Ramsey Medical Center (Ramsey); University Hospitals and Clinics (UHC).

University Hospitals and Clinics commented that "Given that one of the goals of the Medicare program over the years has been to cut down the numbers of days of stay, it appears that this definition is

somewhat in conflict if one were to take too liberal of an approach to the terminology 'foreseeable complication'." As indicated in their comments, UHC did not see this as a controversial issue for the rule. Ramsey and MHA, however, suggested that the term "reasonably" be inserted in the definition to clarify the definition of "foreseeable complication" as follows:

> Subp. 21a. Foreseeable complication. "Foreseeable complication" means a complication that can be reasonably predicted from a recipient's medical history and by a physician using standards of practice accepted by the medical community.

The department believes that the definition of "foreseeable complication" is clear as written and that changing the definition is unnecessary. The department therefore does not accept the suggestion to insert the term "reasonably" because the term would give the department too much discretion in deciding which complications are "foreseeable", and because the term is unnecessarily redundant of the phrase "using standards of practice accepted by the medical community." Also, if a hospital disagrees that a complication should be deemed "foreseeable", it can appeal the decision under part 9500.1140.

Subp. 42. Readmission. (page 3 of adopted rule).

Commentator: Ramsey

Ramsey commented that the proposed amendments to the definition of readmission do not differentiate between readmissions to the same facility and a different facility. It seems that Ramsey believes it would not be reimbursed at all if Ramsey did not know that a person was being readmitted (because the person did not tell Ramsey that he or she had been in another hospital within the past seven days) instead of being admitted.

The department does not agree with Ramsey's comments because proposed amendments to part 9500.1130, subpart 8 provide for adequate reimbursement in situations such as those discussed by Ramsey. Under subpart 8, a hospital that admits a person less than seven days after the person was treated at another hospital is reimbursed for that person's care as if the person was transferred to the second hospital. A hospital that admits a person for a condition unrelated to a previous admission to a different hospital is reimbursed with a separate categorical rate (even if the admissions are within seven days of each other).

Commentators: MHA and UHC

MHA and UHC questioned the department's ability to monitor all readmissions within 7 days. UHC questioned whether additional examination is needed and if funds are available for such review.

The department does not agree with the comments. Records maintained by the department show that there is a significant number of readmissions. The additional clarifying language contained in amendments to part 9500.1130, subparts 7 and 8 will help the

department review these cases. Since the original language prohibited payment for readmissions for the same or related diagnostic category, each readmission had to be reviewed to determine if the category was related. The additional language will streamline these procedures and decrease review costs.

Subp. 45. Relative value.

Commentators: MHA; Ramsey; and UHC.

All the commentators on subpart 45 suggested the following revision to subpart 45:

> Subp. 45. Relative value. Relative value means . . . in each diagnostic category ~~in relation to~~ divided by the arithmetic mean. . . .

The department does not accept the above suggestion to change the definition of "relative value" because the definition as written is clear, the phrase "in relation to" adequately describes the statistics used to determine a relative value.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1, Determination of Relative Values, item E, (page 5 of adopted rule).

Commentators: MHA, UHC

MHA and UHC commented on the rule language describing the computer software used to determine with ICD - 9CM coding, the diagnostic related group of an admission (commonly known as the "GROUPER" software). In their comments MHA and UHC asked the department to use the same GROUPER in use by Medicare and update the department's rate system with each Medicare revision of the GROUPER. To accomplish this the hospitals suggested the phrase "provided that" be deleted from page 5, line 35 of the adopted rule.

The department does not accept deletion of "provided that". The department does not intend to use the same DRG grouper in use by Medicare. To incorporate each change in the DRG grouper, the department would have to buy the new GROUPER computer software and redetermine all base rates, case mix indexes, and relative values. The department does not have enough resources to do the redeterminations or to keep pace with the changes in Medicare's DRG grouper. The department also does not agree that all Medicare changes are appropriate for Minnesota's Medical Assistance program. The department has purchased the the newest version of the DRG grouper in use by Medicare, version 4, and will use version 4 for future adjudication of claims. The department will be consistent with Medicare until Medicare issues a new version of the GROUPER.

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1, Pass-through cost reports, (page 7 of the adopted rule).

Commentator: Ramsey.

Ramsey requested in its comments that the department not require current year and budget year data on the pass-through cost reports. Ramsey believes that such data are "purely conjectural" and that the data "would not exist for a current year or a budget year" .

The department does not agree with Ramsey's comment on subpart 1. Hospitals have been submitting pass-through cost data for the current and budget years since August of 1985 when the rule was first effective. The amendment only requires the submission of additional data on charges, admissions, and days of inpatient hospital stays. During the review and formulation of the proposed rules hospitals asked the department to base pass-through payments on budgeted program admissions instead of base-year admissions which is the current practice. Current year and and budget year data are needed to base pass-through payments on budgeted program admissions. Further, it is reasonable to request the data because hospitals prepare the same or similar data for their own use, for the Health Information Resources of Minnesota, and for the state of Minnesota Department of Health.

Subpart 6, Effective date, (page 11 of adopted rule).

Commentators: Ramsey and MHA

The commentators requested clarification of the effective date of the inclusion of the outlier claims into the computation of base rates and relative values.

The department believes the effective dates are clear as written. The effective dates in the rule and the effective dates in Minnesota Statutes, section 256.969, and Laws of Minnesota 1986, chapter 320, section 6 sufficiently describe the effective dates of each rule part.

9500.1130, REIMBURSEMENT PROCEDURES

Subpart 7, Reimbursement for transfers, (page 13, line 28 of adopted rule)

Commentators: MHA and Ramsey

Commentators suggested that "reasonably" be inserted in front "foreseeable complication".

The department's response to the comments made under this subpart is equivalent to its response to comments under 9500.1100, subpart 21a.

Subpart 8, Reimbursement for readmissions, (page 13, of adopted rule)

Commentator: Ramsey

Ramsey requested specific language regarding reimbursement for readmissions for situations in which a recipient leaves the hospital

against medical advice or when the recipient leaves the facility so that the physician can postpone or reevaluate the patient's condition.

The department does not believe the additional language is necessary. It is not the department's intent to penalize a hospital when a recipient leaves against medical advice. However, the department believes the language of this subpart does not preclude payment for the second admission. To the extent that the hospital could not treat the recipient during intial admission due to the recipient's absence, the second admission will be reimbursed at a separate categorical rate.

The department does not intend to dictate physician practice patterns. The department believes that while in many cases it is appropriate for a physician to release a recipient to study the recipient's condition, it is inappropriate to provide two categorical payments when all the necessary care could have been provided during the first admission. Further, if such allowances were provided it would be impossible for the department to differentiate between valid situations and cases where an attempt is being made to obtain more reimbursement than is appropriate.

Commentator: UHC

UHC commented that they are concerned that "considerable amounts of language have been added to broaden the definition under which readmissions would be examined.".

The department's response to UHC's comments on readmissions under this subpart is the same as was given to the UHC comments on readmissions under part 9500.1100, subpart 42.

Subpart 10, Reimbursement to an out-of-area-hospital, (page 15 of the adopted rule).

Commentator: UHC

UHC suggested that the department consider how Minnesota's method of reimbursement for out-of-state hospitals impacts on how Medicaid programs of other states reimburse Minnesota hospitals for care provided to Minnesota recipients by those states.

The department acknowledges the comment and notes that staff has been concerned about this issue. The issue merits further discussion and possible future reimbursement rule amendments. The department does not, however, intend to address it in the current amendments because the issue needs more discussion and analysis than can be completed in the time allowed to complete the currently proposed amendments.

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT

Subpart 1, Determination of disproportionate population adjustment, (page page 17 of the adopted rule).

Commentator: Ramsey

Ramsey requested that those recipients who are enrolled in a prepaid health plan be included in the determination of the disproportionate population adjustment.

The department does not agree with this comment because inpatient hospital sevices provided to participants in a prepaid health plan are being reimbursed under a different payment system. Reimbursement provided by this rule should not be used to subsidize other programs.

Commentator: MHA

MHA requested that the department use only claims payment data to redetermine disproportionate population adjustments (DPA).

The deparment will not agree to use only claims payment data to redetermine a DPA because claims payment data does not contain all the data elements needed to determine a DPA. Total admissions for all payers is not contained in our claims payment data and thus it is necessary to use the cost report or pass-through cost report data.

Based on the above findings I hereby conclude that:

1. The commissioner has statutory authority to promulgate parts 9500.1090 to 9500.1155.
2. Proper notice of the Department's intent to adopt the proposed permanent rules was given as required by law, and all interested persons were afforded an opportunity to submit data and views on the proposed rules.
3. All modifications made to the proposed rules are supported by the data and views submitted to the department and are not substantial changes.
4. Parts 9500.1090 to 9500.1155, 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.

NOW, THEREFORE, IT IS ORDERED that the rule identified as amendments to the rule of the State Department of Human Services Governing Inpatient Hospital Reimbursement, Minnesota Rules, parts 9500.1090 to 9500.1155 (as modified) is adopted this 13th day of February, 1987, pursuant to authority vested in me by Minnesota Statutes, section 256.969 and Laws of Minnesota 1986, chapter 320, section 6.

SANDRA GARDEBRING
COMMISSIONER OF HUMAN SERVICES

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO RULES OF THE DEPARTMENT OF HUMAN SERVICES GOVERNING INPATIENT HOSPITAL REIMBURSEMENT UNDER MA AND GAMC, PARTS 9500.1090 TO 9500.1155.

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

Parts 9500.1090 to 9500.1155 became effective in August, 1985. Their implementation has shown the Department of Human Services and managers of some hospitals that some of those parts need to be amended to compensate hospitals more equitably, to clarify rule language, and to correct inadvertent technical and grammatical errors.

To amend parts 9500.1090 to 9500.1155 the department worked closely with a public advisory committee consisting of hospital representatives. A list of the committee members is attached as an appendix. To solicit additional public input on the amendments the department published a notice to solicit outside opinion in the State Register in February, 1986.

The committee and the department developed and suggested statutory changes needed to authorize some of the amendments. Some of the suggested statutory changes were adopted by the legislature in Laws of Minnesota 1986, chapter 420, section 6. Therefore some amendments are needed because they are required by or are consistent with state law, including the principles of the prospective reimbursement system authorized under Minnesota Statutes, section 256.969. Other amendments are needed because they are required by or are consistent with other Minnesota rules or Federal laws and regulations.

9500.1090 PURPOSE AND SCOPE

The amendment changing "all" to "the" is needed and reasonable because it is a technical amendment relating to grammar and does not change the meaning of the rule.

The amendment indicating that rates for reimbursements shall be partitioned into rates for admissions of persons who receive AFDC (MA/AFDC recipients) and rates for all other admissions (MA/non-AFDC recipients) is needed to establish rates that are more equitable. The amendment is reasonable because past department reimbursements show that Medical Assistance reimbursements for MA/AFDC recipients are much lower than Medical Assistance reimbursements for MA/non-AFDC recipients. As a group, MA/AFDC recipients are less costly for a hospital to serve than MA/non-AFDC recipients. Without the amendment, therefore, a hospital that has served a large percentage of the Medical Assistance/AFDC population would receive reimbursements that are disproportionately higher than reimbursements received by a hospital that served a high percentage of MA/non-AFDC recipients.

The amendment is also reasonable because it reduces the incentive of a private hospital to send MA/non-AFDC recipients to public hospitals.

9500.1100 DEFINITIONS

Subp. 4. Admission certification. Rule parts "9505.0500 to 9505.0540" govern admission certification, which is a required procedure to be elgible for medical assistance payment. Therefore, inclusion of this citation is necessary and reasonable to inform persons affected by these rules of compliance requirements.

Revision of parts 9505.5000 to 9505.5020 (Emergency) to 9505.5000 to 9505.5030 is necessary as these rules superceded the emergency rule.

It is necessary and reasonable to insert "9505.5105", which pertains to appeals regarding prior authorization, because it informs persons affected by these rules of their right to appeal and on how to appeal.

Subp. 4a. Aid to families with dependent children or AFDC. AFDC is a new term used in the amendments to identify for whom separate reimbursement rates are determined for in the amendments proposed in part 9500.1090, Purpose and Scope. The definition is necessary to clarify the meaning of AFDC.

The definition is reasonable because it specifies that AFDC is the federally aided program under Title IV-A of the Social Security Act which has specific eligibility and benefit criteria and because it is consistent with the definition used in rules that govern Minnesota's AFDC program, part 9500.2060, subpart 6.

Subp. 5. Allowable base year cost per admission. Including reimbursable inpatient hospital costs in the cost per admission up to their applicable trim points is necessary and reasonable because it is consistent with the Laws of Minnesota 1986, chapter 420, section 6. Changing the term "which" to "that", deleting the terms "which" and "and", and inserting a comma after "case mix" are necessary and reasonable amendments because they correct grammatical errors.

Subp. 7. Appeals board. The amendments in this definition are needed to clarify that the appeals board can advise on adjustments to any reimbursement under the prospective reimbursement system if the hospital requests adjustments. The amendment is reasonable because it is consistent with Minnesota Statutes, section 256.969, subdivision 4. Changing the term "which" to "that" is necessary and reasonable because it corrects a grammatical error.

Subp. 8a. Arithmetic mean length of stay. This definition is needed because it is a new term used in amendments governing transfer reimbursement. The definition is reasonable because it is consistent with the mathematic principles that guide the computation of means.

Subp. 12. Categorical rate per admission. These amendments are necessary to clarify the equation used to determine categorical rates per admission. The amendments are reasonable because they correct grammatical errors and do not change the equation's outcome.

Subp. 20. Diagnostic categories. This amendment is necessary and reasonable because it corrects a grammatical error.

Subp. 21a. Foreseeable complication. "Foreseeable complication" is a new term used in amendments governing transfer reimbursement. A definition is necessary to clarify its meaning. The definition is reasonable because it is consistent with principles of medical care.

Subp. 24a. Health care financing administration (HCFA). This definition is necessary because it is a term used in part 9500.1125. The definition is reasonable because it clearly identifies the office referred to in part 9500.1125.

Subp. 30. Medically necessary. This definition is needed to change a reference to emergency rules that became permanent after the promulgation of parts 9500.1090 to 9500.1155. The amendment is reasonable because the permanent version of the emergency rules is substantially the same as the emergency rules.

Subp. 30a. Medically needy. "Medically needy" is a term used in the proposed amendment of part 9500.1090. A definition is necessary to clarify its meaning in these rules. The definition is reasonable because it is

consistent with the federal regulations which set the conditions for federal financial participation in the medical assistance program.

33a. Minnesota supplemental aid. "Minnesota supplemental aid" is a term used in these amendments. This definition is needed to clarify its meaning in these rules. The definition is consistent with Minnesota Statutes. Its abbreviation, MSA, is not applicable to these rules.

Subp. 39. Prior authorization. It is necessary to delete "9505.5020 [Emergency]" and insert "9505.5030 and 9505.5105" to convert a reference to emergency rules to the permanent version of those emergency rules. The reference to "9505.5105" is needed and reasonable because it informs affected persons of their rights to appeal and on how to appeal decisions about prior authorization under parts 9505.5000 tO 9505.5020.

Subp. 41. Prospective reimbursement system. This amendment is necessary to clarify that the term "prospective reimbursement system" includes all forms of reimbursement available under parts 9500.1090 to 9500.1155. The amendment is reasonable because it is consistent with the meaning the department originally intended for the term, because it corrects a technical error, and because it will not change the way reimbursements amounts are determined for a hospital.

Subp. 42. Readmission. These amendments are necessary to clarify the definition of readmission. The amendments are reasonable because they do not change how the term "readmission" is used to reimburse hospitals.

Subp. 43a. Recipient resources. This definition is needed to clarify the meaning of a term used in the proposed amendments. The term is reasonable because it is an abbreviation used to avoid burdening the rule with unnecessary words.

Subp. 45. Relative value. Amendment of the definition to exclude inpatient hospital costs in excess of applicable trim points in determining relative values is consistent with the requirements of Laws of Minnesota, 1986, chapter 420, section 6.

Subp. 47. This amendment is necessary and reasonable because part 9505.5030 [Emergency] was replaced by rule parts 9505.5035 to 9505.5105.

Subp. 47a. Supplemental security income. "Supplemental security income" is a term used in the rule amendments. A definition is needed to clarify its meaning. The definition is consistent the definition of the term given at Code of Federal Regulations, title 42, section 435.4 (2).

Subp. 49. Total reimbursable costs. The amendments to this subpart are necessary and reasonable because they are consistent with the Revisor of Statute's rules governing incorporations by reference.

Subp. 51. Trim point. "Trim point" is an abbreviation used in the proposed rule amendments. A definition is necessary to clarify its meaning. The definition is reasonable because it is consistent with and provides an efficient way to refer to the requirement of Laws of Minnesota, 1986, chapter 420, section 6, that the computation of relative values and base year costs include identified outlier cases and their weighted costs up to the point that they become outliers.

Subp. 52. Usual and customary. "Usual and customary" is a term used in the proposed rule amendments. A definition is necessary to clarify its meaning. The definition is consistent with the upper payment limits under Code of Federal Regulations, title 42, section 447.271 (a), and with the way the department has historically used the term.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES

Subp. 1. Determination of relative values.

D.(1) and (2). These amendments are needed to clarify the source of data used to determine the cost of routine and acilliary sevices.

Inclusion of the source of data is reasonable because affected persons have the right to know the source. The sources of data chosen are reasonable because they are consistent with the department's practice in implementing these rules following their adoption.

E. This amendment is necessary and reasonable to give the department the authority to use a DRG assignment software that is technically feasible and convenient for the department to use, but which is also consistent with the software in use by Medicare. Therefore the amendment gives the department the choice to continue using the DRG Support Group software, which was in use by Medicare until recently, or to use the same software now in use by Medicare.

H. This amendment is necessary and reasonable because it is consistent with of Laws of Minnesota 1986, chapter 420, section 6.

I. The amendment is necessary to clarify the calculation used to truncate a day outlier and thus establish a uniform method. The methodology of the amendment is consistent with Laws of Minnesota 1986, chapter 420, section 6. Use of 0.8 instead of 0.6 for diagnostic category 0 (neonate care) is needed to reflect the difference between the greater resources used for neonate care and all other types of care.

J. and K. It is necessary to include outlier cases in the determination of base rates and relative values up to the applicable trim points for their diagnostic categories to comply with by Laws of Minnesota 1986, chapter 420, section 6. Inserting the parentheses is needed and reasonable to clarify the calculation.

Amending the letters that designate items I to L under this subpart is necessary and reasonable because two items were added to this subpart.

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

B.(1) These amendments are necessary to ensure consistency with Laws of Minnesota 1986, chapter 420, section 6.

B.(2) These amendments are needed for clarification. Insertion of "inpatient hospital" is reasonable because the term "costs" was used interchangably with the defined term "inpatient hospital costs", therefore the amendment does not change policy or administrative practice. Insertion of the commas is reasonable because they clarify that for the purposes of this subitem, pass-through costs do not include malpractice insurance costs.

C, D(2) and (4). It is necessary and reasonable to include outliers in the determination of base rates and relative values up to the applicable trim points for their diagnostic categories because their inclusion is required by Laws of Minnesota, chapter 420, section 6.

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION.

Subpart 1. Pass-through cost reports. The amendments that require submission of total charges, admissions and days are needed to separate a hospital's pass-through costs that are attributable to welfare business from that hospital's pass-through costs that are attributable to non-welfare business. These amendments are reasonable because a hospital would be inappropriately compensated if costs that are not associated with welfare business were submitted as pass-through costs to be reimbursed by medical assistance funds.

Changing "prior to" to "before" is necessary and reasonable because "before" is a more familiar word and therefore clarifies the rule.

Changing the item designations and adding the subitem designations are needed to indicate that subitems (1) to (7) belong to the category of pass-through costs under item A and is reasonable because it clarifies the subpart.

The requirement to submit HCFA Form 2552 is necessary because the department needs the data on the form to determine reimbursement rates. The requirement was reviewed and accepted by the public advisory committee. The HCFA Form is convenient to submit because the form is already required by Medicare. Therefore, the requirement is reasonable because it permits hospitals to use the same form to report the same information needed by two different agencies and thus minimizes the reporting burden placed on the hospitals.

The requirement to submit the worksheets from HCFA form 2552 is needed and reasonable because the department will need the information on the worksheets to determine categorical rates per admission even if medicare stops requiring the worksheets or the information contained on them.

Subp. 2. Determination of budget year pass-through cost per admission. Inserting "inpatient hospital" is needed to clarify the term "reimbursable cost" and thus be consistent in the use of terms that are defined. The change is reasonable because the term "reimbursable costs" was used synonymously with the defined term "reimbursable inpatient hospital costs".

Changing the references under item B is necessary and reasonable because those changes are consistent with the item designation changes under subpart 1.

Deleting "base year" from item C will enable the collection of current data for use in computing pass-through costs. The hospital industry supported this change and the department has determined that the amendment would allow for more acccurate determinations of pass-through costs.

Subp. 3. Categorical rate per admission. These amendments are technical amendments that clarify the formula. They do not change policy or administrative practice.

Subp. 4. Pass-through cost per admission adjustment. Inserting "for Minnesota hospitals" and "for a Minnesota hospital" is necessary and reasonable because it clarifies that this subpart applies only to hospitals in Minnesota.

The remaining amendments are needed to clarify how the department may separate a hospital's MA pass-through costs and GAMC pass through costs from total pass through costs attributable to all payers and to show which documents the department must use to determine the pass-through cost per admission adjustment. Medicare requires the same documents for outpatient cost settlement and as part of its own cost-effectiveness evaluation of the DRG payment system. Therefore the proposed document requirement is reasonable because the proposed rule does not add a significant burden on the hospitals if the department uses those documents to determine pass-through cost adjustments.

The amendments are also reasonable because the department worked closely with the Minnesota Hospital Association to ensure that the amended method is accurate and convenient to use. The amendments also help ensure that the calculation will be done in the same way for all hospitals statewide.

Subp. 5. [see repealer]. It is proposed that this subpart be replaced by the amendment designated as item H. under subpart 4, pass through cost per admission adjustment. Repeal of this subpart is reasonable and necessary if the replacement language is adopted because it would conflict with the proposed language.

Subp. 6. Effective date. Adding the other forms of reimbusement to this subpart is necessary for clarification. The amendment is reasonable because this is what was originally intended by the department and because the amendment does not change policy or administrative practice.

9500.1126 RECAPTURE OF DEPRECIATION.

Subp. 1. Recapture of depreciation. These amendments are necessary to clarify the original rules. The recapture of depreciation is necessary because some hospitals are sold at an appreciated value and is reasonable because it prevents multiple payments for depreciation. The amendment clarifies that the methods used to determine the amount of depreciation recaptured by the state shall be consistent with the method used by Medicare to determine amounts of depreciation to be recaptured. The amendment is also reasonable because it allows the state to adjust its method if the method in use by Medicare changes.

Subpart 2. Payment of recapture of depreciation to commissioner. This amendment is needed and reasonable because it is for clarification purposes only.

The phrase that was deleted is unnecessary because it is redundant. Interest charges are also governed by the last paragraph of this subpart. The deletion does not change rule policy.

9500.1130 REIMBURSEMENT PROCEDURES.

Subp. 2. Required claims. This amendment is needed to prevent a hospital from billing the state more than it bills other payers for the same service. The amendment is reasonable because it helps prevent discrimination against the state, as required by the Code of Federal Regulations, Title 42, section 447.271 and prevents government from paying other costs. The amendment is also reasonable because it requires actual data and thus provides an historical basis for future rates or relative values rather than anticipated or projected amounts. Should a hospital provide incomplete data or "artificially" reduced charges, future rates and relative values would also be lowered artificially.

Subp. 3. Reimbursement in response to submitted claims. These amendments are necessary and reasonable because they are for clarification purposes only.

Subp. 6. Medicare crossover claims. The amendments in the Medicare crossover reimbursement formula are necessary to ensure that Medical Assistance is used only as a co-insurer and and to ensure that medical assistance reimbursements do not exceed Medicare upper payment limits. This is reasonable because such a payment limit is consistent with the upper payment limits under the Code of Federal Regulations, title 42, section 447.271. Medicare reimbursement for a diagnostic related group is considered complete payment for that diagnostic related group. Therefore it is reasonable that Medical Assistance payments be only for deductibles and coinsurance less recipient resources and third party payments.

Subp. 7. Reimbursement for transfers. Inserting the phrase "reimbursements for transfers shall be made according to items A and B" is a technical amendment that is necessary and reasonable because it clarifies that items A and B apply to transfer reimbursements only, not to reimbursements of other admissions.

A. Except for the amendments in the equation, the amendments in this item are necessary and reasonable because they are for clarification only.

The changes in the transfer formula are needed to equitably reimburse hospitals for transfers. Including the hospital cost index (HCI) in the transfer reimbursement formula is reasonable because the HCI compensates a hospital for inflation. Not including the HCI in the formula could result in insufficient reimbursement to a hospital.

It is reasonable to use the arithmetic mean length of stay in the denominator instead of the geometric mean length of stay because the

arithmetic mean is consistent with the arithmetic mean in the numerator.

The amendments to the equation are reasonable because they strengthen the distinction between partial and full medical care under the diagnostic classification reimbursement system. Transfer of a patient from one hospital to another represents partial medical care by each facility involved in the transfer. Therefore each hospital involved in a transfer may not necessarily be entitled to full reimbursement under a diagnostic category.

B. The amendment indicating that the inpatient hospitalization be medically necessary is reasonable because it is consistent with the requirements of rules regarding inpatient admission certification, parts 9505.0500 to 9505.0540, and the Code of Federal Regulations, title 42, section 440.230 (d).

The other amendments in item B are necessary to protect the state from paying for unnecessary inpatient hospital services. The amendments are reasonable because it is possible that a hospital could fail to provide the recipient with available services or admit a recipient to get reimbursement though the hospital knew it could not provide necessary services . The amendments are also reasonable because they are consistent with rules governing admission certification that are based on medical necessity, parts 9505.0500 to 9505.0540.

Subp.8. Reimbursement for readmissions. The amendments clarify the subpart by including a standard that can be used to judge whether a hospital should receive separate reimbursement for an admission and a readmission. Clarification is necessary so that the rule can be uniformly applied to claims for reimbursement. If a person is admitted and readmitted for the same illness or a condition related to that illness, the hospital shall receive only one reimbursement for the admission and readmission. The amendment is reasonable because under the prospective reimbursement system, where reimbursement is not dependent on the length of an inpatient stay, hospitals have an incentive to discharge inpatients as soon as possible. Such incentives could result in under-use of hospital services (such as premature discharge), a second admission, and a second reimbursement for the same illness episode.

The amendments also allow multiple categorical payments to a hospital for an admission that occurs within seven days of a discharge if the second admission within the seven days is for an unrelated illness or a separate episode of an illness. This amendment is reasonable because the base year data set contained similar occurrences and because it is medically possible for separate illness episodes to occur within a seven day period.

Subp. 9. Reimbursement for outliers. Except for the changes discussed for items A and B below, the amendments in this subpart are needed and reasonable because they clarify but do not affect its substance or administration.

A. and B. The amendments to these items are needed and reasonable because they make payments to hospitals more equitable by including the H.C.I. as a factor in the calculation; by substituting the arithmetic mean in place of the geometric mean to make the formula mathmatically consistent; and by including outlier trim points in the data used to determine reimbursements for outliers. Including outlier trim points in the data is reasonable because this is consistent with Laws of Minnesota 1986, chapter 420, section 6.

Subp. 10. Reimbursement to out-of-area hospitals. Except for the amendments in items A, C, D, and F that are discussed below, the amendments in this subpart are needed and reasonable because they are for clarification

only and because they do not change the rule's substance or administration.

A., C., D., and F. It is necessary to delete "allowable" from "adjusted allowable base year cost per admission" in item A because "adjusted base year cost per admission" is the term that is defined - "allowable" was inadvertently included in the term. Deleting "allowable" is reasonable because the deletion is for clarification only. It is necessary to use the HCI to determine the out-of-area categorical rates per admission because out-of-area hospitals have costs that increase because of inflation. Use of the HCI is reasonable because this is the measure of inflation used to determine inflation for hospitals in Minnesota and because use of the HCI is consistent with the requirements of Minnesota Statutes, section 256.969, subdivision 1.

Including outliers in the determination of reimbursements for out-of-area hospitals instead of excluding them is necessary and reasonable because it is consistent with Laws of Minnesota, 1986, chapter 420, section 6.

G. The amendment inserting "budget year" is necessary and reasonable because it clarifies the term "base year" and thereby removes a source of misunderstanding. The amendment does not affect the rule's substance or administration.

Subp. 11. Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year. Except for the amendments to item E the amendments in this subpart are needed for clarification and are reasonable because they do not affect the rule's substance or administration.

E. Including the HCI in the formula used to reimburse Metropolitan Statistical Area (MSA) and non-MSA hospitals that do not have admissions in the base year is needed to reflect inflationary increases in those hospitals' costs. It is reasonable to use the HCI as an inflation indicator because the HCI is used for all other Minnesota hospitals and because the HCI is consistent with the requirements of Minnesota Statutes, section 256.969, subdivision 1.

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart. 1. Determination of disproportionate population adjustment. It is necessary under Minnesota Statutes 1984, Section 256.969; United States Code, title 42, section 1396 (a)(13) and Code of Federal Regulations, title 42, section 447.252 (a)(3)(i)(1982) to offer an annual inflationary supplemental increase to a hospital's base rate when that hospital serves a disproportionate number of low income patients so that it has an unusually high volume of MA or GAMC business in proportion to its total clientele. It is reasonable to exclude admissions of MA and GAMC recipients who participate in prepaid health plans because the costs of providing care to those recipients are included in the determinations of prepayments for health services provided under those health plans. The prepaid health plans should not financially benefit by the ability to negotiate a lower hospital rate because the hospitals receive a supplement from the State, nor should the hospital receive a supplement from both the State and the prepaid health plan.

It is reasonable to redetermine a hospital's disproportionate population adjustment because the proportion of M.A. or G.A.M.C. admissions in a hospital's base year could change. Using the four percentage categories listed under this subpart to redetermine disproportionate population adjustments is reasonable because this enables the department to make objective and consistent redeterminations statewide.

Using the four percentage categories to redetermine a disproportionate

population adjustment for a hospital is also reasonable because the same four categories are used to make an initial determination of a disproportionate population adjustment for a hospital.

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155

Subp. 4. Determination of allowable rate period costs, allowable rate period for each admission, and allowable rate period cost per day.

I. Deleting "and 9500.1145" from this item is necessary for clarification. The amendment is reasonable because "and 9500.1145" is a reference to part numbers that the department changed when drafting parts 9500.1090 to 9500.1155. The amendment does not change policy or administrative practice.

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155, subpart 5; and 9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE, Subpart 6.

Subp. 5 and Subp. 6. Determination of reimbursements for Medicare crossover claims. The addition of subpart 5 to part 9500.1155 and subpart 6 to part 9500.1555 is necessary to outline the procedures for settling medicare crossover claims. It is necessary to settle these claims in which the state paid full charges for services that Medicare did not provide. It is reasonable because the methodology is consistent with the procedures the department has been using to settle Medicare crossover claims.

EXPERT WITNESSES AT PUBLIC HEARING

If a public hearing is held on these amendments the department will not use expert witnesses from outside the department to testify at the hearing.

Dated: 10/31, 1986

LEONARD W. LEVINE
Commissioner
Minnesota Department of Human Services

APPENDIX A

INPATIENT HOSPITAL REIMBURSEMENT RULE ADVISORY COMMITTEE

Ken Peterson, Hennepin County Medical Center
Jay Addy, Fairview Hospitals
Vern Silvernale, Minnesota Hospital Association
David Lee, Minnesota Hospital Association
Brian Juaire, Children's Health Center
Al Johnson, Council of Community Hospitals
Marianne Miller, Minnesota Department of Health
Marc Engelhardt, United Hospital
Dick Peterson, North Memorial Hospital

Amendments to these rule parts are necessary to clarify specific portions of the rule parts and to incorporate changes that have been made in the statutes governing child protective services since the rules were promulgated in 1982. Amendments are being considered in each of the following rule parts.

Part 9560.0270 Definitions

Part 9560.0280 Delivery of Child Protective Services;

Part 9560.0290 Official Reports; and

Part 9560.0300 Administrative Requirements

All interested or affected parties are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment should be addressed to:

Paul Spears
Child Protective Services
Department of Human Services
4th Floor
Centennial Office Building
658 Cedar Avenue
St. Paul, Minn. 55155

Oral statements of information and comment will be received during regular business hours over the phone at (612) 296-6740.

All statements of information and comment will be accepted until further notice is given. Any written material received by the Department shall become part of the hearing record.

Department of Human Services Health Care Programs Division

Meetings on Medicaid Prepaid Demonstration Project

The Minnesota Department of Human Services is implementing a Prepaid Medicaid Demonstration Project in Hennepin, Dakota, and Itasca counties. The purpose of the project is to determine if contracting with prepaid health plans allows the state and counties to provide quality health care to Medical Assistance clients for a fixed and predictable amount of money. The state is contracting with prepaid health plans to provide the covered services. Medical Assistance clients are being asked to choose which of the health plans they wish to join.

Health care providers who want MA reimbursement for serving these groups of people must be affiliated with one or more of the participating plans.

To answer health care providers' questions about the implementation of the project in Dakota and Hennepin counties, the following open meetings have been scheduled for health care providers and their staff; e.g., administrators, business managers, clinical staff. Representatives of the participating health plans have been invited to be present to answer questions.

Dakota County

Wednesday, February 26
7:00-8:30 a.m.
or 3:00-4:30 p.m.
Wentworth Office Building
33 East Wentworth Avenue
West St. Paul
(Just off Robert Street on Wentworth)

Hennepin County

Wednesday, March 12
7:00-8:30 a.m.
or 3:00-4:30 p.m.
Hennepin County Government Center
Auditorium (lower level)

Department of Human Services Health Care Programs Division

Outside Opinion Sought Concerning Amendments to Inpatient Hospital Reimbursement Under the Medical Assistance and General Assistance Medical Care Programs

Notice is hereby given that the Minnesota Department of Human Services is considering amendments to Minnesota Rules, Parts

9500.1090 to 9500.1155, rules governing inpatient hospital reimbursement under the Medical Assistance and General Assistance Medical Care programs.

The Commissioner is authorized to promulgate rules governing reimbursement methods and procedures for services rendered by hospitals participating in the Medical Assistance or General Assistance Medical Care programs, under Minnesota Statutes section 256.969, subdivision 6. Rule changes being considered include allowable base year cost per admission computations, relative values, pass-through costs, disproportionate population adjustment, adjustment of outlier and transfer reimbursement formulas, and separate rate computations for specific welfare program eligibility groups (such as recipients of Aid to Families with Dependent Children).

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be addressed to:

Thomas JoliCoeur
Health Care Programs
Department of Human Services
Fourth Floor, Space Center
444 Lafayette Road
St. Paul, Minnesota 55101

Oral statements of information and comments will be received by telephone at (612) 297-2022 between 9:00 a.m. and 4:00 p.m. Mondays through Fridays, except holidays.

Statements of information and comment will be accepted until further notice. Any written material received by the Department shall become part of the rulemaking record. Oral statements will be considered but will not become part of the rulemaking record.

Department of Jobs and Training
Division of Rehabilitation Services

Outside Opinion Sought Concerning a Proposed Rule Certifying Centers for Independent Living

Notice is hereby given that the Division of Rehabilitation Services is seeking information or opinions from interested or affected persons or groups in preparing to promulgate permanent rules governing certification of Centers for Independent Living. Authority for promulgation of these rules is contained in Minnesota Statutes, section 129A.10 (1985 Supplement).

The Division of Rehabilitation Services requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing. Written statements should be addressed to:

Scott Rostron
Division of Rehabilitation Services
390 North Robert Street, Fifth Floor
St. Paul, Minnesota 55101

Oral statements will be received during regular business hours over the telephone at (612) 296-5085 and in person at the above address.

All statements of information and comments will be accepted until March 3, 1986. Any written material received will become part of the record in the event the rules are promulgated.

Joseph Samargia
Commissioner of Jobs and Training

Pollution Control Agency
Division of Water Quality

Approval of Amendments to the Metropolitan Council's 208 Plan (Part 1) and Recommendation for Certification by the Governor

On January 28, 1986, pursuant to Section 208(a)(4) and 40 CFR Part 35, the Minnesota Pollution Control Agency (MPCA) approved amendments to the Metropolitan Council's 208 Water Resources Management Development Guide/Policy Plan, Part 1,

Department of Human Services

Proposed Rules Relating to Hospital Medical Assistance Reimbursement

Rules as Proposed

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for ~~all~~ the hospitals that participate in and are reimbursed by medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 5, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

9500.1100 DEFINITIONS.

Subpart 1. to 3. [Unchanged.]

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to ~~9505.5020 [Emergency]~~ 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy families with dependent children.

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Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission ~~which~~ that is adjusted for case mix ~~and which~~, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. [Unchanged.]

Subp. 7. **Appeals board.** "Appeals board" means the board ~~which~~ that advises the commissioner on a hospital's request for adjustments to ~~a categorical rate per admission, rate per admission, or a rate per day~~ reimbursements made under the prospective reimbursement system.

Subp. 8. [Unchanged.]

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. to 11. [Unchanged.]

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the [(adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (~~DRG's~~ DRGs) under medicare with adjustments as follows:

Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A. to JJ. [Unchanged.]	

Subp. 21. [Unchanged.]

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards

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of practice accepted by the medical community.

Subp. 22. to 24. [Unchanged.]

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. to 29. [Unchanged.]

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in ~~parts 9505.0530 {Emergency} and~~ part 9505.0540 ~~{Emergency}~~ cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. to 33. [Unchanged.]

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. to 38. [Unchanged.]

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to ~~9505.5020 {Emergency}~~ 9505.5030 and 9505.5105.

Subp. 40. [Unchanged.]

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or ~~some~~ a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

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Subp. 42. **Readmission.** "Readmission" means an admission ~~which~~ that occurs within seven days of a discharge~~,-whose diagnostic-category-or-a-related-diagnostic-category-is-the-same as-that-identified-for-that-discharge~~ of the same recipient.

Subp. 43. [Unchanged.]

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. [Unchanged.]

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission ~~for-all-admissions~~, excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all ~~other~~ the diagnostic categories on a statewide basis.

Subp. 46. [Unchanged.]

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in ~~part-9505.5030-[Emergency]~~ parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. [Unchanged.]

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing Administration (HCFA) Form 2552, 1981 revision, Worksheet A, column 7, line 84. ~~Health-Care-Financing-Administration-Form 2552,-1981-revision-is-incorporated-by-reference.--The-form-is published-by-Medicare,-Part-A-Office,-3535-Blue-Cross-Road,-P.O.~~

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~~Box-43560,-Saint-Paul,-Minnesota-55164.--The-form-is-available through-the-minitex-interlibrary-loan-system.~~ The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. [Unchanged.]

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. to C. [Unchanged.]

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined ~~in~~ from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio ~~as identified~~

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~~in-Worksheet-C-determined-in~~ from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(3) and (4) [Unchanged.]

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all computations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. and G. [Unchanged.]

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's diagnostic category day outlier trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the diagnostic category day outlier trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital ~~cost~~ costs for all admissions ~~excluding outliers~~ less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions ~~excluding~~ including outliers;

~~I.~~ K. determine the statewide arithmetic mean cost

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per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic category ~~excluding outliers~~ less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category ~~excluding~~ including outliers; and

~~J.~~ L. determine the relative value for each diagnostic category by dividing item ~~I~~ K by item H J.

Subp. 2. and 3. [Unchanged.]

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. [Unchanged.]

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers ~~as determined~~ in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, ~~item G~~ items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital ~~excluding~~ including outliers;

D. adjust item C for case mix as follows:

(1) [Unchanged.]

(2) multiply ~~each~~ the hospital's number of base year ~~admission-excluding~~ admissions within each diagnostic category including outliers by the relative value of ~~the~~ that diagnostic category ~~assigned to that admission~~,

(3) [Unchanged.]

(4) divide the sum from subitem (3) by the number

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of base year admissions ~~excluding~~ including outliers, and

(5) [Unchanged.]

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, ~~each~~ the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total Medical Assistance non-AFDC admissions. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days ~~prior to~~ before the start of each hospital's budget year and must include the following information:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
~~A.~~ (1)	Depreciation			
~~B.~~ (2)	Rents and leases			
~~C.~~ (3)	Property taxes			
~~D.~~ (4)	Property insurance			
~~E.~~ (5)	Interest			
~~F.~~ (6)	Malpractice insurance			
~~G.~~ (7)	Total Pass-Through Costs (~~Items A to F~~ Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to ~~items A to F~~ item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the

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HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to medicare. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/medicaid cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. **Determination of budget year pass-through cost per admission.** The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A. Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs			
B. Pass-through costs as specified in subpart 1, item ~~G~~ A, subitem (7), multiplied by item A			
C. Number of ~~base-year~~ Medical Assistance admissions including outliers			
D. Pass-through cost per admission (item B divided by item C)			

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission~~)~~ multiplied by ~~(~~budget year HCI~~)~~ and multiplied by ~~(~~the relative value of the appropriate diagnostic category), plus ~~(~~budget year pass-through cost per admission~~)~~]

Subp. 4. **Pass-through cost ~~per-admission~~ adjustment.** After the end of each budget year, the commissioner shall redetermine the ~~categorical-rate-per-admission.--The~~

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~~commissioner-shall-substitute-actual-pass-through-costs-as determined-by-medicare-for-budgeted-pass-through-costs-in subpart-2,-item-B-for-that-year.--If-the-adjustment-indicates-an overpayment-to-a-hospital,-that-hospital-shall-pay-to-the commissioner-the-overpayment-within-60-days-of-the-written notification-from-the-commissioner.--If-the-adjustment-indicates an-underpayment-to-a-hospital,-the-commissioner-shall-pay-that hospital-the-underpayment-within-60-days-of-written-notification from-the-commissioner~~ budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This computation produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as computed in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This computation produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. Compute the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This computation produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using HCFA Form 2552, Worksheet

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D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs computed in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted per-admission pass-through cost used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated. This computation produces the actual value of the pass-through cost payments made during the year.

G. Subtract the actual value of the medical assistance pass-through cost payments during the completed year (computed at item F) from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be payed by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the 61st day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

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Subp. 5. [See Repealer.]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall ~~use-medicare-to~~ determine the recapture of depreciation due to a change in the ownership of a hospital ~~and~~ that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner. ~~Interest-charges-must-be-assessed according-to-part-9500.1125,-subpart-5.~~

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. [Unchanged.]

Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.**

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The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission~~,~~; out-of-area categorical rate per admission~~, or the~~; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. and 5. [Unchanged.]

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	~~{~~{Medicare deductibles~~}~~, plus ~~{~~Medicare coinsurance~~}~~~~,~~ ~~plus {amounts for services covered by medical assistance but not by medicare}}~~ less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse ~~hospitals who discharge transfers and who admit transfers~~ both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[{(The product of the adjusted base year cost per admission~~}~~ multiplied by the budget year HCI and multiplied by ~~{~~the relative value of the appropriate diagnostic category~~}~~, divided by ~~{~~the ~~geometric~~ arithmetic mean length of stay of the diagnostic category) and multiplied by ~~{~~the number of days of inpatient hospital services~~}~~}, plus ~~{~~budget year pass-through cost per admission~~}~~]

In no case of a transfer may a hospital receive a ~~transfer~~ reimbursement that exceeds the applicable categorical rate per admission, ~~out of area~~ or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year,

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unless ~~the transfer~~ that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, ~~out-of-area~~ the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a transferred recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to the other hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if ~~appropriate~~ eligible. The combined stay of the admission and readmission shall be used to determine qualification for outlier payment. If the readmission to the same hospital is for a

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condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission. ~~A~~ An admission and subsequent readmission to a different hospital shall be reimbursed ~~as a transfer~~ as specified ~~in~~ under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with ~~a~~ the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA ~~hospitals~~ hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the ~~geometric~~ arithmetic mean length of stay for the diagnostic category;

(3) [Unchanged.]

(4) subtract the ~~number of days of inpatient hospital services at two standard deviations~~ day outlier trim point for the appropriate diagnostic ~~categories A to N and P to II under part 9500.1100, subpart 20 or the number of days of inpatient hospital services at one standard deviation for diagnostic category 0, under part 9500.1100, subpart 20, as~~

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~~determined under part 9500.1110, subpart 1, item G~~ category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) [Unchanged.]

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) [Unchanged.]

(3) subtract the cost at three standard deviations for diagnostic ~~categories A to N, and P to II~~ category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item G from the adjusted cost from subitem (2); and

(4) multiply the amount determined in subitem (3) by 60 percent for diagnostic ~~categories A to N, and P to II~~ category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, ~~the~~ a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse out-of-area hospitals based on the lesser of billed charges or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted ~~allowable~~ base year cost per admission in effect on the first day of a calendar year for each hospital statewide by ~~the~~ that hospital's HCI and by the number of admissions in ~~each~~ that hospital's base year, ~~excluding~~ including outliers;

B. sum the products in item A;

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C. divide the sum from item B by the sum of all admissions for all hospitals statewide, ~~excluding~~ including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base year, ~~excluding~~ including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, ~~excluding~~ including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission	=	[(statewide budget year adjusted base year cost per admission~~)~~ multiplied by ~~(~~the relative value of the appropriate diagnostic category), plus ~~(~~statewide budget year pass-through cost per admission~~)~~]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

A. Multiply the adjusted ~~allowable~~ base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, ~~excluding~~ including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of ~~all~~ the admissions for all MSA hospitals statewide, ~~excluding~~ including outliers, to determine the statewide ~~adjusted~~ allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission

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must be determined according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart 5 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per Admission for MSA Hospitals Statewide ~~Which~~ That Do Not Have ~~Admission~~ Admissions In The Base Year	=	[(adjusted base year cost per admission for MSA hospitals statewide~~)~~ multiplied by the budget year HCI and multiplied by ~~(~~the relative value of the appropriate diagnostic category) plus ~~(~~budget year pass-through cost per admission~~)~~]

F. [Unchanged.]

Subp. 12. [Unchanged.]

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Determination of disproportionate population adjustment.** The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions according to the ~~following~~ schedule~~:~~ below.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are ~~Medical Assistance~~ MA and ~~General Assistance Medical Care~~ GAMC, and Recipients

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Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. [Unchanged.]

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

Subpart 1. to 4. [Unchanged.]

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. to 5. [Unchanged.]

Subp. 5a. **Determination of reimbursements for medicare**

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crossover claims. The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. [Unchanged.]

REPEALER. Minnesota Rules, part 9500.1125, subpart 5 is repealed.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Hospital Medical Assistance Reimbursement

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9500

INCORPORATION BY REFERENCE:

Rule Number: 9500.1100, subpart 49

Material Incorporated: 1981, 1983, and 1985 revisions of Health Care Financing Administration Form 2552

The attached rules are approved for publication in the State Register

Susan E. Quayle
Assistant Revisor

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

Department of Human Services
In the Matter of the Proposed
Adoption of Amendments to the Rule of
the State Department of Human
Services Governing Inpatient
Hospital Reimbursement Under MA and
GAMC, Parts 9500.1090 to 9500.1155.

NOTICE OF INTENT
TO ADOPT A RULE WITHOUT
A PUBLIC HEARING

Notice is hereby given that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 256.969 and Laws of Minnesota, 1986, Chapter 420, section 6.

All persons have 30 days or until 4:30 p.m. on December 31, 1986 in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Julie Menssen
Director, Hospital Rates
444 Lafayette Road, 4th floor
St. Paul, MN 55101
Telephone: (612) 296-9939

AN EQUAL OPPORTUNITY EMPLOYER

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

Parts 9500.1090 to 9500.1155 became effective in August, 1985. Implementation of those parts has shown the Department of Human Services that some of those parts need to be amended to compensate hospitals more equitably, to clarify rule language, and to correct technical and grammatical errors.

The proposed amendments to parts 9500.1090 to 9500.1155 apply to hospital administrators and other persons interested in inpatient hospital reimbursement rates under Medical Assistance and General Assistance Medical Care.

The amendments that will have the most impact on hospital rates include the partitioning of rates into rates for the care of persons who are eligible for Medical Assistance (MA) because they are also eligible for Aid to Families with Dependent Children (AFDC) and for the care of all other MA recipients; the inclusion of cost outliers up to their trim points and day outliers up to their trim points plus 40 per cent of costs beyond the trim point in the calculation of relative values; settling pass-through costs by using actual experience for the budget year; and the inclusion of Medicare crossover claims in the calculation of the disproportionate population adjustment and redetermination of the disproportionate population adjustment using actual data.

The amendments also include definitions of new terms used in the amendments.

A free copy of the rule is available upon request from Julie Menssen. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Julie Menssen upon request.

Adoption of these rules will increase aggregate local public body spending by over $100,000 in either of the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. See the fiscal note attached to this notice which contains the estimated total cost to all local local public bodies and an explanation of how the cost was calculated. An additional copy of the fiscal note is available to the public from Julie Menssen upon request.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Julie Menssen.

11-18-86

Date

LEONARD W. LEVINE
COMMISSIONER OF HUMAN SERVICES

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
444 Lafayette Road
St. Paul, MN 55101

Fiscal Note
for
1986 Amendments to Minnesota Rules, Parts 9500.1090 to 9500.1155
Inpatient Hospital Reimbursements

INTRODUCTION

The following describes the net change in state and local spending resulting from amendments to Minnesota Rules, parts 9500.1100 to 9500.1155. Many amendments are housekeeping amendments, such as language changes to improve clarity and grammatical changes, and have no effect on state or local spending. In the interest of brevity fiscal impacts for housekeeping amendments are not discussed below. If an amendment is not discussed below, therefore, it can be assumed that amendment will have no fiscal impact.

9500.1090 PURPOSE AND SCOPE

Description of amendment/s: Amendments to this part partition inpatient hospital reimbursements into reimbursements for persons who receive medical assistance because they are eligible for AFDC and all other persons who receive medical assistance.

Method used to calculate change in state and local spending: Past department reimbursements show that medical assistance payments for hospital services to AFDC recipients are much lower than medical assistance payments for hospital services to all other recipients of medical assistance. Therefore, when the costs to serve both populations are averaged to determine reimbursements, the higher cost of serving non-AFDC medical assistance recipients results in a disproportionately high amount of reimbursements for medical assistance/AFDC recipients. A hospital that has served a large percentage of the medical assistance/AFDC recipients will receive lower reimbursements per admission as a result of the amendments and a hospital that has served a relatively small percentage of medical assistance/AFDC recipients will receive higher reimbursements per admission.

Projected net change in state or local spending: The department knows that amounts of reimbursements to individual hospitals will change. But the exact change in total reimbursement amounts will not be known until the amendments are implemented. Because in the past the Department has averaged the two populations and now is partitioning the payments into two separate rates the net affect of partitioned rates on State and local expenditures will be negligible.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES AND 9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION

Description of amendments: Amendments to parts 9500.1110 and 9500.1115 allow inclusion of cost outliers up to their trim points and day outliers up to their trim points plus 40 percent of costs beyond the trim

point in the calculation of relative values. These amendments to these parts make up the substantive portion of the amendments from a fiscal perspective. Other amendments will have negligible fiscal impacts.

Method used to calculate change in state and local spending: The revisions to Part 9500.1110 will intensify the revision to Part 9500.1115 since these two parts describe components to the reimbursement formula. In general, a hospital payment is calculated by multiplying a base rate per admission, by a health care cost index, and by an appropriate statewide ralative value. The product is summed with a pass-through cost amount. These amendments will cause the hospital-specific base rate to change as well as the relative values. A change to one factor may be either magnified or mitigated by a change in another factor. Experience in prospective payment reimbursement provides a basis for assessing the fiscal impact of the amendments to parts 9500.1110 and 9500.1115..

Projected net change in state and local spending: The inclusion of outliers into the detemination of the base year cost per admission will necessarily increase the base year cost per admission because by definition outlier cases are higher cost admissions and thus will push up the allowable base year cost per admission.

Changes to the relative values as a result of including outlier cases will have a varying impact on the hospital reimbursement. Since the relative value magnifies the base year cost per admission the effect on a particular hospital will depend on the change in the base year cost, the change in the relative values, and the relative distribution of each hospital's claims within the diagnostic category. Thus, changes to Parts 9500.1110 and 9500.1115 may increase or decrease individual claim payment amounts such that some hospitals may receive additional money while other hospitals may owe the department. Because of the changes to the various components, the exact fiscal impact of the amendments would have to be determined through the use of a specially designed computer simulation. The resources for such a simulation are unavailable, however projections indicate that the expenditures are within the amounts budgeted for fiscal year 1986 and 1987. In effect these amendments are budget nuetral against all current appropriations for this biennium. The following data shows the increases in expenditures over the current expenditures for state fiscal years 1986, 1987, and 1988:

		FY 1986		FY 1987		FY 1988
		(Thousands of Dollars)				
MEDICAL ASSISTANCE						
Inp. Hosp. Costs / Current Level (Actual '86; Projected '87-'88)		123,443		130,919		138,394
% Increase	x	9.7%	x	9.7%	x	9.7%
9 Mos. / 12 in '86	x	0.75				
Projected Increase		9,011		12,743		13,470
State Share %	x	0.4210	x	0.4193	x	0.4155
State Share Increase		3,794		5,343		5,597

		FY 1986		FY 1987		FY 1988
		(Thousands of Dollars)				
GENERAL ASSISTANCE MEDICAL CARE						
Inp. Hosp. Costs / Current Level (Actual '86; Projected '87-'88)		34,822		33,366		42,902
% Increase	x	7.9%	x	7.9%	x	7.9%
9 Mos. / 12 in '86	x	0.75				
Projected Increase		2,072		2,647		3,404
State Share %	x	0.90	x	0.90	x	0.90
State Share Increase		1,865		2,382		3,063

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION SUBPART 4

Description of amendments: Pass through costs consist of the following costs: depreciation, rents and leases, property taxes, property insurance, interest, and malpractice insurance. As per the rule, the hospital estimates these costs for the forthcoming rate year. These amendments allow the department to more accurately settle pass through costs because they allow the department to apply actual utilization rates by ancillary and routine cost centers to total pass through costs.

Method used to calculate change state and local spending: It is not possible to calculate the fiscal impact of this amendment because changes in reimbursement due to pass-through cost settlement depends on the hospital's ability to forecast their pass-through costs. It is expected that some hospitals will over budget these costs while other hospitals will under budget these costs.

Projected net change in state or local spending: The net effect of these amendments on all hospitals in aggregate is expected to be a very small decrease to no decrease in reimbursements. In fact, pass through settlements may vary from year to year.

500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT

Description of amendment/s: Amendments to this part clarify that Medicare crossover claims are included in the calculation of the ratio. Further these amendments will allow the department to redetermine the ratio based on actual data for the rate year.

Method used to calculate change in state and local spending: Changes in spending due to these amendments will depend on whether hospital utilization by MA, GAMC, and Medicare crossover recipients changed significantly as a percent of total hospital patient load from the base year, 1981. If there has been a significant change, these amendments will allow the Department to reflect these changes in reimbursements.

Projected net change in state or local spending: The fiscal impact of these amendments is expected to be extremely small as a percent of total reimbursement.

EFFECT ON MEDICAL ASSISTANCE ADMINISTRATIVE EXPENDITURES

The adoption of these amendments will not increase or decrease the personnel requirements of the Department of Human Services or any local government.

EFFECT ON LOCAL AGENCY EXPENDITURES

Based on the same methodology used above to calculate the fiscal impact on state expenditures the estimated increase in aggregate local agency expenditures will be over $100,000 for each of the two years following the adoption of the amendments. The estimated aggregate increased expenditures for local agencies will be $1.5 million for State fiscal year 1986, $2.1 million for state fiscal year 1987, and $2.3 million for state fiscal year 1988.

Date: 11-18-86

LEONARD W. LEVINE, COMMISSIONER
Department of Human Services

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICES RULES GOVERNING INPATIENT HOSPITAL REIMBURSEMENT UNDER MA AND GAMC, PARTS 9500.1090 TO 9500.1155

AFFIDAVIT OF MAILING

Nancy Storelee, being first duly sworn, deposes and says:

That on the 25th day of November, 1986, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Intent to Adopt a Rule Without a Public Hearing by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of hearing by this Department.

Nancy Storelee

Subscribed and sworn to before me

this 25 day of November, 1986

Louise J. Bridel

A. The department shall select for audit either ten percent or ten, whichever is greater, of the assessments submitted in accordance with part 9549.0059, subpart 2, as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted, or ten percent or ten, whichever is greater, of the assessments submitted during the previous four months in accordance with part 9549.0059, subparts 1 and 4 as proposed at *State Register*, volume 11, pages 988 to 1004 and as subsequently adopted.

B. If more than 20 percent of the assessments audited under item A contain errors that could result in a change of classification, the auditors shall remain on-site and audit a second sample equal in size and selected from the same types of assessments as in item A.

C. If more than 20 percent of the assessments audited under item B contain errors that could result in a change of classification, the facility shall be subject to an additional audit of up to 100 percent of the assessments.

Subp. 6. **Special audits.** The department may conduct special audits whenever it deems such audits necessary.

Subp. 7. **Notice to facility.** No exit interview will be conducted at the facility to discuss the preliminary findings of the department. Within 15 working days of completing the audit process, the department shall mail the written results of the audit to the facility, along with a written notice to the resident and to the facility which contains the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the department's documents supporting the classification and to request a reconsideration of the classification.

4656.0090 DEATH, DISCHARGE, CHANGE OF PAYMENT SOURCE, AND TRANSFER INFORMATION.

Every month, certified facilities shall provide updated information to the department relating to the deaths, discharges, changes in payment source when the resident payment goes from private pay to medicaid sponsored, and transfers that occurred within the facility the previous month. This information must be provided on forms developed by the department.

Department of Human Services

Proposed Rules Relating to Hospital Medical Assistance Reimbursement

Notice of Intent to Adopt a Rule without a Public Hearing

Notice is hereby given that the State Department of Human Services intends to adopt the above-entitled rule without a public hearing following the procedures set forth in the Administrative Procedure Act for adopting rules without a public hearing in Minnesota Statutes, sections 14.22 to 14.28. The statutory authority to adopt the rule is Minnesota Statutes, section 256.969 and Laws of Minnesota, 1986, Chapter 420, section 6.

All persons have 30 days or until 4:30 p.m. on December 31, 1986 in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule. Comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, sections 14.131 to 14.20.

Comments or written requests for a public hearing must be submitted to:

Juli Menssen
Director, Hospital Rates
444 Lafayette Road, 4th floor
St. Paul, MN 55101
Telephone: (612) 296-9939

The proposed rule may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed rule as noticed.

Parts 9500.1090 to 9500.1155 became effective in August, 1985, Implementation of those parts has shown the Department of

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Human Services that some of those parts need to be amended to compensate hospitals more equitably, to clarify rule language, and to correct technical and grammatical errors.

The proposed amendments to parts 9500.1090 to 9500.1155 apply to hospital administrators and other persons interested in inpatient hospital reimbursement rates under Medical Assistance and General Assistance Medical Care.

The amendments that will have the most impact on hospital rates include the partitioning of rates into rates for the care of persons who are eligible for Medical Assistance (MA) because they are also eligible for Aid to Families with Dependent Children (AFDC) and for the care of all other MA recipients; the inclusion of cost outliers up to their trim points and day outliers up to their trim points plus 40 per cent of costs beond the trim point in the calculation of relative values; settling pass-through costs by using actual experience for the budget year; and the inclusion of Medicare crossover claims in the calculation of the disproportionate population adjustment and redetermination of the disproportionate population adjustment using actual data.

The amendments also include definitions of new terms used in the amendments.

A free copy of the rule is available upon request from Juli Menssen. A copy of the rule may also be viewed at any of the 87 county welfare or human services agencies in the State of Minnesota.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Juli Menssen upon request.

Adoption of these rules will increase aggregate local public body spending by over $100,000 in either of the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. See the fiscal note attached to this notice which contains the estimated total cost to all local public bodies and an explanation of how the cost was calculated. An additional copy of the fiscal note is available to the public from Julie Menssen upon request.

If no hearing is required, upon adoption of the rule, the rule and the required supporting documents will be submitted to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Juli Menssen.

Leonard W. Levine, Commissioner
Dept. of Human Services

Fiscal Note for 1986 Amendments to Minnesota Rules, Parts 9500.1090 to 9500.1155 Inpatient Hospital Reimbursements

INTRODUCTION

The following describes the net change in state and local spending resulting from amendments to Minnesota Rules, parts 9500.1100 to 9500.1155. Many amendments are housekeeping amendments, such as language changes to improve clarity and grammatical changes, and have no effect on state or local spending. In the interest of brevity fiscal impacts for housekeeping amendments are not discussed below. If an amendment is not discussed below, therefore, it can be assumed that amendment will have no fiscal impact.

9500.1090 PURPOSE AND SCOPE

Description of amendment/s: Amendments to this part partition inpatient hospital reimbursements into reimbursements for persons who receive medical assistance because they are eligible for AFDC and all other persons who receive medical assistance.

Method used to calculate change in state and local spending: Past department reimbursements show that medical assistance payments for hospital services to AFDC recipients are much lower than medical assistance payments for hospital services to all other recipients of medical assistance. Therefore, when the costs to serve both populations are averaged to determine reimbursements, the higher cost of serving non-AFDC medical assistance recipients results in a disproportionately high amount of reimbursements for medical assistance/AFDC recipients. A hospital that has served a large percentage of the medical assistance/AFDC recipients will receive lower reimbursements per admission as a result of the amendments and a hospital that has served a relatively small percentage of medical assistance/AFDC recipients will receive higher reimbursements per admission.

Projected net change in state or local spending: The department knows that amounts of reimbursements to individual hospitals will change. But the exact change in total reimbursement amounts will not be known until the amendments are implemented. Because in the past the Department has averaged the two populations and now is partitioning the payments into two separate rates the net affect of partitioned rates on State and local expenditures will be negligible.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES AND 9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION

Description of amendments: Amendments to parts 9500.1110 and 9500.1115 allow inclusion of cost outliers up to their trim points and day outliers up to their trim points plus 40 percent of costs beyond the trim point in the calculation of relative values.

These amendments to these parts make up the substantive portion of the amendments from a fiscal perspective. Other amendments will have negligible fiscal impacts.

Method used to calculate change in state and local spending: The revisions to Part 9500.1110 will intensify the revision to Part 9500.1115 since these two parts describe components to the reimbursement formula. In general, a hospital payment is calculated by multiplying a base rate per admission, by a health care cost index, and by an appropriate statewide relative value. The product is summed with a pass-through cost amount. These amendments will cause the hospital-specific base rate to change as well as the relative values. A change to one factor may be either magnified or mitigated by a change in another factor. Experience in prospective payment reimbursement provides a basis for assessing the fiscal impact of the amendments to parts 9500.1110 and 9500.1115.

Projected net change in state and local spending: The inclusion of outliers into the determination of the base year cost per admission will necessarily increase the base year cost per admission because by definition outlier cases are higher cost admissions and thus will push up the allowable base year cost per admission.

Changes to the relative values as a result of including outlier cases will have a varying impact on the hospital reimbursement. Since the relative value magnifies the base year cost per admission the effect on a particular hospital will depend on the change in the base year cost, the change in the relative values, and the relative distribution of each hospital's claims within the diagnostic category. Thus, changes to Parts 9500.1110 and 9500.1115 may increase or decrease individual claim payment amounts such that some hospitals may receive additional money while other hospitals may owe the department. Because of the changes to the various components, the exact fiscal impact of the amendments would have to be determined through the use of a specially designed computer simulation. The resources for such a simulation are unavailable, however projections indicate that the expenditures are within the amounts budgeted for fiscal year 1986 and 1987. In effect these amendments are budget neutral against all current appropriations for this biennium. The following data shows the increases in expenditures over the current expenditures for state fiscal years 1986, 1987, and 1988:

		FY 1986		FY 1987 (Thousands of Dollars)		Fy 1988
MEDICAL ASSISTANCE						
Inp. Hosp. Costs / Current Level (Actual '86; Projected '87-'88)		123,443		130,919		138,394
% Increase	x	9.7%	x	9.7%	x	9.7%
9 Mos. / 12 in '86	x	0.75				
Projected Increase		9,011		12,743		13,470
State Share %	x	0.4210	x	0.4193	x	0.4155
State Share Increase		3,794		5,343		5,597
		FY 1986		**FY 1987 (Thousands of Dollars)**		**FY 1988**
GENERAL ASSISTANCE MEDICAL CARE						
Inp. Hosp. Cost / Current Level (Actual '86; Projected '87-'88)		34,822		33,366		42,902
% Increase	x	7.9%	x	7.9%	x	7.9%
9 Mos. / 12 in '86	x	0.75				
Projected Increase		2,072		2,647		3,404
State Share %	x	0.90	x	0.90	x	0.90
State Share Increase		1,865		2,382		3,063

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.

9500.1125 DETERMINATION OF CATEGORIAL RATE PER ADMISSION SUBPART 4

Description of amendments: Pass through costs consist of the following costs: depreciation, rents and leases, property taxes, property insurance, interest, and malpractice insurance. As per the rule, the hospital estimates these costs for the forthcoming rate year. These amendments allow the department to more accurately settle pass through costs because they allow the department to apply actual utilization rates by ancillary and routine costs centers to total pass through costs.

Method used to calculate change state and local spending: It is not possible to calculate the fiscal impact of this amendment because changes in reimbursement due to pass-through cost settlement depends on the hospital's ability to forecast their pass-through costs. It is expected that some hospitals will over budget these costs while other hospitals will under budget these costs.

Projected net change in state or local spending: The net effect of these amendments on all hospitals in aggregate is expected to be a very small decrease to no decrease in reimbursements. In fact, pass through settlements may vary from year to year.

500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT

Description of amendment/s: Amendments to this part clarify that Medicare crossover claims are included in the calculation of the ratio. Further these amendments will allow the department to redetermine the ratio based on actual data for the rate year.

Method used to calculate change in state and local spending: Changes in spending due to these amendments will depend on whether hospital utilization by MA, GAMC, and Medicare crossover recipients changed significantly as a percent of total hospital patient load from the base year, 1981. If there has been a significant change, these amendments will allow the Department to reflect these changes in reimbursements.

Projected net change in state or local spending: The fiscal impact of these amendments is expected to be extremely small as a percent of total reimbursement.

EFFECT ON MEDICAL ASSISTANCE ADMINISTRATIVE EXPENDITURES

The adoption of these amendments will not increase or decrease the personnel requirements of the Department of Human Services or any local government.

EFFECT ON LOCAL AGENCY EXPENDITURES

Based on the same methodology used above to calculate the fiscal impact on state expenditures the estimated increase in aggregate local agency expenditures will be over $100,000 for each of the two years following the adoption of the amendments. The estimated aggregate increased expenditures for local agencies will be $1.5 million for State fiscal year 1986, $2.1 million for state fiscal year 1987, and $2.3 million for state fiscal year 1988.

Rules as Proposed

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for ~~all~~ the hospitals that participate in and are reimbursed by medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 5, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

9500.1100 DEFINITIONS.

Subpart 1. to 3. [Unchanged.]

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to ~~9505.5020 [Emergency]~~ 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy families with dependent children.

Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission ~~which~~ that is adjusted for case mix ~~and which~~, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. [Unchanged.]

Subp. 7. **Appeals board.** "Appeals board" means the board ~~which~~ that advises the commissioner on a hospital's request for adjustments to ~~a categorical rate per admission, rate per admission, or a rate per day~~ reimbursements made under the prospective reimbursement system.

Subp. 8. [Unchanged.]

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. to 11. [Unchanged.]

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the [(adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (~~DRG's~~ DRGs) under medicare with adjustments as follows:

Diagnostic Categories	DRG Numbers Within the Diagnostic Category

A. to JJ. [Unchanged.]

Subp. 21. [Unchanged.]

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards of practice accepted by the medical community.

Subp. 22. to 24. [Unchanged.]

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. to 29. [Unchanged.]

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in ~~parts 9505.0530 [Emergency] and~~ part 9505.0540 ~~[Emergency]~~ cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. to 33. [Unchanged.]

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. to 38. [Unchanged.]

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to ~~9505.5020 [Emergency]~~ 9505.5030 and 9505.5105.

Subp. 40. [Unchanged.]

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or ~~some~~ a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission ~~which~~ that occurs within seven days of a discharge~~, whose diagnostic category or a related diagnostic category is the same as that identified for that discharge~~ of the same recipient.

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Subp. 43. [Unchanged.]

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. [Unchanged.]

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission ~~for all admissions,~~ excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all ~~other~~ the diagnostic categories on a statewide basis.

Subp. 46. [Unchanged.]

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in ~~part 9505.5030 [Emergency]~~ parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. [Unchanged.]

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing Administration (HCFA) Form 2552, 1981 revision, Worksheet A, column 7, line 84. ~~Health Care Financing Administration Form 2552, 1981 revision is incorporated by reference. The form is published by Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, Saint Paul, Minnesota 55164. The form is available through the minitex interlibrary loan system.~~ The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. [Unchanged.]

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. to C. [Unchanged.]

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined ~~in~~ from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio ~~as identified in Worksheet C determined in~~ from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(3) and (4) [Unchanged.]

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all computations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. and G. [Unchanged.]

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's diagnostic category day outlier trim point divided by the day

outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X \ldots \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the diagnostic category day outlier trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital ~~cost~~ costs for all admissions ~~excluding outliers~~ less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions ~~excluding~~ including outliers;

~~I.~~ K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic category ~~excluding outliers~~ less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category ~~excluding~~ including outliers; and

~~J.~~ L. determine the relative value for each diagnostic category by dividing item ~~I~~ K by item ~~H~~ J.

Subp. 2. and 3. [Unchanged.]

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. [Unchanged.]

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers ~~as determined~~ in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, ~~item G~~ items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital ~~excluding~~ including outliers;

D. adjust item C for case mix as follows:

(1) [Unchanged.]

(2) multiply ~~each~~ the hospital's number of base year ~~admission excluding~~ admissions within each diagnostic category including outliers by the relative value of ~~the~~ that diagnostic category ~~assigned to that admission~~,

(3) [Unchanged.]

(4) divide the sum from subitem (3) by the number of base year admissions ~~excluding~~ including outliers, and

(5) [Unchanged.]

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, ~~each~~ the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total Medical Assistance non-AFDC admissions. Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost reports are due 60 days ~~prior to~~ before the start of each hospital's budget year and must include the following information:

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.

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
~~A.~~ (1)	Depreciation			
~~B.~~ (2)	Rents and leases			
~~C.~~ (3)	Property taxes			
~~D.~~ (4)	Property insurance			
~~E.~~ (5)	Interest			
~~F.~~ (6)	Malpractice insurance			
~~G.~~ (7)	Total Pass-Through Costs (~~Items A to F~~ Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to ~~items A to F~~ item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to medicare. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/medicaid cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. **Determination of budget year pass-through cost per admission.** The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs			
B.	Pass-through costs as specified in subpart 1, item ~~G~~ A, subitem (7), multiplied by item A			
C.	Number of ~~base year~~ Medical Assistance admissions including outliers			
D.	Pass-through cost per admission (item B divided by item C)			

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission~~)~~ multiplied by ~~(~~budget year HCI~~)~~ and multiplied by ~~(~~the relative value of the appropriate diagnostic category), plus ~~(~~budget year pass-through cost per admission~~)~~]

Subp. 4. **Pass-through cost ~~per admission~~ adjustment.** After the end of each budget year, the commissioner shall redetermine the ~~categorical rate per admission. The commissioner shall substitute actual pass-through costs as determined by medicare for budgeted pass-through costs in subpart 2, item B for that year. If the adjustment indicates an overpayment to a hospital, that hospital shall pay to the commissioner the overpayment within 60 days of the written notification from the commissioner. If the adjustment indicates an underpayment to a hospital, the commissioner shall pay that hospital the underpayment within 60 days of written notification from the commissioner~~ budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column

1 by column 5 for each routine service type. This computation produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as computed in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This computation produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. Compute the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This computation produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs computed in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted per-admission pass-through cost used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated. This computation produces the actual value of the pass-through cost payments made during the year.

G. Subtract the actual value of the medical assistance pass-through cost payments during the completed year (computed at item F) from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be payed by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the 61st day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [See Repealer.]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall ~~use medicare to~~ determine the recapture of depreciation due to a change in the ownership of a hospital ~~and~~ that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner. ~~Interest charges must be assessed according to part 9500.1125, subpart 5.~~

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. [Unchanged.]

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Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.** The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission~~,~~; out-of-area categorical rate per admission~~, or the~~; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. and 5. [Unchanged.]

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	~~[~~(Medicare deductibles~~)~~, plus ~~(~~Medicare coinsurance~~), plus (amounts for services covered by medical assistance but not by medicare)]~~ less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse ~~hospitals who discharge transfers and who admit transfers~~ both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[~~{~~(The product of the adjusted base year cost per admission~~)~~ multiplied by the budget year HCI and multiplied by ~~(~~the relative value of the appropriate diagnostic category~~)~~, divided by ~~(~~the ~~geometric~~ arithmetic mean length of stay of the diagnostic category) and multiplied by ~~(~~the number of days of inpatient hospital services~~)~~}, plus ~~(~~budget year pass-through cost per admission ~~)~~]

In no case of a transfer may a hospital receive a ~~transfer~~ reimbursement that exceeds the applicable categorical rate per admission, ~~out-of-area~~ or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless ~~the transfer~~ that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, ~~out of area~~ the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a transferred recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to the other hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if ~~appropriate~~ eligible. The combined stay of the admission and readmission shall be used to determine qualification for outlier payment. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission. ~~A~~ An admission and subsequent readmission to a different hospital shall be reimbursed ~~as a transfer~~ as specified ~~in~~ under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with ~~a~~ the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA ~~hospitals~~

hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the ~~geometric~~ arithmetic mean length of stay for the diagnostic category;

(3) [Unchanged.]

(4) subtract the ~~number of days of inpatient hospital services at two standard deviations~~ day outlier trim point for the appropriate diagnostic ~~categories A to N and P to H under part 9500.1100, subpart 20 or the number of days of inpatient hospital services at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20, as determined under part 9500.1110, subpart 1, item G~~ category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) [Unchanged.]

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) [Unchanged.]

(3) subtract the cost at three standard deviations for diagnostic ~~categories A to N, and P to H~~ category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item G from the adjusted cost from subitem (2); and

(4) multiply the amount determined in subitem (3) by 60 percent for diagnostic ~~categories A to N, and P to H~~ category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, ~~the~~ a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse out-of-area hospitals based on the lesser of billed charges or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted ~~allowable~~ base year cost per admission in effect on the first day of a calendar year for each hospital statewide by ~~the~~ that hospital's HCI and by the number of admissions in ~~each~~ that hospital's base year, ~~excluding~~ including outliers;

B. sum the products in item A;

C. divide the sum from item B by the sum of all admissions for all hospitals statewide, ~~excluding~~ including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base year, ~~excluding~~ including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, ~~excluding~~ including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission = [(statewide budget year adjusted base year cost per admission~~)~~ multiplied by ~~(~~the relative value of the appropriate diagnostic category), plus ~~(~~statewide budget year pass-through cost per admission~~)~~]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

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A. Multiply the adjusted ~~allowable~~ base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, ~~excluding~~ including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of ~~all~~ the admissions for all MSA hospitals statewide, ~~excluding~~ including outliers, to determine the statewide ~~adjusted~~ allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission must be determined according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart ~~5~~ 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per Admission for MSA Hospitals Statewide ~~Which~~ That Do Not Have ~~Admission~~ Admissions In The Base Year	=	[(adjusted base year cost per admission for MSA hospitals statewide~~)~~ multiplied by the budget year HCI and multiplied by ~~(~~the relative value of the appropriate diagnostic category) plus ~~(~~budget year pass-through cost per admission~~)~~]

F. [Unchanged.]

Subp. 12. [Unchanged.]

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Determination of disproportionate population adjustment.** The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions according to the ~~following~~ schedule~~:~~ below.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are ~~Medical Assistance~~ MA and ~~General Assistance Medical Care~~ GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. [Unchanged.]

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

Subpart 1. to 4. [Unchanged.]

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. to 5. [Unchanged.]

Subp. 5a. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. [Unchanged.]

REPEALER. Minnesota Rules, part 9500.1125, subpart 5 is repealed.

Department of Human Services

Proposed Permanent Rules Relating to Inpatient Hospital Reimbursement Under Medical Assistance and General Assistance Medical Care

Notice of Public Comment Period

Pursuant to Laws of Minnesota, 1986, chapter 420, section 6, subdivision 2, as amended by Laws of Minnesota, 1986, 1st Special Session, chapter 3, article 2, section 51, "The commissioner may reconstitute the diagnostic categories to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories, after notice in the *State Register* and a 30-day comment period". Revision of the Diagnostic Categories is exempt from Minnesota Statutes, chapter 14 rulemaking requirements. The State Department of Human Services gives notice that it intends to amend diagnostic categories established at Minnesota Rules, part 9500.1100, subpart 20, as follows:

Rules as Proposed

9500.1100 DEFINITIONS.

Subpart 1. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (DRG's) under medicare with adjustments as follows:

	Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A.	to M. [Unchanged.]	
N.	Pregnancy, Childbirth, and the Puerperium	(~~370, 374, 375~~ 376-384)
O.	to BB. [Unchanged.]	
CC.	Caesarean ~~section without cormorbidities and complications~~ sections	(370-372)
DD.	Vaginal delivery with complicating diagnosis or operating room procedures	(372,374-375)
EE.	Vaginal delivery without complicating diagnosis or operating room procedures and Normal newborns	(373), (391)
FF.	to JJ. [Unchanged.]	

Subp 21. to 50. [Unchanged.]

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UNIVERSITY OF MINNESOTA
TWIN CITIES

University Hospitals and Clinics
420 Delaware Street S.E.
Minneapolis, Minnesota 55455



December 23, 1986

Juli Menssen
Director, Hospital Rates
444 Lafayette Road
4th Floor
St. Paul, Minnesota 55101

RE: Proposed Rules Relating To Hospital Medical Assistance Reimbursement

Dear Ms. Menssen:

The purpose to this letter is to respond to the above noted proposed rules as printed in the State Register on Monday, December 1, 1986 on behalf of the University of Minnesota Hospital and Clinic (UMHC).

On the whole, the revisions to the previously announced rules conform to those changes discussed in our joint meetings with HFMA, MHA, COCH, and your Department. UMHC's comments, therefore, are brief and noncontroversial. They are as follows:

A. Subpart 21a of the Definitions (9500.1100) defines the term "foreseeable complication." While the definition as written appears innocuous, when put into practice it could be difficult to define under "standards of practice." Given that one of the goals of the Medicare Program over the years has been to cut down the numbers of days of stay, it appears that this definition is somewhat in conflict if one were to take too liberal of an approach to the terminology "foreseeable complication."

B. Subpart 42 of the Definitions (9500.1100) defines the term "readmission." We note that this a change from the previous definition and opens all readmissions for additional scrutiny. We question whether there has been any history over the past year and a half to indicate a need for such scrutiny when there is less review now being done by Medicare and Blue Cross in this same area. Expansion of the definition as proposed will cost both the health care institution and the Department additional funds in order to review each situation where there is readmission.

C. Subpart 45 of the Definitions (9500.1100) defines the term "relative value." It has been pointed out to us that the words at the beginning of the third line of this definition "in relation to" would, if changed to "divided by" better clarifies this definition.

D. Subpart 1E under Section 9500.1110 (Determination and Publication of Relative Value of Diagnostic Categories) indicates the usage of software to determine via ICD-9CM coding the diagnostic related group. UMHC has consistently suggested that the Department use the same grouper as that being used by Medicare so that hospitals would not have two different

systems in place by two different programs under HCFA. We, therefore, suggest that this section be revised to indicate that the Department through its subcontractor will use the same version of the grouper as currently in place and used by HCFA during the life of these rules and regulations.

E. Subpart 1 (Pass-through Cost Reports) of Section 9500.1125 (Determination of Categorical Rate Per Admission For A Minnesota Hospital) requires that the hospital submit to the Department a written report which would include "total Medical Assistance AFDC admissions." As these rules are written, it would appear that this requirement could retroactively apply to August 1, 1985 for each of the hospitals subject to the rules. We believe that this would be an inappropriate requirement on the hospitals since this hospital and most others have not kept a separate data base to identify AFDC admissions up to the present time. Most institutions, we believe, like UMHC have merely collected admissions by the identification of the payer (i.e., Medical Assistance - all programs). If the Department wishes this information, we believe that the requirement to gather such information should begin with the date these rules are promulgated as final rules. The Department should announce now its requirement for hospitals to begin to collect such data so that this information will be available at the point in time that the Department wishes it to be submitted.

F. Subpart 4D under 9500.1125 (Determination of Categorical Rate Per Admission For A Minnesota Hospital) requests information be submitted for allowable assistance share of malpractice insurance costs using HCFA Form 2552, Worksheet D-8. It has been indicated to us that the noted worksheet does not include all the costs associated with malpractice and this is due to a change in the form sheets effective by Medicare in 1985. We request that the Department take this into consideration and seek the additional information to ensure that all costs associated with malpractice be submitted.

G. Subpart 6 under 9500.1130 (Reimbursement Procedures) removes language associated with Medicare crossover claims. The language removed was "plus (amounts for services covered by Medical Assistance but not by Medicare)". It must be noted that there are a number of occasions in which the Department has traditionally covered expenses not covered by the Medicare Program. To our knowledge, the Department has not indicated prior to the announcement of these rules that it was rescinding these types of coverages. We would appreciate knowing what coverages are being rescinded or have the language as previously included in this subpart to be continued to be included.

H. Subpart 8 under 9500.1130 (Reimbursement Procedures) discusses the reimbursement for readmissions. In this subpart, considerable amounts

of language have been added to broaden the definition under which readmissions would be examined. As noted above, UMHC is concerned with the review process which will be necessitated by expansion of the Department's concerns related to readmission. We believe, given our previous history at this institution and others, that there has not been a demonstrated need to expand this review and we note this because other agencies who have subjected readmissions to review have tended to reduce these reviews over the last year.

I. Subpart 10 under 9500.1130 (Reimbursement Procedures) discusses reimbursement to an out-of-area hospital. While we have no problem with the language currently introduced in these proposed rules and have not indicated in the past that there was a problem, we believe that some time in the immediate future the Department needs to consider this subparagraph in light of the problems Minnesota hospitals are having with other states Medical Assistance programs. We believe this is necessary because there is some tendency for one state to look at another state's reimbursement of the former state's hospitals and attempt to put in the same type of regulations, creating a situation where "If you don't treat my hospitals right, I won't treat your hospitals right." As a tertiary care hospital, UMHC believes that an intelligent and thoughtful discussion needs to occur to determine the appropriate way to reimburse out-of-area hospitals, especially in border situations, and that this review and discussion should be on the part Medical Assistance programs on both sides of the border.

At this time, these are all the comments and concerns we have related to the proposed rules of December 1. If we can answer any further questions or concerns you have in relation to the comments above, please feel free to contact me (626-3190).

Sincerely,

Daniel F. Rode

Daniel F. Rode
Associate Director, UMHC
Finance Division

DFR/jes

cc: JoAnn Kramer, UMHC

minnesota hospital association

REPRESENTING NONPROFIT HOSPITALS

December 23, 1986

Juli Menssen
Director, Hospital Rates
444 Lafayette Road
4th Floor
St. Paul, MN 55101

Dear Juli,

I have identified several problem areas within the Proposed Rules relating to hospital Medical Assistance Reimbursement.

9500.1100 Definitions

Subp. 21a. Foreseeable Complication. The definition lacks clarity. The predictability of a complication is, in most cases, a function of hindsight. I think that without exception, a medical complication could have been foreseen with the information available after the fact. Current medical standards do not have a set or series of characteristics which would designate a complication as foreseeable. Without these guidelines, the hospital is at risk for every transferred patient that develops a complication. I would recommend that "reasonably" be inserted into the language to add clarity.

> Subp. 21a. Foreseeable Complication. "Foreseeable Complication" means a complication that can be reasonably predicted from a recipient's medical history and by a physician using a standard of practice accepted by the medical community.

Subp. 42. Readmission. The deletion of the reference to a diagnosis category opens all readmissions for review. Section 9500.1130, Subp. 8, Reimbursement for Readmission, reinstates the qualification for a condition unrelated to the previous admission. Can the Department monitor all cases which have a readmission within 7 days, and what documentation is necessary to ensure that these cases will be properly identified in the medical records?

2221 UNIVERSITY AVENUE SE, SUITE 425 • MINNEAPOLIS, MINNESOTA 55414-3085 • PHONE (612) 331-5571

I would recommend that the language limit the review to those discharges which have the same diagnosis, ie, leave the definition as it is with the additional language added.

Subp. 45. Relative Value. The definition could be clarified by changing the language from "in relation to",to "divided by".

9500.1110. Determination and Publication of Relative Value of Diagnostic categories.

Subp. 1.E. The assignment of DRG's should be based upon the most current GROUPER available. The language seems to indicate that intent, but adds a stipulation that; "provided that the system of DRG assignment used must be used exclusively and uniformly". If the Medicaid system uses a GROUPER different than Medicare, both confusion and cost to the hospital will be the end result. I would suggest that additional clarification can be achieved by deleting "providing that".

> E. Assign each admission identified in item B to the appropriate diagnostic related group under Medicare using the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by Medicare, the system of DRG assignment used must be used exclusively and uniformly throughout all computations of rates and adjudications under parts 9500.1090 to 9500.1155;

9500.1125 Determination of Categorical Rate Per Admission for a Minnesota Hospital.

Subp. 1 Pass-through Cost Reports. The requirement to submit total admissions broken down into AFDC and non-AFDC cannot currently be accomplished by hospitals. They do not gather medical assistance information in that detail. Some hospitals identify MA and GAMC admissions but most do not split out the AFDC patients. Recognizing the Department's need for this information, I would recommend that the rule be applied to future reporting and that a bulletin explaining this requirement be sent out to hospital providers as soon as possible.



Subp. 4.D. The Determination of Allowable Medical Malpractice Insurance Cost will be understated using the section quoted in the rule.

> D. Determine the allowable medical assistance share of malpractice insurance cost, using HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

Because of the changes in how medical malpractice costs are being treated by Medicare it is difficult to identify the specific sections within the worksheet. I would suggest additional language to clarify this section.

> D. Determine the allowable medical assistance share of malpractice insurance cost, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

Subp. 6. Effective date. The effective date stated here is confusing. It seems to imply that these rates become effective on the date the rule becomes final. Minnesota Law, Chapter 420, requires that the changes anticipated in the rule become effective for claims paid after August 1, 1985. I would suggest amending the section to include the actual statutory language.

9500.1130 Reimbursement Procedures.

Subp. 6. Medicare Crossover Claims. The deletion of the phrase "(amounts for services covered by medical assistance but not by Medicare)" removed from payment those services paid through Medicaid but not covered by Medicare. The rule does not address how these services will be paid. I would recommend that this language be retained.

Subp. 7.B. (1) This section of the rule should be amended to add clarity to the definition of forseeable complication. As stated previously, the need for some statement of reasonableness is necessary.

> (1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a reasonably forseeable complication of the original diagnoses; or



9500.1135 Disproportionate Population Adjustment.

Subp.1. The paragraph addressing redetermination should be consistent in its application. As it is written, there are various methods to accomplish the redetermination. I would recommend that the Department's own claim date be used.

> The Department may redetermine disproportionate population adjustments using its own claims payments data.

I hope that these comments will assist you in the modification of the rule.

Sincerely,

Vern

Vern Silvernale
Vice President
Health Care Finance

VS:cj



St. Paul·Ramsey
Medical Center

Executive Offices
640 Jackson Street, St. Paul, Minnesota 55101 • 612/221-2191

December 30, 1986



Ms. Juli Menssen
Director, Hospital Rates
444 Lafayette Road - 4th floor
Space Center
St. Paul, MN 55101

Dear Ms. Menssen:

On behalf of St. Paul-Ramsey Medical Center, the following comments are submitted regarding the proposed rules relating to hospital reimbursement for Medical Assistance as published in the December 1, 1986, issue of the State Register, beginning at Page 975.

Directing your attention to Section 9500.1100 (Definitions), and particularly to Subpart 21a, we would suggest that the word "reasonably" be inserted after the words "a complication that can be" and prior to the word "predicted". The predictability of a complication is a function of hindsight. Certain complications can be reasonably predicted at the time of diagnosis. For example, certain specific complications can be assumed and predicted once a diagnosis of diabetes is made. However, many other illnesses do not present this predictability. The current rule would penalize a hospital because it does not limit the predictability to those conditions or complications which can reasonably be predicted at the time of initial diagnosis.

Directing your attention to Subpart 42 related to "readmissions", the proposed rule does not differentiate between whether the readmission occurs to the same facility or whether the patient has presented himself/herself at a different facility. Unless the second facility is given accurate information, the second facility would not know that this is a readmission. The present rule would penalize the second facility for a readmission due to the patient and not to the facility.

Directing your attention to Subpart 45 defining "relative value", we would suggest that the language could be clarified by striking the words "in relation to" and substituting the language "divided by".

Directing your attention to Proposed Rule 9500.1125, Subpart 1, relating to pass-through cost reports, the requirement that the facility provide information for a current year and a budget year is requesting data which the hospitals do not have. The information requested would be purely conjectural. In contrast, we might be able to provide you with data as to a prior year (actual). However, this type of data would not exist for a current year or a budget year.

Directing your attention to Rule 9500.1125, Subpart 6, relating to the "effective date" of the rules, it appears that clarification of the language is in order. The original rules were effective August 1, 1985. If the amended language is retroactive to August 1, 1985, it should state so clearly. The proposed language can arguably be interpreted as being effective when the amended rule takes effect. Clearly, that is not the intent of the Commissioner, nor of the Legislature. The legislative intent was clear to make these changes retroactively effective to August 1, 1985. This language needs to be clarified.

Directing your attention to Proposed Rule 9500.1130 (Reimbursement Procedures), Subpart 6, relating to calculation of reimbursement for Medicare cross-over claims, we believe you have erroneously deleted the language "plus amounts for services covered by Medical Assistance but not by Medicare". As written, the proposed rule would eliminate reimbursement to the facility for these services. The alternative to restoring the stricken language would be to create a separate Medical Assistance eligible classification for those individuals not covered by Medicare.

Directing your attention to Proposed Rule 9500.1130, Subpart 7 (B)(1), the concept of "reasonably foreseeable complication" should be inserted for the same reasons that the word "reasonably" needs to be inserted in Rule 9500.1100, Subpart 21a.

Directing your attention to Proposed Rule 9500.1130, Subpart 8, we would suggest that additional language be added regarding reimbursement for readmissions. Specifically, the proposed rule does not address the situation in which a patient leaves Against Medical Advice (AMA) or alternatively, leaves the facility in order to postpone or reevaluate the need for a procedure. Under any of these circumstances you may have a readmission to the same facility for the same diagnosis. The present proposed rule would penalize the facility for this type of readmission.

Directing your attention to Proposed Rule 9500.1135, Subpart 1, relating to determination of disproportionate population adjustment, we would like to bring to your attention the

significant impact which the proposed rule would have on St. Paul-Ramsey Medical Center due to the existence of the RamseyCare program established between the Medical Center, Ramsey County, and the State Department of Human Services. As you are aware, during 1986 the Commissioner developed a pilot program with St. Paul-Ramsey Medical Center for prepaid health services for GAMC recipients. This program has been denominated as RamseyCare. The proposed rule would exclude admissions of "participants in a prepaid health plan". This would be applicable to admissions of RamseyCare patients. Were it not for the fact that the RamseyCare program has been established, these admissions would be reimbursed as GAMC admissions. The existence of this pilot program does not change the economic eligibility of these individuals for Medical Assistance. The proposed rule should be changed to reflect this type of program. It is our understanding that this would also impact pilot programs in Hennepin County and St. Louis County.

Thank you for your consideration of these comments.

Yours truly,

David Fortney

David M. Fortney
Vice President - Law

DMF/lh
00371

In the Matter of the Adoption
of the Rule of the State Department
of Human Services Governing Hospital
Medical Assistance and General Assistance
Medical Care Reimbursement, parts
9500.1090 to 9500.1155

DECLARATION OF
COUNSEL

I, Gail Olson, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0866.

Gail Olson

Special Assistant
Attorney General

Dated: February 13, 1987

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICES RULES GOVERNING INPATIENT HOSPITAL REIMBURSEMENT UNDER MA AND GAMC, PARTS 9500.1090 TO 9500.1155

CERTIFICATE

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1a, and 14.22 or 14.30, that their names be placed on the State Department of Human Services rulemaking mailing list is accurate, complete, and current as of this 25th day of November, 1986.

Nancy Storlie

12/13/87

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
444 LAFAYETTE ROAD
ST. PAUL, MINNESOTA 55101

TO: Rita Desmond
Legal Assistant
Attorney General's Office, Administrative Division

FROM: Michael Dean

SUBJECT: Review of a Rule Adopted Without a Public Hearing; Hospital Medical Assistance and General Assistance Medical Care Reimbursement, Minnesota Rules, parts 9500.1090 to 9500.1155.

Enclosed are the documents required to be submitted under Minnesota Rules, part 2010.0300 for your review of a rule adopted without a public hearing for the above entitled matter.

Official documents in this submitted material include:

1. A copy or photocopy of the notice of solicitation of outside information or opinions as published in the State Register.

2. A copy of the proposed rule with a certificate of approval as to form by the revisor of statutes attached.

3. The notice of intent to adopt a rule without a public hearing as mailed.

4. The statement of need and reasonableness in support of the proposed rule complying with part 2010.0700.

5. The affidavit of mailing the notice of intent to adopt a rule without a public hearing. The affidavits state that the mailing list maintained by the agency pursuant to Minnesota Statutes, sections 14.22 and 14.14, subdivision 1a is accurate, complete, and current and that the notice of intent to adopt the rule without a public hearing was mailed to all persons and groups whose names appear on the list.

6. A copy or photocopy of the notice of intent to adopt the rule without a public hearing as published in the State Register.

7. Four copies of the rule as adopted. Any modification made to the proposed rule is reflected on the rule as adopted and is approved as to form by the revisor of statutes.

8. The findings of fact, conclusions, and order adopting the rule.

9. All written requests, submissions, or comments on the rule received by the agency except requests solely for copies of the rule or of the statement of need and reasonableness.

10. The declaration of the attorney in the attorney general's office who represents the agency.

11. No requests to be notified of submittal of the rule to the Attorney General.

12. The affidavit of mailing notice of submission of the rule to the attorney general, if applicable.

If you have any questions on this submitted material, please call me at 297-1488.

NOTE: Also included for your convenience is one document that is not required. This document is the handwritten changes that were submitted to and approved by the revisor of statutes. The page and line numbers on the findings of fact coincide with the page and line numbers on the adopted rule with the handwritten changes.

Notice of Intent

No Small Business Statement

Rule

256.969 (subd 6) ok
laws of Minn, 1986 ch 420 § 6

P1 Line 23 "medically needy" (P3 line 15 ^ Definition)
p1 Line 34-35 "needy families"
p2 line 6 "trim points" What Are they ? } Definition p 5 ℓ 11-13
p2 Line 17 " " " " }
p4 " 14, 18 " " " "

Boring !

Department of Human Services

Adopted Rules Relating to Hospital Medical Assistance and General Assistance Medical Care Reimbursement

Rules as Adopted

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for inpatient hospital services provided under the ~~hospitals that participate in and are reimbursed by~~ medical assistance.

All provisions of parts 9500.1090 to 9500.1155, except part 9500.1155, subpart 5, shall apply to general assistance medical care substituting the terms and data for general assistance medical care for the terms and data referenced for medical assistance.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

9500.1100 DEFINITIONS.

Subpart 1. to 3. [Unchanged.]

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy families with dependent children.

Subp. 5. **Allowable base year cost per admission.** "Allowable base year cost per admission" means a hospital's base year reimbursable inpatient hospital cost per admission that is adjusted for case mix, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. [Unchanged.]

Subp. 7. **Appeals board.** "Appeals board" means the board that advises the commissioner on a hospital's request for adjustments to reimbursements made under the prospective reimbursement system.

Subp. 8. [Unchanged.]

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. to 11. [Unchanged.]

Subp. 12. **Categorical rate per admission.** "Categorical rate per admission" means the [(adjusted base year cost per admission multiplied by the budget year hospital cost index and multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. to 19. [Unchanged.]

Subp. 20. **Diagnostic categories.** "Diagnostic categories" means the classification of inpatient hospital services according to the diagnostic related groups (DRGs) under medicare with adjustments as follows:

Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A. to JJ. [Unchanged.]	

Subp. 21. [Unchanged.]

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards of practice accepted by the medical community.

Subp. 22. to 24. [Unchanged.]

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. to 29. [Unchanged.]

Subp. 30. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. to 33. [Unchanged.] See INSERT B A

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. to 38. [Unchanged.]

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to 9505.5030 and 9505.5105.

Subp. 40. [Unchanged.]

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission that occurs within seven days of a discharge of the same

INSERT 5A

Subp. 32. Medicare crossover claims. "Medicare crossover claims" means information contained on the inpatient hospital invoices submitted to the department on forms or computer tape by a hospital to request reimbursement for medicare eligible inpatient hospital services provided to a recipient who is also eligible for medicare.

recipient.

Subp. 43. [Unchanged.]

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. [Unchanged.]

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all the diagnostic categories on a statewide basis.

Subp. 46. [Unchanged.]

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. [Unchanged.]

Subp. 49. **Total reimbursable costs.** "Total reimbursable costs" means the costs identified in a hospital's base year medicare/medical assistance cost report, Health Care Financing Administration (HCFA) Form 2552, 1981 revision, Worksheet A, column 7, line 84. The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. [Unchanged.]

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. to C. [Unchanged.]

D. determine reimbursable inpatient hospital costs for each hospital's admissions for state fiscal years 1983 and 1984 using each hospital's base year data from the HCFA Form 2552 Worksheet, 1981 revision according to subitems (1) to (4):

(1) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) determine the cost of ancillary services by multiplying the ancillary charges for each admission identified in item B by the appropriate cost-to-charge ratio from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(3) and (4) [Unchanged.]

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using a version of the Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment Software distributed and developed by DRG Support Group Limited, a subsidiary of Health Systems International, Incorporated, or the system in use by medicare, provided that the system of DRG

assignment used must be used exclusively and uniformly throughout all ~~computations~~ determinations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. and G. [Unchanged.]

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's ~~diagnostic category day outlier~~ trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through ~~the~~ start ~~diagnostic category day outlier~~ trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital costs for all admissions less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions including outliers;

K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic category less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category including outliers; and

L. determine the relative value for each diagnostic category by dividing item K by item J.

Subp. 2. and 3. [Unchanged.]

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

To determine the allowable base year cost per admission the department shall:

A. [Unchanged.]

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, items H and I, and

(2) pass-through costs, except malpractice insurance costs, apportioned to medical assistance based on the ratio of reimbursable inpatient hospital costs as adjusted in subitem (1) to total reimbursable costs;

C. divide the reimbursable inpatient hospital costs as adjusted in item B by the number of base year admissions in each hospital including outliers;

D. adjust item C for case mix as follows:

(1) [Unchanged.]

(2) multiply the hospital's number of base year admissions within each diagnostic category including outliers by the relative value of that diagnostic category,

(3) [Unchanged.]

(4) divide the sum from subitem (3) by the number of base year admissions including outliers, and

(5) [Unchanged.]

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's budget year, the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance ~~AFDC~~ admissions, ~~and total Medical Assistance non-AFDC admissions~~ and total general assistance admissions. V Pass-through cost reports must include actual data for the prior year and budgeted data for the current and budget years. Pass-through cost

INSERT AA1

INSERT AA1

A pass-through cost report for a hospital budget year that begins on or after July 1, 1987 must separate Medical Assistance admissions data into AFDC or non-AFDC admissions data.

reports are due 60 days before the start of each hospital's budget year and must include the following information:

	Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A.	Pass-through costs			
(1)	Depreciation			
(2)	Rents and leases			
(3)	Property taxes			
(4)	Property insurance			
(5)	Interest			
(6)	Malpractice insurance			
(7)	Total Pass-Through Costs (Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to item A, as determined by medicare. Pass-through costs do not include costs derived from capital projects requiring a certificate of need for which the required certificate of need has not been granted.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to ~~medicare~~ medical assistance. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/~~medicaid~~ medical assistance cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

Subp. 2. **Determination of budget year pass-through cost per admission.** The department shall determine the budget year pass-through cost per admission from the submitted pass-through cost report as specified in subpart 1 as follows:

Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A. Ratio of reimbursable inpatient hospital costs as determined in part 9500.1115, item A to total reimbursable costs			
B. Pass-through costs as specified in subpart 1, item A, subitem (7), multiplied by item A			
C. Number of Medical Assistance admissions including outliers			
D. Pass-through cost per admission (item B divided by item C)			

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category), plus the budget year pass-through cost per admission]

Subp. 4. **Pass-through cost adjustment.** After the end of each budget year, the commissioner shall redetermine the budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This ~~computation~~ determination produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as ~~computed~~ determined in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. Determine ~~Compute~~ the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs ~~computed~~ determined in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted per-admission pass-through cost used in paying claims for inpatient hospital services during the year for which the adjustment is being calculated. ~~This computation produces the actual value of the pass-through cost payments made during the year~~.

G. Subtract the amount ~~actual value of the medical assistance pass-through cost payments during the completed year~~ ~~computed~~ determined at item ~~F)~~ from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be ~~payed~~ paid by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts

owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the ~~61st~~ 6th day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [See Repealer.]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

Subp. 2. **Payment of recapture of depreciation to commissioner.** A hospital shall pay the commissioner the recapture of depreciation within 60 days of written notification from the commissioner.

Interest charges must be assessed on the recapture of depreciation due the commissioner outstanding after the deadline. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. [Unchanged.]

Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement by the department.

Subp. 3. **Reimbursement in response to submitted claims.** The department will reimburse a hospital for inpatient hospital services only after processing that hospital's properly submitted claim. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. and 5. [Unchanged.] SEE INSERT A1

Subp. 6. **Medicare crossover claims.** Medicare crossover claims shall be reimbursed as follows:

Medicare Crossover Reimbursement	=	Medicare deductibles, plus Medicare coinsurance less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

Transfer Reimbursement	=	[{(The product of the adjusted base year cost per admission ~~multiplied~~ and by the budget year HCI ~~and~~ multiplied by the relative value of the appropriate diagnostic category, divided by the arithmetic

INSERT A1

Subp. 4. Adjustment to reimbursement. Reimbursements shall be adjusted by the department for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be by debit.

mean length of stay of the diagnostic category) and multiplied by the number of days of inpatient hospital services}, plus the budget year pass-through cost per admission]

In no case of a transfer may a hospital receive a reimbursement that exceeds the applicable categorical rate per admission, or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for outlier reimbursements under subpart 9.

A hospital that admits a transferred recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services.

Subp. 8. Reimbursement for readmissions. An admission and

readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if eligible. The combined stay of the admission and readmission shall be used to determine ~~qualification~~ eligibility for outlier ~~payment~~ reimbursement. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission INSERT A B. An admission and subsequent readmission to a different hospital shall be reimbursed as specified under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission INSERT A B

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA hospital that does not have admissions in the base year, plus an amount for outliers as follows:

A. To determine reimbursements for day outliers the department shall:

(1) multiply a hospital's adjusted base year cost per admission by the budget year HCI and by the relative value of the appropriate diagnostic category;

(2) divide the product in subitem (1) by the arithmetic mean length of stay for the diagnostic category;

(3) [Unchanged.]

INSERT B

out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and Non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission.

(4) subtract the day outlier trim point for the appropriate diagnostic category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) [Unchanged.]

B. To determine reimbursements for cost outliers the department shall:

(1) determine a statewide base year cost-to-charge ratio according to hospitals' statewide base year medicare/medical assistance cost reports for all medical assistance admissions combined;

(2) [Unchanged.]

(3) subtract the cost at three standard deviations for diagnostic category W, under part 9500.1100, subpart 20 and at one standard deviation for diagnostic category O, under part 9500.1100, subpart 20 as identified in part 9500.1110, subpart 1, item ~~G~~ H from the adjusted cost from subitem (2); and

(4) multiply the ~~amount~~ difference determined in subitem (3) by 60 percent for diagnostic category W, under part 9500.1100, subpart 20 or by 80 percent for diagnostic category O, under part 9500.1100, subpart 20.

C. If an admission is a day and a cost outlier, a hospital shall receive reimbursement as a day outlier.

Subp. 10. Reimbursement to an out-of-area hospital. The department shall reimburse ^on out-of-area hospitals ^for an admission based on the lesser of billed charges ^for the admission or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each hospital statewide by that hospital's HCI and by the number of admissions in that hospital's base year, including outliers;

B. sum the products in item A;

C. divide the sum from item B by the sum of all admissions for all hospitals statewide, including outliers, to determine the statewide budget year adjusted allowable base year cost per admission;

D. multiply the pass-through cost per admission in effect on the first day of a calendar year for each hospital statewide by the number of admissions in each hospital's base year, including outliers;

E. sum the products in item D;

F. divide the sum from item E by the sum of all admissions for all hospitals statewide, including outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission	=	[(statewide budget year adjusted base year cost per admission multiplied by the relative value of the appropriate diagnostic category), plus statewide budget year pass-through cost per admission]

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year.** The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

A. Multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of the admissions for all MSA hospitals statewide, including outliers, to determine the statewide allowable base year cost per admission for MSA hospitals.

D. The budget year pass-through cost per admission must be determined according to part 9500.1125, subpart 2. The

pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and must be subject to part 9500.1125, subpart 4, item H.

E. Determine the categorical rate per admission for MSA hospitals statewide as follows:

Categorical Rate per Admission for MSA Hospitals Statewide That Do Not Have Admissions In The Base Year	=	[(adjusted base year cost per admission for MSA hospitals statewide multiplied by the budget year HCI and multiplied by the relative value of the appropriate diagnostic category) plus budget year pass-through cost per admission]

F. [Unchanged.]

Subp. 12. [Unchanged.]

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. Determination of disproportionate population adjustment. The department shall increase the adjusted base year cost per admission for hospitals whose medical assistance and general assistance medical care admissions during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions, ~~according to the schedule below~~.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are MA and GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage

	point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

The department shall multiply the disproportionate population adjustment by the adjusted base year cost per admission after the application of any statutory limits to the growth in hospital rates or unit costs.

Subp. 2. [Unchanged.]

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

Subpart 1. to 4. [Unchanged.]

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

Subpart 1. to 5. [Unchanged.]

Subp. 5a. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items

A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. [Unchanged.]

REPEALER. Minnesota Rules, part 9500.1125, subpart 5 is repealed.