

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

November 20, 2018

Marie Zimmerman
State Medicaid Director
Minnesota Department of Human Services 540 Cedar Street
P.O. Box 64983
St. Paul, MN 55164-0983

RE: Minnesota State Plan Amendment (SPA) 18-0009

Dear Ms. Zimmerman:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0009. Effective for services on or after August 1, 2018, Minnesota 18-0009 revises methodologies and standards for Inpatient Hospital rates. Specifically, this amendment proposes a one-time adjustment to a supplemental payment provided to certain safety-net hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 18-0009 is approved effective August 1, 2018. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,



Kristin Fan
Director

Enclosure

STATE: MINNESOTA
Effective: August 1, 2018
TN: 18-09

ATTACHMENT 4.19-A
Inpatient Hospital
Page 1

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**Methods and Standards for Determining Payment Rates for Inpatient
Hospital Services Provided by Non-State Owned Facilities**

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SECTION 1.0 PURPOSE AND SCOPE

The Minnesota inpatient hospital payment system for the Medical Assistance Program is authorized by state statute. Payment rates for rehabilitation and most other large hospitals are based on the 3M All Patient Refined Diagnosis Related Grouper (APR-DRG) to reflect a per discharge payment schedule. Additional rate methodologies are established for critical access hospitals (CAH) and long-term hospitals.

Rates for the other payment methodologies are based on the cost finding principles of the Medicare program in the base period. The rates are established for each rate period year using hospital specific Medical Assistance claims and cost data.

To be eligible for payment, inpatient hospital services must be medically necessary, and if required, have the necessary prior approval from the Department.

Minnesota has in place a process for public comment that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SECTION 2.0 DEFINITIONS

Accommodation service. "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. They are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency units.

Adjusted base year operating cost. "Adjusted base year operating cost" means a hospital's allowable base year operating cost adjusted by the hospital cost index.

Admission. "Admission" means the time of birth at a hospital or the act that allows a recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Allowable base year operating cost. "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per discharge, admission or per day that is adjusted for case mix and excludes property costs.

Ancillary service. "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical

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dependency services customarily charged in addition to an accommodation service charge.

Base year. "Base year" means a hospital's fiscal year or years that is recognized by Medicare, or a hospital's fiscal year specified by the Commissioner if a hospital is not required to file information with Medicare from which cost and statistical data are used to establish rates.

Charges. "Charges" means the usual and customary payment requested by the hospital of the general public.

Cost outlier. "Cost outlier" means a claim with significantly higher costs.

Cost-to-charge ratio (CCR). "Cost-to-charge ratio" means a ratio of a hospital's allowable inpatient hospital costs to its allowable charges for inpatient hospital services, from the appropriate Medicare cost report.

Critical Access Hospital. "Critical access hospital" means inpatient hospital services that are provided by a hospital designated by Medicare as a critical access hospital.

Diagnostic categories. "Diagnostic categories" means the assignment of all patient-refined diagnosis-related groups (APR-DRGs). The DRG classifications must be assigned according to the base year discharge for inpatient hospital services under the APR-DRG, rehabilitation, and long term hospital methodologies.

Discharge. "Discharge" means the act that allows a recipient to officially leave a hospital.

Fixed-loss amount. "Fixed-loss amount" means the amount added to the base DRG payment to establish the outlier threshold amount. For rates set using 2012 as the base year, the fixed loss amount is \$70,000 dollars.

Frontier State. "Frontier state" means a state where at least 50 percent of the counties have a population density of less than six people per square mile.

Frontier State Adjustment. The frontier state adjustment is a provision of the Affordable Care Act that requires CMS to adopt a hospital wage index that is not less than 1.0 for hospitals located in frontier states.

Healthcare Cost and Utilization Project (HCUP). "HCUP" is a family of health care databases and related tools for research and decision making. HCUP is sponsored by the Agency for Healthcare Research and Quality. It is the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988.

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Hospital-acquired condition. “Hospital-acquired condition” means a condition represented by an ICD-9-CM or ICD-10-CM diagnosis code, that is listed on the Centers for Medicare and Medicaid Services annual hospital-acquired conditions list that is not identified by the hospital as present on admission and is designated as a complicating condition or major complicating condition.

Hospital outlier index. “Hospital outlier index” means a hospital adjustment factor used to calculate outlier payments to prevent the artificial increase in cost outlier payments from the base year to the rate year resulting from charge or cost increases above the Medicare estimated projected increases.

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare including direct and indirect medical education costs.

Inpatient hospital service. "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital. This includes outpatient services provided by the same hospital that directly precede the admission.

Labor-related share. “Labor-related share” means an adjustment to the payment rate by a factor that reflects the relative differences in labor costs among geographic areas.

Local trade area hospital. "Local trade area hospital" means a hospital that is located in a state other than Minnesota, but in a county that is contiguous to the Minnesota boarder.

Long-term hospital. “Long-term hospital” means a Minnesota hospital or a local trade area hospital that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

Marginal cost factor. “Marginal cost factor” means a percentage of the estimated costs recognized above the outlier threshold amount. For rates set using 2014 as the base year, the marginal cost factor is 50 percent for DRGs with a severity of illness factor of 1 or 2 and 62.5 percent for DRGs with a severity of illness factor of 3 or 4.

Metropolitan statistical area hospital or MSA hospital. "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a hospital that is not located in a

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Metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means all allowable operating costs.

Outlier threshold amount. "Outlier threshold amount" is equal to the sum of the hospital's standard payment rate and the fixed-loss amount.

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota, and is not a local trade area hospital.

Policy Adjuster. "Policy adjuster" means an adjustment made to a specific range or subset of APR-DRGs based on category of service, age, or hospital type to allow for a payment adjustment to the specific APR-DRG claims.

Property Costs. "Property Costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes and property insurance.

Policy Adjustment Factor. "Policy adjustment factor" means the base value of the specific policy adjuster as adopted by the Department.

Provider-Preventable Condition. "Provider-Preventable Condition" means a condition identified by the state for non-payment under Section 5.a. of Attachment 4.19-B which includes:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient.

In compliance with 42 CFR 447.26(c), the State provides:

1. That no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. That reductions in provider payment may be limited to the extent that the following apply:
 - a. The identified PPC would otherwise result in an increase in payment.
 - b. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.
 - c. Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

Rate year. "Rate year" means a state fiscal year from July 1 through June 30 in which the

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discharge occurred.

Rehabilitation Hospital. "Rehabilitation hospital" means inpatient hospital services that are provided by a hospital or unit designated by Medicare as a rehabilitation hospital or rehabilitation distinct part. The term rehabilitation hospital encompasses rehabilitation hospitals and rehabilitation distinct parts.

Relative value. "Relative values" are weighted adjustments applied to the APR-DRG to reflect the resources required to provide a given service. The relative values of APR-DRG hospitals and rehabilitation hospitals are based on APR-DRG "standard" national weights, developed by 3M based on Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (NIS) discharge data.

Seven-county metropolitan area. "Seven-county metropolitan area" includes the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Severity of Illness. "Severity of illness" (SOI) means the extent of physiologic decompensation or organ system loss of function the extent of which is noted by the four distinct subclasses: 1 - Mild; 2 - Moderate; 3 - Major; 4 - Extreme. The higher SOI subclasses reflect higher utilization of hospital resources and are generally expected to incur greater costs.

Transfer. "Transfer" means the movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation hospital.

Transitional Period. "Transitional period" applies to the initial period of time for APR-DRG Hospitals in Minnesota or local trade areas for discharges occurring on or after November 1, 2014 until the next re-basing.

Upper Payment Limit Demonstration Year. "Upper payment limit demonstration year" means the four consecutive quarters for which the upper payment limit demonstration was calculated.

Wage Index. "Wage index" means an adjustment to compensate for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. For areas with frontier state status the "Pre-floor Wage Index" is used.

SECTION 3.0 MEDICAL ASSISTANCE COST REPORTS

All Minnesota and local trade area hospitals receiving a disproportionate population adjustment

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payment, and all hospitals classified as a Critical Access Hospital must annually submit a Medical Assistance cost report within six months of the end of the hospital's fiscal year. The Department shall suspend payments to any hospital that fails to submit the required cost report. Payments will remain suspended until the report is filed with, and accepted by, the Department.

SECTION 4.0 ALL PATIENT-REFINED DIAGNOSIS-RELATED GROUP (APR-DRG) HOSPITALS

4.01 Establishment of base years.

Effective for discharges occurring on or after November 1, 2014, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012.

The rebasing in 2014 will be budget neutral, to ensure that the total aggregate payments under the rebased system are equal to the total aggregate payments made for the same number and types of services in the base year. Existing applicable rate increases or decreases applied to the hospitals being rebased during the entire base period will be incorporated into the budget neutrality calculation.

Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. Changes in costs between base years shall be measured using the lower of the hospital cost index, or the percentage change in the case mix adjusted cost per claim. The base year for each rebasing period is established by considering the most recent year for which filed Medicare cost reports are available.

4.02 Determination of relative values. The APR-DRG relative values of the diagnostic categories will be based on the "standard" national weights developed by 3M utilizing the HCUP NIS discharge data applicable to the base year.

4.03 Statewide Standardized APR-DRG amount. The statewide, standardized amount is set such that aggregate, simulated new APR-DRG system-payments are equal to aggregate DRG model-claim, allowed amounts under the DRG system in effect in each base year plus the applicable inflation factor. For rates effective July 1, 2017, the model claims data will be CY 2014. The wage index and labor portions are based on factors in the FFY 2016 Medicare Inpatient Prospective Payment System (IPPS). The wage indices include provider-specific reclassifications in the FFY 2016 Medicare IPPS, but do not include the frontier state adjustment in their FFY 2016 Medicare IPPS wage index.

4.04 Wage-adjusted Base Rate. APR-DRG wage-adjusted base rates are calculated using a statewide standardized amount with the labor percentage adjusted by the applicable Medicare

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IPPS wage index for the rate year. MSA hospitals use the standard wage index.
Non-MSA hospitals use the rural wage index, but the Frontier State adjustment is not applied.

Wage-adjusted Base Rate =	(Statewide standardized APR-DRG amount multiplied by the labor percentage, multiplied by the applicable wage index) plus the (Statewide standardized APR-DRG amount multiplied by (1.0 minus the labor percentage))
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A. Labor portion:

- (1) Determine the Statewide standardized APR-DRG amount for the discharge
- (2) Multiply by the product of the labor percentage and the applicable wage index

B. Non-labor portion:

- (1) Determine the Statewide standardized APR-DRG amount for the discharge
- (2) Multiply by the difference between one and the labor percentage

C. Sum the results of A and B.

SECTION 4.1 POLICY ADJUSTMENT FACTOR

Policy Adjustment factors are category-specific adjustments made to the payment. They are defined in terms of APR-DRG Base Groupings and include all SOI Categories. Policy Adjustment factors have a base value of 1.0 unless an adjustment factor has been adopted and indicated below by the Department.

Effective for the discharges on or after November 1, 2014, policy adjustments are applied to the following APR-DRG categories:

A. Mental Health: 740, 750, 751,752, 753, 754, 755, 756, 757, 758, 759,760

- A policy adjustment factor of 2.20 will be applied when the SOI is equal to one .
- A policy adjustment factor of 2.25 will be applied with the SOI is equal to two.
- A policy adjustment factor of 1.90 will be applied when the SOI is equal to three.
- A policy adjustment factor of 1.90 will be applied when the SOI is equal to four.

B. Neonate: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 630, 631, 633, 634, 636, 639, 863

C. Normal New Born: 626, 640

- A policy adjustment factor of 1.25 will be applied to deliveries without medical

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complications.

D. Obstetrics – Vaginal Deliveries: 560

- A policy adjustment factor of 1.35 will be applied to vaginal deliveries in a hospital located outside the seven-county metro area.
- A policy adjustment factor of 1.15 will be applied to vaginal deliveries in a hospital located within the seven-county metro area.

E. Obstetrics Cesarean: 540

- A policy adjustment factor of 1.15 will be applied to cesarean deliveries.

F. Obstetrics Other: 541, 542, 544, 545, 546, 561, 563, 564, 565, 566

- A policy adjustment factor of 1.15 will be applied for obstetrics services, other than child birth.

G. Transplant: 001, 002, 003, 006, 440

H. Trauma: 020, 055, 135, 308, 384, 910, 911, 912

I. Rehabilitation: 860

- A policy adjustment factor of 1.50 will be applied to rehabilitation services.

J. Other Pediatric: all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and provided in a Children's hospital

- A policy adjustment factor of 1.15 will be applied regardless of SOI.

K. Other Pediatric all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and not provided in a Children's hospital

- A policy adjustment factor of 1.15 will be applied regardless of SOI.

L. Other Adult all other Base Groups with Age >18 years old

SECTION 4.2 TRANSITION ADJUSTMENT FACTOR

The transition adjustment factor is a provider-specific prospective value applied during the transitional period to ensure that a provider's aggregate simulated payments under rebased rates using base period claims data do not increase or decrease by more than five percent from aggregate base period payments.

SECTION 4.3 CALCULATION OF PAYMENT RATES

4.31 Standard Payment for Minnesota Hospitals

Standard Payment =	Wage-adjusted base rate, multiplied by the APR-DRG relative value, multiplied by the DPA factor, multiplied by the policy adjustment
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	factor
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- A. Calculate wage-adjusted base rate
- B. Multiply by the APR-DRG relative value
- C. Multiply by the policy adjustment factor
- D. Multiply by Disproportionate Population Adjustment factor

4.32 Standard Payment for Local Trade Area Hospitals

Standard Payment =	Wage-adjusted base rate, multiplied by the APR-DRG relative value, multiplied by the policy adjustment factor
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- A. Calculate wage-adjusted base rate
- B. Multiply by the APR-DRG relative value
- C. Multiply by the policy adjustment factor

4.33 Transfer Payment for Minnesota, Local Trade Area, and Out-of-area Hospitals

Transfer Payment =	(Standard payment, divided by the average length of stay for the APR-DRG discharge), multiplied by the (actual length of stay plus 1.0)
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- A. Divide the standard payment by the average length of stay for the APR-DRG
- B. Multiply by the sum of the actual length of stay plus 1.0

The value calculated in B cannot exceed the average length of stay for the APR-DRG. Average lengths of stay for APR-DRG discharges are listed in the HCUP data file. A hospital may not receive a transfer payment that exceeds the hospital's applicable standard payment rate unless that discharge is an outlier.

A discharge that immediately precedes an admission paid pursuant to Section 4.57 governing contracts for psychiatric services is ineligible for a transfer payment.

4.34 Outlier Payment for Minnesota Hospitals

Outlier Payment =	The applicable marginal cost factor multiplied by the DPA factor, multiplied by the difference between (allowable charges, multiplied by the hospital's overall cost to charge ratio) and the [(wage-adjusted base rate, multiplied by the relative value, multiplied by the policy
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	adjustment factor) plus the fixed loss amount]
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A. Calculate cost

- (1) Multiply allowable charges by the hospital's base year cost to charge ratio

B. Calculate facility outlier threshold amount

- (1) Multiply the wage-adjusted base rate by the relative value
- (2) Multiply the result in item (1) by the policy adjustment factor
- (3) Add the fixed loss amount to the result in item (2)

C. Subtract B from A.

- D. If the result in C is positive, multiply the difference by the applicable marginal cost factor and the DPA factor to determine the outlier payment. If result in C is negative, the outlier payment is zero.

4.35 Outlier Payment for Local Trade Area and Out-of-Area Hospitals

Outlier Payment =	The applicable marginal cost factor multiplied by the difference between (allowable charges, multiplied by the hospital's overall cost to charge ratio) and the [(wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor) plus the fixed loss amount]
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A. Calculate cost

- (2) Multiply allowable charges by the hospital's base year cost to charge ratio

B. Calculate the facility outlier threshold amount

- (4) Multiply the wage-adjusted base rate by the relative value
- (5) Multiply the result in item (1) by the policy adjustment factor
- (6) Add the fixed loss amount to the result in item (2)

C. Subtract B from A.

- D. If the result in C is positive, multiply the difference by the marginal cost factor to determine the outlier payment. If the result in C is negative, the outlier payment is zero.

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4.36 Out-of-area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor
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- A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
- B. Multiply by the relative value
- C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

4.37 Interim Payment Methodology

The Department shall pay an interim payment based on the methodologies existing prior to the rebasing effective July 1, 2017.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under an interim payment methodology.

4.38 Alternative Payment Methodology for Children's Hospitals

Effective for audit years following July 1, 2017, for each audit year in which the audit of the Disproportionate Share Hospital (DSH) payment requires the inclusion of days, costs, and revenues associated with patients who have private health care coverage and who are eligible for Medicaid, an alternative payment rate shall be calculated for Minnesota hospitals that are designated as Children's hospitals and enumerated as such by Medicare.

Alternative Payment =	Allowable Charges multiplied by the product of: The applicable base year cost-to-charge ratio and The cost coverage percentage for the applicable base year minus two percentage points.
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- A. Calculate Base Year Cost Coverage Percentage for each eligible hospital
 - (1) Multiply Base Year allowable charges by the hospital's Base Year cost-to-charge ratio to determine base year costs.
 - (2) Divide total Base Year Payments by total Base Year Costs as determined in (1).
- B. Reduce Base Year Payment to Cost Ratio
 - (1) Subtract two percentage points from the result of (A).
- C. Determine Payment Year Costs

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(1) Multiply Payment Year Allowable Charges by the Base Year cost-to-charge ratio for each eligible hospital.

D. Determine Final Payment Amount

(1) Multiply the result of (C) by the result of (B).

Allowable base year costs are limited to Medicare allowable costs for providing inpatient hospital services to patients enrolled in Minnesota Medicaid on a fee-for-service basis. Base year costs shall be determined using the most recent Medicare Cost Report available on the date that is two years after the beginning of the calendar year that is the base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods.

In any year in which a Children's hospital is paid using this alternative payment methodology, no payments under Section 8 shall be made to the hospital.

SECTION 4.4 Reserved

SECTION 4.41 RATE ADJUSTMENT

For hospitals located in Minnesota, the total payment, after third-party liability and spend down is increased by 2 percent.

SECTION 4.5 OTHER PAYMENT FACTORS

4.51 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

4.52 Reserved

4.53 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

4.54 Non-payment for hospital-acquired and provider-preventable conditions. No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

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4.55 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

4.56 Reserved

4.57 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with either serious emotional disturbance or serious and persistent mental illness, who have been civilly committed or voluntarily hospitalized, and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

- A. Parameters related to the acceptance of a proposal other than cost include:
 - (1) the quality of the utilization review plan;
 - (2) experience with mental health diagnoses; and
 - (3) the commitment process.

- B. Parameters related to acceptance of a proposal on a financial and cost basis include:
 - (1) payer of last resort/payment in full compliance assurances;
 - (2) general experience operating within the Medicare/Medical Assistance programs; and
 - (3) financial integrity.

- C. Voluntary hospitalizations are included in the contracts: If the attending physician

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indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

4.58 Medical Education and Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

4.59 Reserved

4.60 Additional adjustment for Certain Hospitals

Hennepin County Medical Center and Regions Hospital. Effective July 15, 2001, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment, in total for Hennepin County Medical Center and for Regions Hospital, will be made each year, after the close of the federal fiscal year, that is the difference between the non-State government-owned or operated hospital Medicare upper payment limit, as specified in Code of Federal Regulations, title 42, section 447.272, using Medicare payment methods for hospitals, and the non-State government-owned or operated hospital payments of this Attachment.

Effective for the payment attributable to the upper payment limit demonstration year 2010, and thereafter, out of the total available funding, payments to each of the two hospitals will be determined by:

- A. Calculating an upper payment limit for each of the hospitals receiving payment under this section using the same methodology applied to the entire group of non-State government-owned hospitals.
- B. Calculating a ratio for each of the hospitals receiving a payment under this section that is equal to:
 - (1) the difference between the upper payment limit for each hospital computed in A and total Medicaid payments to that hospital and, if positive,
 - (2) divided by the sum of the positive amounts of the differences between the upper payment limit and the Medicaid payments to each of the hospitals.

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- C. Applying the ratio computed in B to the difference between the upper payment limit for the non-State government-owned group of hospitals and total Medicaid payments to that group of hospitals.

The Department will make a one-time interim payment after the close of the 2018 federal fiscal year for payment years 2016, 2017, and 2018. The Department will then reconcile the interim payment for each payment year after calculating the total value of the payment adjustment for each payment year.

SECTION 5.0 RESERVED

SECTION 6.0 CRITICAL ACCESS HOSPITALS (CAH)

6.01 Establishment of base years.

Effective for discharges occurring on or after July 1, 2015, payment rates for services provided by critical access hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012. The base year will be updated (re-based) every two years to the most recent year for which filed, Medicare cost reports are available. The re-basing shall reflect changes in hospital costs between the existing base year and the next base year.

For every year that is not a re-basing year, payment rates shall be inflated using the Centers for Medicare & Medicaid Services' Inpatient Hospital Market Basket Index.

SECTION 6.2 CALCULATION OF PAYMENT RATES

6.21 Standard Payment for Minnesota and Local Trade Area Hospitals

Effective for discharges on or after July 1, 2015, payment rates shall be facility-specific, per diem payment rates. The per diem rates shall be based on a facility-specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March, 2014 for the cost report period ending in 2012. Effective for discharges on or after July 1, 2017, the per diem rates shall be based on a facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March 2016 for the cost report period ended in 2014. The calculated cost based rate shall be the final rate and will not be settled to actual, incurred costs.

Standard Payment =	Covered Days multiplied by facility-specific per diem rate.
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- A. Calculate a payment-to-cost ratio using allowable cost and revenue data from Medicare Cost Report

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B. Determine payment-to-cost ratio tier

- (1) Hospitals with base year payment-to-cost ratios at or below 80 percent shall have a per diem payment rate set to reimburse 85 percent of base year costs.
- (2) Hospitals with base year payment to cost ratios above 80 percent up to and including 90 percent shall have a per diem rate set to reimburse 95 percent of base year costs.
- (3) Hospitals with base year payment to cost ratios above 90 percent shall have a per diem rate set to reimburse 100 percent of base year costs.

C. Set facility specific per diem rates to reimburse the target payment to cost ratio as determined in B.

6.22 Transfer Payment for Minnesota and Local Trade Area Hospitals

Transfer Payment =	Standard payment (per diem), multiplied by the actual length of stay.
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6.24 Out-of-Area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor
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- A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
- B. Multiply by the relative value
- C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

6.25 Interim Payment Methodology

If the methodology described in this attachment cannot be implemented prior to July 1, 2017, the Department will employ an interim payment methodology.

The interim payment rate is equal to the rate in effect on July 1, 2016.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under the interim payment methodology.

SECTION 6.3 OTHER PAYMENT FACTORS

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Supersedes: 17-08 (16-19,15-19,14-15,13-18,13-04,12-25,11-30a,11-22,11-12,11-05,10-23,10-11,09-21,09-13,09-08,09-02,08-10,07-12,07-11,07-03,07-02,05-13,04-15(a),04-02,03-39,03-02,02-28,02-11,02-05,01-25,01-19,01-17,01-01,00-29,00-04,99-23,99-05,98-37,97-42,97-19,97-15,97-03,95-20,95-04,94-18,94-08,93-39,93-33,92-44,92-31,91-17,90-25)

6.31 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

6.32 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

6.33 Non-payment for hospital-acquired or provider-preventable conditions. No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

6.34 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

6.35 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with either serious emotional disturbance or serious and persistent mental illness, who have been civilly committed or voluntarily hospitalized, and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

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- (1) the quality of the utilization review plan;
- (2) experience with mental health diagnoses; and
- (3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

- (1) payer of last resort/payment in full compliance assurances;
- (2) general experience operating within the Medicare/Medical Assistance programs; and
- (3) financial integrity.

C. Voluntary hospitalizations are included in the contracts: If the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

6.36 Medical Education and Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

6.37 Reserved

SECTION 7.0 LONG-TERM HOSPITALS

7.01 Establishment of base years.

For the January 1, 2011, rebased rate year, rates for Minnesota long term hospitals (section 7.0) only will be rebased to the most recent hospital fiscal year ending on or before September 1, 2008, not including payments described in section 8.01 or section 7.45. Effective January 1, 2013, and after, rates for all long-term hospitals will not be rebased. For long-term hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report.

7.02 Determination of Base Year Operating Cost and Rate per Diem

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The Department determines the base year operating cost per day for long term hospitals for the rate year according to items A and B.

A. Determine the operating cost per day as follows:

(1) Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

(2) Exclude the claims and charges in subitems a to e:

a. Medicare crossover claims;

b. inpatient hospital services for which Medical Assistance payment was not made;

c. inpatient hospital services not covered by the Medical Assistance program on October 1 prior to a rebased rate year;

d. inpatient hospital charges for non-covered days calculated as the ratio of non-covered days to total days multiplied by charges; and

e. inpatient hospital services paid under Section 7.46.

(3) Combine claims into the admission that generated the claim according to readmissions at Section 9.02.

(4) Determine operating costs for each hospital admission using each hospital's base year data according to subitems (a) to (e).

a. Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

b. Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist costs and charges if the hospital determines that certified registered nurse anesthetist services will be paid separately.

c. Determine the operating cost of services rendered by interns and residents not

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in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (a) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

d. Add subitems a to c.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

SECTION 7.1 CALCULATION OF PAYMENT RATES

7.11 Standard Payment Rate for Minnesota Hospitals

Standard Payment =	Operating rate per diem, multiplied by the DPA factor, multiplied by Medicaid-eligible patient days
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- A. Determine the hospital's operating rate per diem for the base year
- B. Multiply by the Disproportionate Population Adjustment factor
- C. Multiply by the number of Medicaid-eligible patient days

7.12 Standard Payment Rate for Local Trade Area, and Out-of-area Hospitals

Standard Payment =	Operating rate per diem, multiplied by the rateable reduction factor, multiplied by Medicaid-eligible patient days
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- A. Determine the hospital's operating rate per diem for the base year
- C. Multiply by the rateable reduction factor
- D. Multiply by the number of Medicaid-eligible patient days

7.13 Transfer Payment Rate for Minnesota, Local Trade Area, and Out-of-area Hospitals

Transfer Payment =	Standard payment, multiplied by the actual length of stay.
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SECTION 7.2 RATEABLE ADJUSTMENTS

7.21 Reserved

7.22 Reserved

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7.23 Reserved

7.24 Reserved

7.25 Reserved

7.26 Reserved

7.27 Reserved

7.28 Reserved

7.29 Hearing detection fee increase. Effective for admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under Minnesota Statutes §141.125, subdivision 1, that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

Effective for admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2013, for the early hearing detection and intervention program recipients under Minnesota Statutes §144.125, subdivision 1, paragraph (d) that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

7.291 Reserved

SECTION 7.3 (Reserved)

SECTION 7.4 OTHER PAYMENT FACTORS

7.41 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

7.42 Non-payment for hospital-acquired and provider-preventable conditions. No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable

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condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

7.43 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

7.44 Medical Education and Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

7.46 Reserved

SECTION 7.5 RESERVED

SECTION 8.0 DISPROPORTIONATE POPULATION ADJUSTMENT

8.01 Disproportionate population adjustment or DPA eligibility. A Minnesota hospital that is not state-owned, not a facility of the federal Indian Health Service, and not a critical access hospital and that meets the criteria of items A to C is eligible for an adjustment to the payment rate.

- A. A hospital must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medical Assistance recipients. For non-MSA hospitals the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.
- B. A hospital that did not offer non-emergency obstetric services as of December 21, 1987 or a hospital whose inpatients are predominately under 18 years of age is not subject to item A.
- C. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds 1 percent.

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MA Inpatient Utilization Rate (MIUR) =	Medical Assistance inpatient days, divided by total inpatient days
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8.02 Disproportionate population adjustment factors. Eligible hospitals that are not licensed children’s hospitals may qualify for the contract bed factor, the transplant hospital factor and one of three volume factors.

- A. Contract Bed Factor – a hospital that has a contract with the Department to provide extended inpatient psychiatric services in the rate year shall have a factor of 0.0160.
- B. Transplant Factor – a hospital that has received Medical Assistance fee-for-service payment for at least 20 transplant services in the base year shall have a factor of 0.0435.
- C. Volume Factor
 - i. Hospitals with an MIUR in the base year of at least 20 percent up to one standard deviation above the statewide mean shall have a factor of 0.0468.
 - ii. Hospitals with an MIUR in the base year that is at least one standard deviation above the statewide mean, but less than three standard deviations above the statewide mean shall have a factor of 0.2300.
 - iii. Hospitals with an MIUR in the base year that is more than three standard deviations above the statewide mean shall have a factor of 0.3711.
- D. Final DPA Factor – the final DPA factor for hospitals qualifying under this section is equal to one plus the sum of A through C.

Final DPA Factor =	1 + (Contract Bed factor + Transplant factor + Volume factor)
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8.03 Disproportionate population adjustment factors – children’s hospitals. Eligible hospitals that are licensed children’s hospitals may qualify for one DPA factor based on the number of fee-for-service Medical Assistance discharges in the base year.

- A. Licensed children’s hospitals with at least 1,000 fee-for-service discharges in the base year shall have a factor equal to 1.868.
- B. Licensed children’s hospitals with fewer than 1,000 fee-for-service discharges in the base year shall have a factor equal to 1.7880.

The applicable DPA factor (from A or B) is the final DPA factor for the qualifying children’s hospital.

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8.04 Limitation on DPA payment amounts. In the event that DPA payments to a qualifying hospital exceed the facility-specific DSH limit for the hospital for the applicable DSH year, the DPA payment to the hospital will be limited to the facility-specific DSH limit.

Payments in excess of the applicable facility specific DSH limit shall be returned to the Department for redistribution to qualifying hospitals.

8.05 Redistribution of Returned DPA amounts. Excess DPA payments that are returned to the Department in accordance with section 8.04 shall be redistributed to qualifying hospitals. Hospitals qualified to accept redistributed DPA funding must:

- A. Be eligible to receive DPA payments under section 8.01;
- B. Be eligible to receive DPA payments under section 8.02 and have a volume factor as described paragraphs C(ii) or C(iii); and
- C. Not have exceeded the limit in section 8.04

Returned DPA funding shall be distributed to qualifying hospitals based on each hospital's Medical Assistance fee-for-service discharges expressed as a percentage of the total Medical Assistance fee-for-service discharges of all of the hospitals qualified to receive additional DPA payments under this section.

The final redistributed DPA payment amount to a receiving hospital may not result in total DPA payments to that hospital exceeding the limit in section 8.04.

Final Redistributed DPA Payment Amount =	Lesser of: The difference between the amount paid in accordance with section 8.02 and the limit in section 8.04, Or The amount equal to the total amount of DPA funding to be redistributed, multiplied by (the hospital's number of fee-for-service MA discharges divided by the total number of fee-for-service MA discharges of all of the hospitals eligible to receive redistributed DPA funds in the rate year).
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SECTION 9.0 PAYMENT PROCEDURES

9.01 Submittal of Claims. Hospital billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the

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diagnostic category.

9.02 Readmission. An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)

- A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:
- (1) A recipient leaving the hospital of the first admission against medical advice;
 - (2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or
 - (3) A recipient having a new episode of an illness or condition.
- B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:
- (1) Hospital or physician scheduling conflict;
 - (2) Hospital or physician preference other than medical necessity;
 - (3) Patient preference; or
 - (4) Referral.
- C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.