IN THE MATTER OF THE PROPOSED

ADOPTION OF MINN. RULES

9500.1090 - 9500.1155

STATEMENT OF NEED

AND REASONABLENESS

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INTRODUCTION AND BACKGROUND

Minnesota Rules parts 9500.1090 - 9500.1155 establish a prospective reimbursement system for inpatient hospital services under the Medical Assistance (MA) and General Assistance Medical Care (GAMC) Programs. The reimbursement system established by these rules promotes cost containment without negative effects on patient care, by offering financial incentives for efficient and economical hospital operations. Minnesota Laws 1984, chapter 534, section 20 mandates that inpatient hospital reimbursement under the MA and GAMC Programs be based upon a diagnostic classification. These rules contain definitions of terms; provisions governing the determination of relative values; determination of allowable base year cost per admission; determination of the annual hospital cost index; determination of reimbursement rates; reimbursement procedures; and appeal procedures. These rules also prescribe a method for implementing the statutory limitations on the increase in MA and GAMC rates reimbursed for inpatient hospital services, as contained in Minnesota Statutes, section 256.966 (1982), as amended by Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39. This introduction briefly reviews the history of MA and GAMC reimbursement for inpatient hospital services, and the reasons why it is necessary and reaso-

nable to adopt a prospective reimbursement system.

Prior to 1980, the Social Security Act required states to reimburse hospitals for inpatient hospital services under the Medicaid Program on a reasonable cost related basis. Essentially, reasonable costs include all direct and indirect costs that are necessary and proper for the efficient delivery of needed inpatient hospital services to recipients. Within this general framework, there are numerous rules regarding the reasonableness of certain categories of cost, how they are to be determined, and how they are to be reported. In accordance with that mandate, the Department reimbursed for inpatient hospital services under Medicare principles of reimbursement, a method approved by the United States Department of Health and Human Services. This system was established to encourage hospitals to accept MA recipients and was successful in improving quality of care and access to care. The GAMC Program was adopted in 1976. In the interests of consistency and uniformity, this program was modelled after that already in place for MA.

Because actual reasonable costs cannot be determined until the end of a hospital's cost reporting period (fiscal year end), an interim reimbursement percentage approximating actual costs is determined by the Medicare fiscal intermediary (Blue Cross and Blue Shield of Minnesota) for each hospital. During the course of the hospital's fiscal year, the hospital would receive interim reimbursement for inpatient hospital services to MA or GAMC recipients based on the interim reimbursement percentage multiplied by its billed charges. Reimbursement would be made shortly after the services were

rendered. At the end of the hospital's fiscal year, the Department would receive a final audited Medicare cost report for each hospital from the fiscal intermediary and do a cost settlement. The Department would subject the inpatient hospital services rendered to recipients to the reasonable cost finding as determined by the Medicare report to determine the reimbursable program cost. The reimbursable program cost would then be compared to the interim reimbursement to determine the amount either due to the Department or the hospital.

A major drawback to a reasonable cost based system is that it offers few incentives for hospitals to contain costs. In essence, hospitals have the opportunity to be reimbursed for whatever they spend to provide care, as long as those expenditures are for a wide range of allowable costs, including advanced technological equipment and capital building improvements, and are within program limits. The result has been a continuing inordinate increase in the cost of inpatient hospital services.

In 1980 and 1981, the Congress of the United States enacted legislation (section 962 of the Omnibus Reconciliation Act of 1980, and section 2173 of the Omnibus Budget Reconciliation Act of 1981) that made significant changes in the provisions of the Social Security Act relating to reimbursement of Medicaid (known in Minnesota as MA) inpatient hospital services. Congress removed the requirements that state agencies reimburse for inpatient hospital services on a reasonable cost related basis. State agencies are now required to determine rates for inpatient hospital services that the state

finds, upon making assurances acceptable to the Secretary of Health and Human Services, are reasonable and adequate to reimburse for the costs of efficiently and economically operated hospitals that provide care in conformance with applicable state and federal laws, regulations, quality, and safety standards. The legislation also specified that the methods and standards for the reimbursement of inpatient hospital services must take into account other factors including: 1) establishing appeal procedures to allow hospitals to have their rates administratively reviewed; 2) establishing uniform cost reporting and audit requirements; 3) assuring that reimbursement in aggregate for these services shall not be greater than the amount that would be reimbursed under the Medicare principles of reimbursement; 4) assuring that the rates do not exceed customary charges; 5) providing the public with an opportunity to review and comment on significant changes in state agency's methods for determining reimbursement rates before the changes are implemented.

In 1981 the Minnesota Legislature limited the annual increase in the cost per service unit for services under the MA and GAMC Programs to eight percent in Minnesota Statutes, section 256.966 (1982). Implementation of the eight percent limit was difficult since under the cost based reimbursement system previously required by the Social Security Act there was not a uniform unit of service. A unit of service is necessary to provide a way to recognize changes in volume of patient activity.

The Department, in consultation with reimbursement experts of the Minnesota Hospital Association, attempted to implement the limit using the existing

system of reimbursement by adjusting and restricting the interim reimbursement percentage. This method solved the problem of applying the eight percent limitation for interim reimbursement, but a method still did not exist to apply the limitation for cost settlement at the end of a hospital's fiscal year.

The Department then began to develop a reimbursement system that would resolve the limitation issue at the time of cost settlement as well as aid in controlling and budgeting program costs. The Department looked extensively at reimbursement mechanisms in other states. After examining these other reimbursement systems, the Department decided that a prospective reimbursement system would best meet the needs of the MA and GAMC Programs. Essentially, prospective reimbursement is a predetermined reimbursement amount established prior to the delivery of the services. By November 1982, the Department had developed a proposed model. In 1983 the Legislature directed the Commissioner of Human Services[1] to promulgate temporary and permanent rules to implement Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39 which establish a prospective reimbursement system for MA and GAMC inpatient hospital services. The Legislature also limited the annual increase in inpatient hospital rates to five percent.

In response to the legislative mandate, the Department published 12 MCAR §§ 2.05401 - 2.05403 (Temporary) in the State Register on August 1, 1983.

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[1] Prior to July 1, 1984, the Commissioner of Human Services was known as the Commissioner of Public Welfare.

Interested persons had until August 22, 1983, to submit written comments. After reviewing the comments, the Department made minor modifications in the rule. The changes were submitted to the Attorney General of the Administration Division and the Revisor of Statutes for review as to form and legality. The temporary rule was approved and became effective on October 1, 1983. The temporary rule was continued in effect for an additional 180 days under Minnesota Statutes, section 14.35. The temporary rule was again continued in effect until August 1, 1985, unless superseded by permanent rules or legislative action, by the Minnesota Legislature's House File 1966 signed by the Governor on May 25, 1984, effective May 26, 1984.

The temporary rule establishes a single hospital specific reimbursement rate regardless of the recipient's diagnosis. The rate represents an average cost of the inpatient hospital services provided by a hospital during the base year (1981). One of the major assumptions under a single or flat reimbursement system is that the case mix of inpatient hospital services provided in the base year will remain fixed in future years. This assumption is highly unlikely in the hospital industry which experiences continued changes in technology and physician practice patterns. A hospital that changes its case mix of services could either be penalized or receive a windfall. In response to this problem, Minnesota Laws 1984, chapter 534, section 20 mandates that inpatient hospital reimbursement under MA and GAMC Programs be based upon diagnostic classification.

To develop these permanent rules, the Department worked closely with hospital representatives. In September 1983, the Department published a notice

in the State Register soliciting outside opinion regarding its intent to promulgate a permanent hospital reimbursement rule and that the rule would possibly reflect diagnosis related groups (DRG's). A Public Advisory Committee was established to assist in the process. The Public Advisory Committee met approximately five times over a period of about a year. In November 1984, the Department published a notice in the State Register notifying the public that oral and written comments could be made until January 1, 1985 regarding the promulgation of the permanent rule.

Under these rules the Department is proposing to implement a modified diagnosis related groups (DRGs) reimbursement system similar to the Medicare Program. Under the proposed system, inpatient hospital services are divided into 35 diagnostic categories. Each category represents a broad clinical category differentiated from all others based on the body system and disease etiology. Recipients are assigned to a diagnostic category depending on the principal diagnosis, secondary diagnoses, if any, presence or absence of operating room providers, age, sex, and discharge status. Under the system, hospital reimbursement will be related to the treatment provided to each recipient. The system uses an additional diagnostic category (i.e., item JJ) to identify admissions when information is incorrect, missing, or invalid.

While the diagnostic categories are the basis of the system, other factors are necessary in determining reimbursement. A determination must be made of a hospital's allowable base year cost per admission that is standardized to

remove the effects of case mix. Another factor is the relative value assigned to the diagnostic categories. Relative values are indices which measure the resource consumption needs of a particular inpatient hospital service relative to the resource consumption needs of an average inpatient hospital service.

Although the Medicare system is used as a model, the MA and GAMC Programs differ in several ways:

1. MA recipients are predominately single parents with children under the age of 21. GAMC recipients are between the ages of 21-65 and use a significant volume of psychological and chemical dependency services. Persons eligible for Medicare are generally elderly or disabled.
2. A reimbursement system at the state level allows the opportunity for a design which reflects Minnesota's hospital environment rather than the national environment of over 7,000 plus hospitals.

Since different populations consume different resources, a system specific to Minnesota with its own relative values assigned to the MA and GAMC Programs would be more appropriate than a national model.

These proposed rules will replace 12 MCAR §§ 2.05401 - 2.05403 (Temporary). The proposed rules, designated as Minnesota Rules parts 9500.1090 - 9500.1055, are hereby affirmatively presented by the Commissioner in accordance with the provisions of the Minnesota Administrative Procedures Act., Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings.

Part 9500.1090 Purpose and Scope

It is reasonable and necessary to inform the affected parties that these rules will be used by the Department to establish a system of reimbursing inpatient hospital services according to a prospective reimbursement system.

It is necessary to inform the affected parties that all the sections of the rule apply to General Assistance Medical Care as well as Medical Assistance. The reasonableness for these rules has already been made. Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39 mandate that the Commissioner develop a prospective reimbursement system for General Assistance Medical Care. The only exception is the four percent reduction under part 9500.1155, subpart 5, which applies only to MA.

This provision is only used to simplify the writing of these rules. Rather than referring to items and data by "medical assistance or general assistance medical care" instead of "medical assistance" is reasonable in deleting unnecessary words.

Part 9500.1095 Statutory Authority

This part names and sets forth the authority of the prospective reimbursement system. In addition, it is necessary and reasonable to inform affected parties that these rules must be read in conjunction with the federal statutes and regulations governing the administration of MA, and other Department rules which govern related aspects of MA and GAMC so that the affected parties will be fully informed.

Part 9500.1100 Definitions

The Commissioner hereby affirmatively presents the need for and reasonableness of the proposed definitions, except that definitions which are solely for the purpose of identification, e.g., "Commissioner," are presumed both needed and reasonable without further justification.

Subpart 1. Scope. This section is necessary and reasonable to clarify that the definitions apply to the entire sequence of reimbursement rules.

Subpart 2. Adjusted base year cost per admission. This phrase describes the allowable base year cost per admission cumulatively multiplied by the hospital cost index (HCI) for years prior to the budget year. It is reasonable and necessary to define this term because it is used in determining the categorical rate per admission. The definition is reasonable because hospital rates must be adjusted annually for inflation, subject to legislatively imposed limits, to ensure that the reimbursement rate will be sufficient to meet the federal standards under CFR Part 447.

Subpart 3. Admission. The term "admission" is used to describe the process by which a recipient becomes an inpatient of a hospital. The definition is necessary because not all recipients treated in hospitals are admitted to inpatient status. The definition is reasonable, because it is the one used by the medical profession to identify the process by which a person is admitted to a hospital as an inpatient. The definition is also reasonable, because it is consistent with the provisions of the admission certification rule, parts 9505.0500 - 9505.0540 [Emergency].

Subpart 4. Admission certification. "Admission certification" is defined as it is in Minnesota Rules, parts 9505.0500 - 9505.0540 [Emergency]. The definition is necessary and reasonable because it ensures that the provision of the reimbursement rule which govern hospital reimbursement are consistent with the provisions of the admission certification rule which establishes standards for determining when inpatient admission and treatment shall be eligible for MA or GAMC reimbursement.

Subpart 5. Allowable base year cost per admission. This phrase defines the costs that are allowed for the hospital's base year and that will then be subjected to the hospital cost index. This definition is necessary because it is a major component in the determination of the categorical rate per admission. It is reasonable to exclude pass-through costs because they are not subject to the hospital cost index. It is also reasonable to exclude outliers since there is an additional reimbursement mechanism for these types of admissions. An adjustment for case mix is necessary and reasonable to remove variations in case mix among hospitals.

Subpart 6. Ancillary services. It is necessary to define "ancillary services" because it is an inpatient hospital service cost that is used in the determination of the relative values and the allowable base year cost per admission. The definition is reasonable, because it is used in the Medicare Program for reimbursement of inpatient hospital services. The Medicare Program has reimbursement objectives which are similar to the Departments, and the Department has adopted the definition to be consistent with the

Medicare Program. Consistency is in the best interests of the Department, recipients, hospitals, and other providers. For a discussion of the relationship of MA and Medicare see pages 22-23, below.

Subpart 7. Appeals board. "Appeals board" means the board which advises the commissioner on adjustments to hospital rates. It is necessary to have an appeals board to settle rate differences as authorized under Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39. It is reasonable to have an impartial third party intervene when the Department and a hospital are in disagreement over a rate determination.

Subpart 8. Arithmetic mean cost per admission. It is necessary to define the mathematical term used to determine average costs for the diagnostic categories in determining relative values. It is reasonable to use this formula since it results in a value that is typical for a set of data.

Subpart 9. Base year. This definition is only for the purpose of identification.

Subpart 10. Budget year. This definition is only for the purpose of identification.

Subpart 11. Case mix. The term "case mix" is defined because it is necessary to measure the inpatient hospital services within a hospital and among hospitals for reimbursement. It is reasonable to measure these services based on the diagnostic categories because that is the classification system used in the rule.

Subpart 12. Categorical rate per admission. It is necessary to define "categorical rate per admission" because it is the unit of inpatient hospital service used to reimburse hospitals. This definition of categorical rate per admission is reasonable because it is consistent with Medicare's diagnosis related groups (DRGs) system of reimbursement, which has the same objectives as this rule. Consistency is in the best interests of the Department, recipients, hospitals, and other providers. In addition, the Medicare method of reimbursement is already understood by affected parties. For a discussion of the relationship of MA and Medicare see pages 22-23, below.

Subpart. 13. Claims. It is necessary to define "claims" because it contains information needed to establish the relative values for the diagnostic categories and to reimburse hospitals. The definition of claims is reasonable because it refers to a form authorized by the Department that contains information needed to determine reimbursements.

Subpart 14. Commissioner. This definition is only for the purpose of identification. Since it would be physically impossible for the Commissioner to personally carry out all the statutory duties assigned to the position, it is necessary and reasonable to permit these duties to be carried out by another under the Commissioner's authorization.

Subpart 15. Cost outlier. It is necessary to define admissions whose related costs are atypical of a set of data in the determination of the relative values and the allowable base year cost per admission. To include

these admissions would skew the arithmetic mean (average) as a measure of central tendency. It is reasonable to establish a threshold at three standard deviations above the geometric mean cost per admission because the reimbursement on a categorical rate per admission is hospital specific without grouping of peers and, therefore, this will adequately reimburse for services provided up to that point. A threshold established at less than three standard deviations would create a volume too great for the Department to administer adequately under outlier reimbursement. It is also reasonable to limit cost outliers to diagnostic categories O and W under Subpart 20, because these categories are relatively expensive. Cost outliers are used in those diagnostic categories by the State of Pennsylvania in the administration of its Medicaid DRG Program that became effective July 1, 1984. The costs of providing services in these diagnostic categories may be very great because of the intensity of the care but the length of stay may not be abnormal. Day outliers are easier to identify and thus administer. Cost outliers are difficult and expensive to identify and, therefore, carry a greater administrative burden for both hospitals and the Department. Also, the application of the outlier criteria is sequential (an admission cannot be considered a cost outlier if it meets the applicable day outlier criteria). Otherwise, cost outliers could result in reimbursement simply because the hospital is a high cost provider, and not as a direct consequence of extraordinary services provided to a recipient.

Subpart 16. Cost-to-charge ratio. "Cost-to-charge ratio" is a statistical term used in Medicare cost reporting.

It is necessary to define "cost-to-charge ratio", because it is used in the determination of the relative values and the allowable base year cost per admission. The definition is reasonable, because the definition is consistent with the Medicare Program.

Subpart 17. Current year. This definition is only for the purpose of identification.

Subpart 18. Day outlier. It is necessary to define admissions whose length of stay are atypical of a set of data in the determination of the relative values and the allowable base year cost per admission. Length of stay measures accurately the resource consumption or cost for an inpatient hospital service. To include admissions with unusually long lengths of stay would skew the arithmetic mean (average) as a measure of central tendency. It is reasonable to establish a threshold at three standard deviations above the geometric mean length of stay because the reimbursement on a categorical rate per admission is hospital specific without grouping of peers and, therefore, will adequately reimburse for services provided up to that point. This system is used by the State of Michigan in the administration of its Medicaid DRG Program effective February 1, 1985. That state's program is hospital specific during its initial year. A threshold established at less than three standard deviations would create a volume too great for the Department to administer adequately under outlier reimbursement.

Subpart 19. Department. This definition is only for the purpose of identification. The term is an abbreviation and is reasonable in deleting unnecessary words in a reference frequently repeated in the rule.

Subpart 20. Diagnostic categories. It is necessary to define "diagnostic categories" to distinguish the different types of inpatient hospital services that are clinically coherent and homogeneous with respect to cost.

This classification system is reasonable because it is modelled from the Medicare DRG prospective reimbursement system that was based on reimbursement per admission according to the type of admission. DRGs were originally developed by Yale University's Center for Health Studies in the late 1960's to monitor the quality of care and to perform utilization review in a hospital. In 1975, the Health Care Financing Administration began working with Yale to develop and then later to improve the DRGs for reimbursement purposes. Under that system 23 Major Diagnostic Categories (MDCs) were developed based on organ systems because medicine is practiced primarily according to specialities based on organ systems. Therefore, these MDCs correspond to medical specialities and the grouping of inpatient hospital services.

The variables used to determine the MDCs were intentionally limited to those that are descriptive of the patient's clinical condition and that are readily available on most discharge abstracts, such as principal diagnosis, secondary diagnoses, surgical procedures, age, sex, and discharge status. Subgroups of cases within the MDCs were examined by physicians to determine whether the proposed distinctions were clinically sensible and whether the cases in each group were medically similar. This process resulted in the development of the 467 mutually exclusive and comprehensive classification

system diagnosis related groups. In the determination of the relative values for the Medicare DRG Program, it was necessary to supplement Medicare inpatient hospital claim data with medical records from Maryland and Michigan hospitals for 109 DRGs that either contained no cases or too few cases to provide a statisticaly valid estimate of the average cost of care. Admissions falling within these 109 DRGs represented less than .3 percent of all Medicare admissions.

The Department has refined the MDCs to make a system compatible with the types of inpatient hospital services provided to MA and GAMC recipients for the reasons cited above, on page 9. The Department has received data from the Council of Community Hospitals that lists the most commonly used DRGs under MA and GAMC and provides a measurement of variation (coefficient of variation) based on length of stay. The Department has incorporated that information so that the classification system would more accurately reflect the proportion of cases reimbursed under MA and GAMC.

The Department feels that a group of 35 diagnostic categories is a more reasonable alternative than the 467 DRGs. The Department does not have the resources to develop a system as detailed as one using 467 DRGs. As was stated above, the Medicare DRG Program had to supplement its data to develop relative values for some of the DRGs. Pennsylvania and Ohio also had to supplement their data from other states when they developed their Medicaid DRG Programs. DRG assignment errors can result from the reporting of principal diagnosis, secondary diagnoses, and principal surgical procedures

incorrectly. The seriousness of principal diagnosis errors depends on the difference in costliness between the correct DRG and the erroneous DRG. Secondary diagnoses are frequently under-reported. This under-reporting results in the designation of a complicated admission as uncomplicated admission. Since admissions involving secondary diagnoses tend to be more expensive than uncomplicated admissions, under-reporting leads to overpricing of the uncomplicated DRGs. Principal surgical procedure coding errors can develop because sometimes procedures are listed chronologically rather than in order of their importance to the principal diagnosis. A high proportion of admissions with coding errors will probably be misassigned to a DRG in the same MDC. Accurate coding was not emphasized in the past, because it did not effect reimbursement under the reasonable cost related basis. As the DRG system is used (Medicare implemented its system starting October 1, 1983), the coding quality should improve so that a full scale DRG system could eventually be put in place. Until such time, it is the Department's position that the proposed 35 diagnostic categories meets the mandate of the Legislature and provides adequate and equitable reimbursement to hospitals and other providers.

Incorporation of Medicare MDCs as modified is particularly appropriate with respect to inpatient hospital reimbursement. The use of Medicare MDCs as modified will eliminate confusion and inconsistency by establishing a uniform, consistent system that can be fairly administered to protect the interests of the hospitals, the recipients, and the Department. In addition, the Medicare system is already understood by the affected parties.

For a discussion of the relationship between MA and Medicare see pages 22-23, below.

Subpart 21. Discharge. It is necessary to define "discharge" to clarify its meaning because a recipient cannot be classified into a diagnostic category, nor can a hospital submit a claim until the discharge of the recipient. This definition is taken from the Nurses's Reference Library Definitions and, therefore, is reasonable because it is consistent with common usage in the medical community.

Subpart 22. General assistance medical care or GAMC. It is both necessary and reasonable to define this term because it is one of the funding programs that comes under the purview of this rule.

Subpart 23. Geometric mean cost per admission. It is necesary to define this term since it is used in determining outliers to be excluded in the determination of the arithmetic mean cost per admission for the diagnostic categories and a hospital's allowable base year cost per admission. The definition is reasonable because it follows the one used in statistics as a measure of central tendency.

It is reasonable to use the cost outlier criteria based on the geometric mean cost per admission instead of the arithmetic means cost per admission because the cost data for admissions is highly skewed, that is, there are many more admissions at the high cost end of the distribution which are not matched at the low cost end. This occurs because, while there is no limit

to how much an inpatient hospital service may cost, the cost can never be below zero. By using the geometric mean, the percent of cases that will be outliers in each diagnostic category is more predictable. Because the geometric mean is lower than the arithmetic mean by definition, a smaller number of admissions will qualify as cost outliers. However, this would be offset by higher reimbursement for those cost outliers. This method is used by the State of Ohio in the administration of its Medicaid DRG Program.

Subpart 24. Geometric mean length of stay. It is necessary to define this term since it is used in determining admissions to be excluded in the determination of the statewide arithmetic mean length of stay for the diagnostic categories. The definition is reasonable because it is the one used by the medical profession to describe the period a recipient is in a hospital as an inpatient incorporated with the common usage of the statistical term "geometric mean."

Subpart 25. Hospital. It is reasonable to define the term "hospital" because it may have several different meanings. This definition of "hospital" has been selected to be consistent with the Medicare Program. Approval under the Medicare Program is a prerequisite to participation in the MA Program and, therefore, the definition is both necessary and reasonable. See Minnesota Rules part 9500.1070, sup. 2 (1983).

Subpart 27. Inpatient hospital services. The term "inpatient hospital services" is defined with reference to Minnesota Rules part 9505.0500 - 9505.0540 [Emergency]. The definition is necessary to clarify a term used

in the reimbursement formula. It is reasonable because it is consistent with the provisions of the admission certification rule.

Subpart 27. Hospital cost index or HCI. This definition is necessary and reasonable because the Legislature has directed the Department to establish a "hospital cost index" or "(HCI)" for the purpose of establishing and controlling rates under Laws of Minnesota 1983, chapter 312, article 5, section 9, subdivision 1.

Subpart 28. Local agency. Local agency is defined because the MA and GAMC Programs are administered on a day to day basis by county or multi-county agencies subject to the supervision of the Department. The definition is for identification purposes only.

Subpart 29. Medical assistance or MA. It is both necessary and reasonable to define the term because it is one of the funding programs that comes under the purview of this rule.

Subpart 30. Medically necessary. The term "medically necessary" is defined with reference to Minnesota Rules parts 9505.0500 - 9505.0540 [Emergency]. This definition is necessary to clarify its meaning in these rules. It is reasonable because it is consistent with the provisions of the admission certification rule which establishes standards for determining when inpatient hospital admission and treatment shall be eligible for MA or GAMC reimbursement.

Subpart 31. Medicare. This definition is for identification purposes. It is also necessary because these rules refer to the Medicare Program and

Subpart 33. Operating costs. It is necessary to define "operating costs" because they are subject to the HCI. It is reasonable to define operating costs that relate to the operation of a hospital in compliance with licensure and certification standards.

Subpart 34. Outlier. This definition is only for the purpose of identification. Outlier is a general term to refer to "cost outlier" and "day outlier" and, therefore, it deletes unnecessary words in a reference frequently repeated in the rule.

Subpart 35. Out of area hospital. This defintion is only for the purpose of identification.

Subpart 36. Pass-through costs. It is necessary and reasonable to define "pass through costs" since they are not subject to the HCI and pass-through costs are a major component of the prospective reimbursement system established in these rules.

Subpart 37. Prior authorization. The term "prior authorization" is defined as it is in Minnesota Rules parts 9505.500 - 9505.5020 [Emergency]. The definition is necessary to clarify its use in these rules. It is reasonable to be consistent with the provisions of the prior authorization rule to avoid confusion and maintain uniform standards.

Subpart 38. Prior year. This definition is only for the purpose of identification.

standards frequently because of the interrelated nature of the MA and Medicare Programs.

Medicare is the federal health insurance program which provides medical care and services to the aged and disabled. See 42 U.S.C.A §§ 1395, et seq. Medicaid (known in Minnesota as MA) is a joint federal-state program which provides medical care and services to families with dependent children, and the aged, blind, or disabled, 42 U.S.C.A. § 1396 et seq.

Many federal standards applicable to the Medicare Program also apply to the MA Program. The state may incorporate certain other Medicare standards into the MA Program. Moreover, some persons are eligible for both Medicare and MA. Therefore, it is necessary and reasonable to adopt Medicare standards, definitions, and procedures for use in MA, and to discuss the relationship of the Medicare and MA Programs. Incorporation of Medicare standards is particularly appropriate with respect to inpatient hospital reimbursement because Medicare uses prospective reimbursement as does MA. The use of Medicare standards will eliminate confusion and inconsistency in inpatient hospital reimbursement.

Subpart 32. Medicare crossover claims. It is necessary to define "medicare crossover claims" because it is a term used in these rules. Certain inpatient hospital costs, such as Medicare deductible, Medicare coinsurance, and other amounts not covered by Medicare, are covered by MA. It is reasonable to define this term for recipients who have both Medicare and MA coverage because it is consistent with common usage in the medical community.

Subpart 39. Prospective reimbursement system. It is necessary to define this term to clarify its use in these rules. The Legislature has directed that such a reimbursement system be established under Laws of Minnesota 1983, chapter 312, article 5, section 9. The definition is reasonable as such because it establishes reimbursement rates that comply with the statutory intent to:

1. encourage hospitals to restrain the use of resources in providing inpatient hospital services and, therefore, establishes efficiency incentives for hospital management;

2. ensure that both hospitals and the Department will have a predictable reimbursement for inpatient hospital services;

3. establish the Department as a prudent buyer of inpatient hospital services;

4. restrain the cost of MA and GAMC; and

5. maintain recipient access to quality care.

The definition is also reasonable, because reimbursement is determined by the base year Medicare/Medical Assistance cost report that recognized Medicare reasonable cost principles.

Subpart 40. Readmission. The term "readmission" is defined as it is in Minnesota Rules, parts 9505.0500 - 9505.0540 [Emergency]. The definition is necessary to clarify its use in these rules. It is reasonable because it is

consistent with the provisions of the admission certification rule which establishes standards for determining when inpatient hospital admission and treatment shall be eligible for MA or GAMC reimbursement.

Subpart 41. Recipient. The definition of "recipient" is reasonable and necessary because the provisions of these rules apply only to inpatient hospital service reimbursement for persons who have been found eligible for MA or GAMC.

Subpart 42. Reimbursable inpatient hospital costs. It is necessary to define this term because it is used in the development of the relative values and the allowable base year cost per admission. It is reasonable to define it as costs allowed under Title XVIII of the Social Security Act for the base year (1981) because those data are contained in the base year Medicare/MA cost report and 1981 is the most recent year for which the data are available.

Subpart 43. Relative values. One of the major premises under the categorical rate per admission is that there should be differentiation in the reimbursement of inpatient hospitals services based upon the costliness of providing these services among the diagnostic categories. The definition is necessary and reasonable to indicate on a scale these differences among the diagnostic categories on a per admission basis.

Subpart 44. Routine services. It is necessary to define "routine services" because it is an inpatient hospital service that is used in the deter-

mination of the relative values and the allowable base year cost per admission. The definition is reasonable because it is according to the Medicare Program and use of a consistent term will avoid confusion.
For a discussion of the relationship of MA and Medicare see pages 22-23, above ~~below~~.

Subpart 45. Second surgical opinion. The term "second surgical opinion" is defined as it is in Minnesota Rules, parts 9505.5030 [Emergency]. The definition is reasonable and necessary because it is consistent with the provisions of the admission certification rule.

Subpart 46. Total hospital admissions. It is necessary to define this term because it is used in the determination of the disproportionate population adjustment in part 9500.1135. Admission is defined in these rules with respect to a MA or GAMC recipient. The determination of the disproportionate population adjustment requires the Department to determine the percentage of MA and GAMC admissions to the hospital's total inpatient hospitalizations for all payors. The definition used is reasonable because it is defined similarly to admission on page 11, above without reference to MA or GAMC.

Subpart 47. Total reimbursable costs. This definition is only for the purpose of identification.
This part states that Health Care Financing Administration (HCFA) Form 2552, 1981 revision is incorporated by reference and made a part of these rules. This is necessary to inform all affected parties that the data contained on

the HCFA Form 2552, 1981 revision, which is used in the determination of the relative values and the allowable base year cost per admission, is a part of these rules.

It is reasonable to adopt the HCFA Form 2552, 1981 revision because that was the report form used in the preparation of the base year Medicare/Medical Assistance cost report.

Subpart 48. Transfers. It is necessary to define this term which is used in determining rates under these rules. Not all recipients treated for inpatient hospital services receive the entire treatment for an episode in one hospital or one service within a hospital. The definition selected is reasonable because it is consistent with the common usage in the medical community.

9500.1105 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES

The necessity of this provision is to inform affected parties as to how inpatient hospital services will be reimbursed. It is reasonable to use a prospective reimbursement system because the Legislature has directed that such a reimbursement system be established under Laws of Minnesota 1983, chapter 312, article 5, section 9.

9500.1110 DETERMINATION OF THE RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES

Subpart 1. It is necessary and reasonable to inform the affected parties as to how the relative values will be determined and by whom.

Item A. It is necessary to inform the affected parties what data and period will be used in these determinations. It is reasonable to use 1983 and 1984 state fiscal year data because they are the most recent available data and contain the information necessary to reflect current patterns of medical practice among the diagnostic categories. Also, the use of this data was recommended by the Public Advisory Committee to the Department.

Item B. It is necessary and reasonable to combine claims for the same admission, e.g., split billing of inpatient hospital services that overlapped a hospital's fiscal years, because the relative values are based on the average cost per admission among the diagnostic categories.

Item C., Subitem (1). It is necessary and reasonable to exclude Medicare crossover claims from the data base because these claims are not reimbursed under the categorical rate per admission. The Medicare crossover claim reimbursement is reflected on page 45 , below.

Item C., Subitem (2). It is necessary and reasonable to exclude claims submitted by out-of-area hospitals, because the Department does not have the base year Medicare cost report for these hospitals which is necessary to do the determination under item D, below. It was the Department's policy in and prior to the base year to reimburse these hospitals at 100 percent of billed charges instead of subjecting their claims to the Medicare reasonable cost principles of reimbursement.

Item C., Subitem (3). It is necessary to establish a point in at which the claims data available to Department should be used in the determination of

the relative values. Claims reimbursed as of February 28, 1985 is reasonable because this date would allow a minimum of eight months for a hospital to bill, e.g., an admission on June 30, 1984. This would allow almost all of the admissions for the 1983 and 1984 state fiscal years to be included. The date of February 28, 1985 is also reasonable to allow the Department enough time to do the determinations and publish them within the time requirement of subpart 3, below.

It is also reasonable to limit the claims to those reimbursed as of February 28, 1985, rather than those submitted as of that date. To do otherwise would require the Department to include claims that were pending and might later be denied or rejected for incomplete or inaccurate information.

Item D. The claims data contain information regarding an inpatient hospitalization according to billed charges as opposed to cost information. Therefore, the billed charges must be converted to costs under the Medicare reasonable cost principles to accurately reflect the relative costliness of an admission among the diagnostic categories. It is reasonable to apply the billed charges to the 1981 Medicare/Medical Assistance cost report because that is the base year used to establish the adjusted allowable cost per admission. That cost report recognizes the Medicare reasonable cost principles without any unit of service limitation under Minnesota Statute. Subitems (1) to (3) set forth how the billed charges on a claim for an admission will be converted to cost:

Item D., Subitem (1). The claim or claims for an admission indicate the amount of routine charges for routine services. It is necessary and reasonable to multiply this amount by the routine cost to charge ratio because this will determine the routine cost for an admission. For the definition of cost-to-charge ratio see page 16.

Item D., Subitem (2). The claim or claims for an admission indicate the amounts of ancillary service charges, including operating room, laboratory, radiology, and anesthesia, if any. It is necessary and reasonable to multiply those amounts by the appropriate ancillary service cost-to-charge ratio as found on Worksheet C because this will determine the ancillary service cost.

Item D., Subitem (3). It is necessary and reasonable to include the costs of interns and residents not in an approved teaching program because these costs were recognized in the base year Medicare/Medical Assistance cost report and are related to the provision of care provided to recipients.

Item E. It is necessary and reasonable to assign the admissions to the appropriate diagnostic related group (DRG) so that an assignment can be made to the appropriate diagnostic category.

This part states that the transfer tape for ICF-9-CM (International Classification of Diseases, 9th revision, Clinical Modification) Diagnosis Related Groups Assignment Software and Installation Manual of DRG Support Group, Ltd., a subsidiary of Health Systems International, Inc. is incor-

porated by reference and made a part of these rules. This is necessary and reasonable to inform all affected parties that the DRG Grouper is a part of these rules.

It is reasonable to use the DRG Grouper because it is the software program used in the Medicare Program for the reimbursement of inpatient hospital services. The Department has adopted the reference so as to be consistent with the Medicare Program. Consistency is in the best interests of the Department, recipients, hospitals and other providers. For a discussion of the relationship of MA and Medicare, see pages 22-23, above.

Item F. It is necessary to assign the admissions to a diagnostic category because diagnostic categories are the basis of the relative values. Because the assignment of an admission determines reimbursement, it is necessary that this assignment be done systematically and uniformly. ~~Subitems (1) to (5) list the necessary criteria for assignment by the DRG Grouper Program.~~

Item G. It is necessary to determine outliers and exclude them from the calculation of the relative values because outliers are by definition atypical.

It is reasonable to use a geometric mean as opposed to the arithmetic mean as a measure of central tendency because the cost data are highly skewed. In other words there are admissions at the high cost end of a distribution which are not matched at the low cost end. Skewing occurs because while there is no limit to how much an inpatient hospital service may cost, the cost can never be below zero. Thus, the distribution of length of stay or

cost per admission is asymmetric around the arithmetic mean. The use of a geometric mean results in a more normal distribution. The geometric mean is used by Medicare and the States of Pennsylvania, Ohio, and Michigan in the administration of their Medicaid DRG Programs.

Item H. It is necessary to establish a "benchmark" or a relative value of 1.0 from which the relative values can be determined for the diagnostic categories. To accomplish this it is reasonable to divide the total cost of all admissions statewide excluding outliers by the number of admissions statewide excluding outliers.

Item I. It is necessary to determine the average cost per admission for each diagnostic category to compare diagnostic categories. To accomplish this it is reasonable to take the total cost of admissions in each diagnostic category statewide excluding outliers and dividing that amount by the total number of admissions for each diagnostic category statewide excluding outliers.

Item J. To determine the relative values to compare diagnostic categories it is necessary and reasonable to divide the average cost per admission for each diagnostic category by the statewide average cost per admission (benchmark) because this method is a standard statistical technique used to determine relative values.

Subpart 2. Redetermination of relative values. It is necessary for the Department to redetermine the relative values because of changes in tech-

nology which create new services and variations in physician practice patterns. Therefore, the relative values, which is a ranking of the costliness of providing inpatient hospital services among the diagnostic categories, should be adjusted to reflect these changes. Also, there should be significant improvements in the accuracy and completeness of the clinical data on the claims in future years because of its increased importance in reimbursement. It is reasonable to do the redetermination each biennium since that period should allow development of a data base large enough to reflect the diagnostic categories.

Subpart 3. Publication of relative values. It is necessary to publish the relative values so that affected parties can be informed. Publication 30 days prior to the start of a biennium is reasonable to allow enough time to inform all hospitals. It is reasonable to publish the relative values in the State Register because that is the official publication for Minnesota state agencies.

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION

It is necessary to inform the affected parties how the allowable base year cost per admission will be determined and by whom. It is reasonable for the Department to do this determination because the Department has the base year Medicare/ Medical Assistance cost reports and the base year claims.

Item A. It is also necessary and reasonable to use the base year (1981) in the determination to perpetuate the legislative limits to the rate of

increase for inpatient hospital services. To use a more recent year would negate the effect of the legislative limits resulting in a higher level of expenditures. Controlling expenditures for inpatient hospital services is essential to prudent management of MA and GAMC.

It is also necessary and reasonable to convert the charges reflected on the claims to allowable cost by the same method used to determine the relative values under part 9500.1110 to be consistent throughout the process.

Item B., Subitem (1). It is necessary and reasonable to subtract outliers because by definition outliers are atypical of a set of data. These admissions are excluded from the determination of the relative values and, therefore, should be excluded in the determination of the allowable base year cost per admission to be consistent.

Item B., Subitem (2). It is necessary to subtract pass-through costs because by definition they are excluded in the determination of the allowable base year cost per admission. It is reasonable to apportion the total hospital pass-through costs to MA based on MA's allowable cost to the hospital's total reimbursable costs since allowable cost is a reasonable basis to allocate pass-through costs among other payors, e.g., Medicare and private insurers.

Item C. It is necessary and reasonable to divide the reimbursable inpatient hospital costs after excluding outliers by the number of admissions excluding outliers because this is needed to determine a cost per admission.

It is necessary and reasonable to exclude outliers because they are skewed values and therefore these admissions have a separate reimbursement formula.

Item D. It is necessary to neutralize the effects of variations in case mix among hospitals. The purpose of relative values is to reflect the cost relationship between admissions in one diagnostic category versus another. If the Department were to determine reimbursement for each hospital by multiplying the average cost per admission as determined in item C, the high cost hospital (where some of its high costs are attributable exclusively to treating higher cost admissions) would, in effect, be reimbursed twice for treating costlier admissions (first, by its high average cost per admission and second by its high relative values). Likewise, a lower cost hospital (to the extent the lower costs are attributable to treating lower cost admissions) would be penalized by multiplying its lower cost per admission by its corresponding lower relative values. To avoid double counting a hospital's case mix, each hospital's average cost per admission must be divided by its corresponding case mix. The result of this computation is the determination of a cost per admission as if a hospital treated an average case mix instead of its actual high or low cost case mix.

Without removing the effects of case mix, reimbursement would be inequitable to either the Department or the hospital. Medicare makes a similar adjustment under its DRG program as well as the states of Pennsylvania, Ohio, and Michigan in the administration of their DRG Medicaid programs.

Item D., Subitems (1) to (3). It is necessary to inform the affected parties as to how the adjustment for case mix is to be made. The procedure is

reasonable because it is modelled from the Medicare Program and other states' DRG Medicaid programs.

Part 9500.1120 DETERMINATION OF HOSPITAL COST INDEX

Subpart 1. Adoption of Health Care Costs. This subpart states that Health Care Costs published by Data Resources Incorporated (DRI) is incorporated by reference and made a part of these rules. This is reasonable and necessary to ensure that all affected parties know that Health Care Costs inflation estimates are a part of these rules.

It is reasonable and necessary to adopt Health Care Costs because it is accepted by industry and government for making inflation estimates. The Public Advisory Committee unanimously recommended that Health Care Costs be adopted by the Department.

Subpart 2. It is necessary and reasonable to inform affected parties when, how, and by whom the hospital cost index will be determined because such information is mandated by Minnesota Statutes, section 256.969(1984).

Item A. It is necessary for the Department to obtain inflation estimates for subitems (1) to (10) from an independent source since an indpendent source is mandated by Minnesota Statutes, section 256.969(1984). The Department and the Public Advisory Committee believe that Health Care Costs published by Data Resources, Inc. is a reasonable source to obtain those estimates because it is an independent source.

Item B., C., and D. It is necessary and reasonable to obtain information from Minnesota hospitals that indicates the relative proportions for subitems (1) to (10) because Minnesota Statutes, section 256.969(1984) requires a "statewide average." It is reasonable to collect information annually because a year is a period long enough to recognize any changes. The fourth quarter of a calendar year is an appropriate time to do this since the Department will have the information soon enough to reflect these changes in the computation of the HCI effective for the first quarter of a calendar year. The first calendar quarter is the most common quarter for hospitals to begin their fiscal years.

It is reasonable to round the inflation estimate to one decimal place since that is the Medicare procedure.

Subpart 3. Publication of HCI. It is necessary to publish the HCI quarterly because quarterly publication is required by Minnesota Statutes, section 256.969(1984). It is reasonable to publish the HCI in the State Register because that is the official publication for Minnesota state agencies.

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION.

Subpart 1. Pass-through cost reports. Budgeted pass-through costs are a component of prospective reimbursement. It is necessary for hospitals to submit this information to the Department so that the Department is able to determine prospective rates. It is reasonable that this report be sub-

mitted at least 60 days prior to the start of each hospital's fiscal year to allow the Department time to review the report, to determine the rate, and to notify the hospital of the rate.

It is not reasonable to subject all costs to the the HCI because certain costs are not controllable and, therefore, subjecting them to the HCI would be inequitable. These uncontrollable costs are depreciation, rents and leases, property taxes, property insurance, interest, and malpractice insurance. These costs are reasonably defined by using Medicare definitions under the Medicare reasonable cost related basis, which are used in developing the cost data for the base year. It is reasonable to include depreciation, rents and leases, property taxes, property insurance, and interest as pass-through costs since these costs are recognized under the Medicare prospective reimbursement system (DRGs) as pass-throughs and will be reimbursed in full for actual costs. Incorporation of Medicare standards is particularly appropriate to the reimbursement of inpatient hospital services to eliminate confusion and ensure consistency. Medicare defintions are already understood by the affected parties. For a discussion of the relationship between MA and Medicare see pages 22-23, above.

Some of these pass-through costs can be referred to as capital costs, e.g. depreciation expense, interest expense, and rents and leases. The term "capital" can be looked at in two ways, physical and financial. The physical aspect of a hospital refers to its facilities, equipment, and other tangible assets which are essential to the delivery of inpatient hospital

services. The financial aspect refers to the funds which the hospital uses to acquire the capital assets. Capital can be classified by its source (e.g., debt, equity, or internally generated) or by the institution of funding (e.g., government, bond issues, commerical banks, stock sales, etc.). A major concern is that funds be made available to a hospital so that the physical plant may be maintained at an acceptable level, both quantitatively and qualitatively. A hospital has many uses of capital costs. Among the most important ones are:

1. additions required due to population shifts with resulting changes in demand of services by recipients;

2. replacement of obsolete or deteriorated facilities and equipment;

3. acquisition of assets due to changes in medical technology;

4. acquisition of assets to improve the quality of care;

5. amenity projects that improve the comfort and convenience offered to patients and physicians, especially now as the market becomes more competitive.

However, capital costs are not directly related to inpatient hospital services. Individual hospitals make capital decisions at different times and incur debt at different interest rates. Hospitals have different capital needs but do not share an equal ability to obtain capital financing. For example, interest expense is determined not only by the dollar amount

borrowed, but by how recently the loan terms were negotiated. This is important because interest rates are highly variable. Similarly, the variation in building and equipment prices means that depreciation expense will vary with the age of a hospital's building and equipment assets. Thus, capital is difficult to limit and control. For these reasons the Medicare prospective reimbursement has excluded these capital costs. These costs are passed through and reimbursed at actual cost. When Congress passed the Medicare prospective payment legislation in April 1983, it was debated as to how hospital capital costs should be reimbursed. The prospective payment legislation required that the administration study this issue and report to Congress in 1985 on suggested changes in capital reimbursement policy, including how capital costs could be incorporated into the prospective payment system. A three year deadline was established for the adoption of a capital reimbursement policy.

Malpractice insurance costs are reasonably included as a pass-through since these costs are not controllable by hospitals and are highly variable and, therefore, it would be inappropriate to subject them to the HCI.

The Department made a random survey of the current reimbursement rates under the temporary rule and found that approximately eight percent of the rate is made up of pass-through costs. The Department believes that eight percent is not significant and, thus, the majority of the costs, which are controllable, are subject to the index.

It is reasonable to exclude pass-through costs relating to capital projects for which a required certificate of need was not granted. To do otherwise

would contravene the federally mandated certificate of need process and the involvement of the Health System Agency, and the Minnesota Certificate of Need provisions as set forth in Minnesota Statutes § 145.832 - 845 (1982).

Subpart 2. Determination of budget year pass-through cost per admission. This provision is necessary to inform the affected parties that the budget year pass-through cost per admission will be derived from the pass-through cost report submitted by a hospital. The formula also informs the affected parties how the budget year pass-through cost per admission will be determined. The formula used is reasonable because it is consistent with the way the base year pass-through costs were determined.

Subpart 3. Categorical rate per admission. It is reasonable because Minnesota Statutes, section 256.969(1984) require rates to be determined on a per admission basis.

Subpart 4. Pass-through cost adjustment. The pass-through costs that are used in the rate determinations are based on budgeted amounts submitted by the hospital. It is necessary and reasonable that an adjustment be made at year end based on actual results to protect the Department. To do otherwise would encourage a hospital to over project its pass-through costs. It is also necessary and reasonable to do this to protect a hospital. As it has been stated before, these costs are not controllable by the hospital. If these costs should exceed a hospital's budgeted amounts that were submitted in good faith, it would be inappropriate to punish the hospital without a year-end review. A 60 day notification to recover adjustments is suf-

ficient. This amount of time would be ample to afford the hospital the opportunity to appeal under part 9500.1145, subpart 1.

Subpart 5. It is necessary to assess the Department or a hospital an interest charge for late payment of the pass-through cost adjustment. To do otherwise would be a disincentive for either party to make timely payments.

Subpart 6. Effective date. It is necessary and reasonable to inform affected parties as to when this method of reimbursement is effective.

9500.1130 REIMBURSEMENT PROCEDURES

Subpart 1. Submittal of claim. It is necessary to inform hospitals when they can bill for inpatient hospital services provided to recipients. It is reasonable to require that this be done after the recipient's discharge, because according to the DRG Grouper program, one of the criteria necessary in assigning an admission to a diagnostic category is the discharge status.

Subpart 2. Required claims. It is necessary and reasonable for the Department to require hospitals to submit invoices using standard forms and procedures to ensure timely and accurate reimbursement. It is reasonable to require hospitals to use standard billing data so that the Department can do required federal reports and utilization review activities.

Subpart 3. Reimbursement in response to submitted claims. This subpart is necessary to inform hospitals that reimbursement will be made only upon the submission of proper claims. It is reasonable for the Department to reim-

burse only for inpatient hospital services provided to individuals who meet applicable federal and state eligibility requirements.

Subpart 4. Adjustments to reimbursements. It is necessary to inform the affected parties the reasons for adjustments to reimbursements. It is reasonable to disallow reimbursements for inpatient hospital services that require prior authorization, second surgical opinion, and admission certification if these approvals were not obtained. It is reasonable to adjust reimbursements for inappropriate utilization as required under parts 9505.1750 - 9505.2150 by making a debit to a hospital's account.

Subpart 5. Rejections of claims. It is necessary to inform affected parties as to why billings will be reimbursed.

Item A. It is reasonable to reject a billing for failing to obtain prior authorization because it is required under parts 9505.5000 to 9505.5020 [Emergency].

Item B. It is reasonable to reject a billing for failure to obtain a second surgical opinion because it is required under parts 9505.5000 to 9505.5020 [Emergency].

Item C. It is reasonable to reject a billing for failure to obtain certification of admission because it is required under parts 9505.0500 to 9505.0540 [Emergency].

Item D. It is reasonable for the Department not to reimburse a hospital for claims assigned to diagnostic category JJ in part 9500.1100, subpart 19

because the information provided by a hospital is incomplete or inaccurate. Consequently, there can be no basis for the Department to reimburse for this inpatient hospital service.

Subpart 6. Medicare crossover claims. It is necessary for the Department to reimburse for Medicare crossover claims because the prospective rate includes only noncrossover claims. Therefore, reimbursement for these claims must be recognized. This subpart of the rule displays the formula to be used in reimbursing these claims. The formula is reasonable because it includes all of the items not covered by Medicare relating to a Medicare crossover recipient.

Subpart 7. It is necessary to have a reimbursement system that differentiates between a transfer and the full treatment of care provided by a hospital for inpatient hospitalization. By definition a transfer occurs when a recipient is moved from one hospital to another for inpatient hospital services. It would be inequitable for the Department to reimburse the full rate when only partial care is provided. The incentive for hospitals would be to increase admissions and discharge them as soon as possible. Therefore, reimbursement should reflect the amount of services provided.

Supbart 8. Reimbursement for readmission. It is necessary to have a policy on readmissions because under a prospective payment system, reimbursement is irrespective of length of stay. Therefore, there is an incentive to discharge recipients as soon as possible. However, if a recipient is discharged prematurely and therefore requires another admission to complete

treatment, the Department would be charged twice for one service. If such a situation were to occur within seven days, it is reasonable to consider the inpatient hospital service as one admission for reimbursement purposes. The seven day criteria is used by Medicare and the states of Pennsylvania and Michigan in the administration of their Medicaid DRG programs.

Subpart 9. Reimbursement for outliers. It is necessary to reimburse an outlier because these admissions have been excluded in the determination of the allowable base year cost per admission. Therefore, there must be a method for additional reimbursement to adequately reimburse a hospital for these types of admissions.

Item A. It is necessary and reasonable to inform affected parties how and by whom reimbursement for day outliers shall be determined.

Item A., Subitem (1). It is necessary to reimburse for day outliers in addition to the categorical rate per admission at a per day amount as opposed to a fixed reimbursement because these admissions have a high variation in length of stay. It is reasonable to multiply the adjusted base year cost per admission as opposed to the categorical rate per admission by the relative value because the adjusted base year cost per admission excludes pass-through costs. Pass-through costs are subject to year end adjustment as stated on page 42, above. Thus, duplicate reimbursement would result if the day outlier reimbursement included pass-through costs.

Item A., Subitem (2). It is reasonable to divide by the geometric mean length of stay for the appropriate diagnostic category because that repre-

sents the average length of stay statewide. A statewide average is more reasonable than the hospital's average length of stay because using a hospital's average would allow inefficient hospitals with longer stays to receive greater reimbursement. Subjecting hospitals to the statewide length of stay is an incentive for hospitals to operate efficiently.

Item A., Subitem (3). It is necessary to multiply the per day amount by a percentage to discount the marginal cost. Marginal cost is the change in total cost associated with one unit change in output. Normally more intensive services are provided during the early portion of an admission, and the marginal cost is usually less than the average cost. The amount of 60 percent is reasonable, because it is used by Medicare and the States of Pennsylvania, Ohio, and Michigan in the administration of their Medicaid DRG Programs. It is important to keep in mind that the proposed reimbursement system is based on averages which balance the expensive admissions by the inexpensive ones. Hospitals are able to keep savings generated from providing care to recipients at costs that are below the average without any adjustment by the Department.

Item A., Subitem (4). It is necessary and reasonable to reimburse only for inpatient hospital days beyond three standard deviations from the geometric mean length of stay because the categorical rate per admission includes admission up to three standard deviations.

Item A., Subitem (5). The necessity and reasonableness of this subitem is to show the mathematical determination of the day outlier reimbursement.

Item B. It is necessary and reasonable to inform affected parties how and by whom reimbursement for cost outliers shall be determined.

Item B., Subitems (1) and (2). It is necessary to convert billed charges to cost according to the base year Medicare/Medical Assistance cost report because cost recognized by the Medicare reasonable cost principles are the basis of the prospective reimbursement system. It is reasonable to use a statewide cost-to-charge ratio because the day and cost outliers are determined from statewide data. A hospital's cost-to-charge ratio would not be equitable to either the Department or the hospital because it could be affected by location, payor mix, the degree of cross subsidization among hospital departments.

Subitem (3). It is necessary and reasonable to determine the cost in excess of three standard deviations for each diagnostic category because the categorical rate per admission, which the hospital is also entitled to for a cost outlier, recognizes reimbursement up to that point.

Subitem (4). It is necessary to multiply the additional cost by 60 percent to determine the additional reimbursement. The reasonableness of using 60 percent for cost outliers is the same for day outliers in item A, subitem (3).

Item C. It is possible that an outlier might be both a day and cost outlier. It is necessary to inform hospitals how such an outlier will be handled for reimbursement. It is reasonable to consider this type of

outlier as a day outlier because the Department and the hospital can easily identify and review day outliers. That is, for utilization review purposes it is easier to review an inpatient day to determine its medical necessity than it is to identify and review various services provided during the inpatient stay to determine their medical necessity. This method is used by the State of Ohio in the administration of its Medicaid DRG Program.

Subpart 10. Items A to G. Reimbursement to out-of-area hospital. It is necessary that reimbursements be made to out-of-area hospitals for services provided to Minnesota recipients. It is also necessary to inform such hospitals how they will be reimbursed.

It is reasonable to reimburse the lesser of billed charges or the categorical rate per admission in order for the Department to be a prudent buyer. It is possible that the billed charges may be less than the prospective reimbursement since the level of charges varies throughout the country and the relative values in these rules are based on Minnesota hospitals' charges. The State of Pennsylvania uses this policy in the administration of its DRG Medicaid Program.

It is necessary to have an alternative to the reimbursement of inpatient hospital services to out-of-area hospitals other than that used for Minnesota hospitals because treating them similar to a Minnesota hospital would be an administrative burden for the Department. The Department does not have any base year Medicare/Medical Assistance cost reports for out-of-area hospitals. Also, there is a great probability that an out-of-area

hospital may not have any MA admission in the base year and thus an allowable base year cost per admission could not be determined. If there were any admissions in the base year of an out-of-area hospital, there probably would not be enough admissions to allow for a statistically valid determination. Finally, the total expenditures of MA and GAMC inpatient hospital services provided by out-of-area hospitals is not significant.

The formula for the reimbursement of these services is reasonable, because it is based on statewide averages for the allowable base year cost per admission as adjusted by the HCI and the budget year pass-through cost per admission. The determination of these averages is reasonable because it is not based on a simple average of all Minnesota hospitals but is weighed by the number of MA or GAMC admissions for each hospital. To do otherwise would allow a Minnesota hospital with only 10 admissions to have the same weight as a Minnesota hospital with 3,700 admissions. The proposed method results in a more accurate determination of Minnesota's average.

It is reasonable for the Department as a prudent buyer of these inpatient hospital services to determine averages that reflect the cost of purchasing these services in a Minnesota hospital. Also, the Department must make the reimbursement system less burdensome for out-of-area hospitals, i.e., the submission of pass-through cost reports, so that they will continue to participate in these health care programs and thus provide recipient access for medically necessary care.

Subpart 11. Reimbursement for hospitals statewide not having admissions in the base year. It is necessary that reimbursements be made for a hospital

that may not have had admissions in the base year and in later years provide inpatient hospital services to recipients. For example, this would occur in the situation of a newly constructed hospital. It is also necessary to inform such hospitals how they will be reimbursed. It is reasonable necessary to develop a separate reimbursement method for these types of hospitals because without any MA or GAMC admissions in the base year makes it impossible to determine an allowable base year cost per admission.

It is reasonable to apply the statewide adjusted base year cost per admission for the reasons cited in subpart 10. This procedure is modelled similar to the Medicare DRG Program for new hospitals. It is reasonable to use the budget year pass-through cost per admission with adjustment under part 9500.1125, subpart 4 because pass-through costs can be determined and, therefore, these hospitals should be treated like other Minnesota hospitals.

Subpart 12. Payor of last resort. This provision is necessary and reasonable because it is required under 42 CFR § 433.138.

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT

This part is necessary to comply with Minnesota Statutes, 256.969 (1984) and 42 U.S.L.A. § 1396 a (a) (13) and 42 CFR § 447.252 (a)(3)(i)(1982). The schedule set forth in the rule is reasonable because it reimburses on an increasing scale to hospitals that serve a population comprised of a large percentage of recipients. The schedule used was established with the consultation of reimbursement experts of the Minnesota Hospital Association.

It is both necessary and reasonable to exempt these additional reimbursements from any statutory limits in the growth of hospital rates or unit costs. To do otherwise would nullify this part and make it meaningless. However, it is reasonable to have an upper limit for this adjustment since reimbursement is based on each hospital's allowable cost under the Medicare reasonable cost related basis. The absence of a limit could result in a hospital receiving unwarranted additional reimbursement.

9500.1140 APPEALS

This section is necessary to comply with Minnesota Statutes, 256.969 (1984), subd. 4, and 42 CFR § 447.252(e)(1982).

Subpart 1. Appointment of appeals board. This section is necessary and reasonable to comply with Minnesota Statutes, section 256.969 (1984), subd. 4.

Subpart 2. Composition of appeals board. The composition of the appeals board is specified by Minnesota Statutes, section 256.969 (1984), subd. 4. The provision is consistent with statute.

Subpart 3. Duties of appeals board. Pursuant to Minnesota Statutes, section 256.969 (1984), the appeals board shall only advise the commissioner on adjustments to hospital rates.

9500.1145 PROCEDURES OF APPEALS BOARD

Subpart 1. Notice of appeal. It is necessary to inform a hospital that it has within 30 days of the effective date of the rate appealed or within

30 days of the change in circumstances which occasioned the appeal. The Department believes that 30 days affords a hospital ample time to consider action, i.e., to agree or appeal. The 30 day notice period for hospitals exceeds the 10 day notice period afforded recipients according to federal regulations at 42 CFR § 431.211. It is reasonable to require that the appeal notice state the rate appealed and the reasons for the appeal to discourage frivolous appeals, and to make the Department aware of the appeal's nature so that the Department can respond.

Item A. It is necessary to inform affected parties as to when an appeal hearing will be conducted. The Department believes that 90 days after proper notification will afford parties ample time to prepare for a hearing. Also this will ensure quick resolution of the appeal.

Item B. It is necessary to inform the affected parties when the hearing will be conducted. The Department believes a notice at least 20 days before the hearing should be sufficient.

Subitem (1). It is necessary and reasonable to inform the affected parties by notice as to the time, date, and place of the hearing so that the parties will be present at the hearing.

Subitem (2). It is necessary to inform the appealing hospital who it may contact in the Department regarding the appeal. This is reasonable because the hospital and the Department may be able to mutually resolve the appeal and thus avoid the cost and time of convening the appeals board.

Subitem (3). It is necessary and reasonable to inform affected parties that they do not have to be represented by an attorney because using an appeals board in lieu of the Office of Administrative Hearings aids cost efficiency, timely presentation of the issue, and rapid decision making.

Subitem (4). It is necessary to inform the affected parties of the consequences of failure to appear at the hearing. Failure to appear should result in default because this provides an incentive for the parties to resolve the appeal without unnecessary delays.

Subpart 2. Items A. B. and C. Rights of the appeals board. It is necessary to inform the appeals board what procedures it must use to conduct a hearing. The procedures are reasonable because they have been modelled closely after existing procedures of the Office of Administrative Hearings for hearings based on the Revenue Recapture Act, in parts 1405.5100 - 1405.7300.

Subpart 3. Appeals Rights. It is necessary and reasonable to inform a hospital that it may appeal a decision made by the Commissioner since this is provided for Minnesota Statutes, section 256.969 (1984), subd. 4.

It is necessary to inform the hospital that it has within 30 days after the effective date of the Commissioner's decision to appeal. Similar to the notice of appeal, the Department believes that 30 days affords the hospital ample time to consider action, i.e., to agree or appeal.

9500.1150 REIMBURSEMENT OF ADMISSIONS HOSPITAL SERVICES FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983 UNTIL JULY 28, 1985

Subpart 1. Purpose. It is necessary and reasonable to inform affected parties about the legislative authority and the period applicable to this rule.

Subpart 2. Definitions. This subpart is necessary and reasonable to clarify that the definitions pertain only to part 9500.1150.

Item A. This phrase describes the allowable base year costs cumulatively multiplied by the hospital cost index (HCI) for years prior to the budget year, and adjustments resulting from appeals or both. It is necessary to define this term because it is used in determining the rate per admission rate per day. The definition is reasonable because hospital rates must be multiplied annually for inflation, subject to legislatively imposed limits, to ensure that the reimbursement rate will be sufficient to meet the federal standards.

Item B. It is necessary to inform the affected parties as to how these costs will be derived. It is reasonable to use Medicare/Medical Assistance cost reports to identify costs for the base year because those reports contain all data necessary to establish a prospective reimbursement system. In addition, hospitals will have the required information readily available to verify the Department's determinations. It is reasonable to use 1981 as the base year because that is the most recent year for which cost data are available.

Subitem (1). It is necessary to subtract malpractice costs because they have been identified as a pass-through cost. If these costs were not

subtracted, it would result in a hospital being reimbursed twice for these costs, once as a allowable base year cost and once as a pass-through cost.

Subitem (2). Similar to the reasons explained in subitem (1) for malpractice insurance, pass-through costs must be subtracted so that a hospital will not be reimbursed twice for these costs. The deduction for pass-through costs is modified to exclude malpractice insurance for the reasons in subitem (1).

It is necessary to apportion pass-through costs to MA and GA since the pass-through costs in subitems (1) and (2) reflect a hospital's total pass-through costs. It is reasonable to apportion total pass-through costs on the ratio of each program's cost to total reimbursable costs as found in the Medicare base year cost report since these costs would be reasonably apportioned for other payors, such as Medicare and private insurers.

Subitem (3). It is reasonable to add costs disallowed on the Medicare/Medical Assistance cost report under the routine service cost limitation and the lower of cost or charge limitation because the Department has no evidence that these limitations equitably apply to economicaly and efficiently operated hospitals.

Item C. It is necessary to define "minimal participation" to comply with Minnesota Statutes, section 256.969 (1984). In consultation with reimbursement experts from the Minnesota Hospital Association, it is reasonable to define minimal participation as having fewer than 100 combined MA and GAMC admissions in a year as being too small for deriving a statistically valid

rate per admission. Without enough admissions a rate might be skewed by an unusually high or low cost admission and might be detrimental to either the hospital or the Department.

Item D. The definition of this term is necessary because there must be an identifiable unit of service to limit the rate of increase for inpatient hospital services and a mechanism that can be used to reimburse for these services. It is reasonable to reimburse a hospital on the basis of an admission, because an admission is a unit of service common to all hospitals. Minnesota Statutes, section 256.969 (1984) requires reimbursement to be based on a rate per admission. It is reasonable to use the "adjusted base year cost per admission" because this reflects costs related to the provision of inpatient hospital services during the base year cumulatively multiplied by the HCI.

It is necessary and reasonable to include budget year pass-through costs per admission. These costs are not included in the adjusted base year cost per admission, but they also relate to the provision of inpatient hospital services. It is necessary and reasonable to use budget year pass-through cost per admission because by definition this cost pertains to the period for which the rate per admission is effective.

Item E. Minnesota Statutes, section 256.969 (1984) require the Department to consider hospitals with minimal MA and GAMC utilization. That mandate can be effectuated by determining reimbursement on a per day basis, which is a smaller unit of service than the admission. A rate per day would be less

sensitive to high and low cost admissions and not detrimental to either the hospital or the Department.

It is reasonable to reimburse a hospital on a per day basis that qualifies for minimal participation because a day is an identifiable unit of service that can be used to limit the rate of increase for inpatient hospital services and such a unit of service is common to all hospitals. It is reasonable to use the "adjusted cost per day" because this reflects costs related to the provision of inpatient hospital services during the base year cumulatively multiplied by the HCI.

It is reasonable to include budget year pass-through costs per day because budget year pass-through costs are not included in the adjusted base year cost per day of inpatient hospital services but these costs also relate to the provision of inpatient hospital services. It is reasonable to use budget year pass-through costs per day because by definition this pertains to the period for which the rate per day is effective.

It is reasonable to allow such hospitals the option to be reimbursed under the per admission rate, which does not depend on the length of stay, since the per admission rate offers financial incentives for economically and efficiently operated hospitals.

Subpart 3. Determination of allowable base year costs, allowable base year cost per admission, and allowable base year cost per day. It is necessary to inform affected parties by whom and how the allowable base year costs, allowable base year cost per admission, and allowable base year cost per day

of inpatient hospital services will be determined. The Department will make this determination because it has the base year Medicare/Medical Assistance cost reports. It is reasonable to require that the Medicare/ Medical Assistance report be used because the cost data contained in the report has been determined on a reasonable cost basis. To establish prospective rates, most systems begin with a base year that recognizes Medicare principles of reasonable cost. The Medicare DRG Program similarly uses reasonable cost data under its DRG prospective reimbursement system. A formula for determining base year costs is necessary to implement the prospective reimbursement system. The formula selected is reasonable because it meets the criteria established in federal and state laws. The formula complies with Minnesota Statutes, section 256.969 (1984). The Department has consulted with reimbursement experts in the Minnesota Hospital Association and they have advised the Department the formula is reasonable to both hospitals and the Department.

Subpart 4. Determination of rate per admission and rate per day. It is necessary and reasonable to inform affected parties as to how reimbursement will be determined to facilitate a hospital's budgeting process.

Item A. The reason that pass-through costs are again included in these rules is because to call attention to one change in its use. Pass-through costs are changed in this part of the rule to include license fees in lieu of property insurance. License fees were included in the definition under 12 MCAR §§ 2.05401 - 2.05403 (Temporary) and thus in the determination of

the current reimbursement rates. Therefore, the Department does not want to make rules retroactively. The change to include property insurance under part 9500.1125 is mutually agreeable to the Department and the Advisory Committee. Property insurance is a capital cost or pass-through under the Medicare DRG Program. Consistency with the Medicare DRG Program is in the best interests of the Department, hospitals and other providers because the Medicare DRG Program is already used and understood by affected parties. For a discussion of the relationship of MA and Medicare, see pages 22-23, above. Although it is reasonable to include license fees as pass-through cost since they are not controllable by a hospital, license fees are an insignificant part of the total operating cost for a hospital. Usually hospitals are not able to readily determine the amount and it is difficult for the Department to verify them.

Item B. The necessity and reasonableness for this provision is as stated on page 41, above. The formula is modified in this provision to take into account that reimbursement is on a per admission and per day basis.

Item C. The need and reasonableness of this unit of reimbursement is discussed in subpart 3, item D.

Item D. The need and reasonableness of this unit of reimbursement is described in subpart 3, item E.

Item E. The necessity and reasonableness of this adjustment is as stated on page 42, above. The necessity and reasonableness of the interest charge for late payment is as stated on page 43, above.

Item F. Hospitals that qualify under the definition of minimal participation may elect to be reimbursed on a per admission basis which has no regard to length of stay, and offers financial incentives for economically and efficiently operated hospitals. It is reasonable to require that notification be made at least 30 days prior to the start of the budget year to allow time for the Department to determine the per admission rate and so that reimbursement is determined prior to the delivery of the inpatient hospital services as prospective reimbursement is defined.

Item G. The need and reasonableness for this provision is discussed on page 51, above.

Item H. The need and reasonableness of this provision is discussed on pages 43-46 above.

Item I. The need and reasonableness of this provision is discussed on pages 52-54.

9500.1155 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES PROVIDED FROM JANUARY 1, 1983 UNTIL PART 9500.1150 BECOMES APPLICABLE

Subpart 1. Purpose. It is necessary and reasonable to inform affected parties of the legislative authority, the limitation of rate increase, and the period this part of the rule is applicable. Also, the reimbursement for inpatient hospital services during this period has not been completed by the Department and, therefore, is necessary to incorporate this provision in these rules.

Subpart 2. Definitions. This subpart is necessary and reasonable to clarify that the definitions pertain only to part 9500.1155.

Item A. This definition follows the one for "adjusted base year costs" found under part 9500.1150, subpart 2, item A with two changes. Under this definition the allowable base year costs are accumulatively multiplied by the eight percent cap instead of the HCI. This is consistent with the limitation to an eight percent cap under Minnesota Statutes, section 256.966 (1984). Secondly, the eight percent cap applies to years prior to the "rate year" instead of the "budget year." This is reasonable because by definition the rate year pertains to the period addressed in this part of the rule addresses. Except for these changes the need and reasonableness is discussed on page 55, above.

Item B. Subitems (1), (2), and (3). Allowable base year costs. This definition follows the one for "allowable base year costs" discussed under part 9500.1150, subpart 2, item A, with one change. Subitem (2) under this definition uses the term "total hospital costs" in place of "total reimbursable costs." Except for this change the need and reasonableness is discussed on page 55, above.

The need for the change mentioned in the prior paragraph is due to how the Department reimbursed for hospital based physician fees (anesthesiology, radiology, and pathology). That is because during the period for this part of the rule (January 1, 1982 through June 30, 1983) the cost for these fees were included in the rate to a hospital.

To apportion pass-through costs to MA based on an amount reflecting a hospital's total cost of operation, it was necessary that that amount include the renumeration for hospital based physician fees. At the request of reimbursement experts in the hospital industry, the reimbursement for these fees was made separate from prospective reimbursement to be consistent with the Medicare Program. Under the Medicare DRG Program these fees are excluded from the rate determinations because they must be billed separtely for reimbursement. Consistency is in the best interests of the Department, hospitals, and other providers. The Department finds this request to reimburse for these fees separately reasonable, and it also should eliminate the opportunity for duplicate reimbursement. Therefore, to determine apportionment of pass-through costs for MA under part 9500.1150, subpart 3, item E., an amount reflecting a hospital's total allowable cost of operation excluding renumeration for hospital based physician fees according to the Medicare Program was used (total reimbursable costs from Worksheet A, column 7, line 84).

Item C. The need and reasonableness for this definition is required under Minnesota Statutes, section 256.966 (1982).

Item D. The need and reasonableness for this definition is discussed on page 57, above.

Item E. The definition of this term is necessary becasue there must be an identifiable unit of service to limit the rate of increase to eight percent for inpatient hospital services. It is reasonable to reimburse a hospital

on the basis of an admission because an admission is a unit of service common to all hospitals. Minnesota Statute, section 256.969 (1984) requires reimbursement to be made on a rate per admission. It is appropriate to apply the eight percent cap to the allowable base year costs per admission. By definition, the allowable base year cost per admission pertains to 1981, the last year of the biennium prior to the 1983 biennium for which the eight percent cap is applicable.

It is necessary and reasonable to include the rate year pass-through cost per admission. These costs are not included in the allowable base year cost per admission, but these costs also relate to the provision of inpatient hospital services. It is necessary and reasonable to use the rate year pass-through cost per admission because by definition this pertains to the period for which the rate per admission is effective.

Item F. The necessity for using the day as a basis for reimbursement to hospitals with minimal participation is discussed on page 60, above.

It is reasonable to reimburse a hospital on a per day basis that qualifies for minimal participation because a day is an identifiable unit of service that can be used to limit the rate of increase to eight percent for inpatient hospital services and is a mechanism that can be used to reimburse a hospital. It is reasonable to reimburse a hospital on the basis of a day because such a unit of service is common to all hospitals. It is appropriate to apply the eight percent cap to the allowable base year cost per day. By definition the allowable base year cost per day pertains to

1981, the last year of the biennium prior to the 1983 biennium for which the eight percent cap is applicable.

It is necessary and reasonable to include the rate year pass-through cost per day. These costs are not included in the allowable base year cost per day, but these costs also relate to the provision of inpatient hospital services. It is necessary and reasonable to use the rate year pass-through cost per day because by definition this pertains to the time period for which the rate per day is effective.

Item G. This definition is only for the purpose of identification.

Subpart 3. Determination of allowable base year costs, allowable base year cost per admission, and allowable base year cost per day. The need and reasonableness for this subpart is discussed on page 58, above in part 9500.1150, subpart 3. The only change in the formula is due to the Department's policy to exclude hospital based physician fees in prospective reimbursement effective July 1, 1984. Since the period covered by this subpart is prior to July 1, 1984, the hospital based physician fees are not subtracted as was done in part 9500.1150, subpart 3, item C. Item E is necessary for the subtraction of malpractice insurance costs which are a pass-through cost. The subtraction was not necessary under part 9500.1150, subpart 3 because malpractice insurance costs are not included under item E for total reimbursable costs.

Subpart 4. Determination of rate per admission and rate per day. It is necessary and reasonable to inform affected parties as to how reimbursement will be determined.

Item A. It is necessary and reasonable to inform affected parties that the Department will do the determinations for the rate year pass-through cost per admission or per day. Since the period covered by this rule is retrospective rather than prospective, rate year pass-through costs are used in lieu of budgeted pass-through costs for the rate year, which by definition covers the period of this rule. It is also reasonable to use the pass-through costs as determined by Medicare since Medicare is understood by the affected parties.

Item B. It is necessary to use the allowable base year costs from 1981 and increase it by the eight percent cap which is allowed under Minnesota Statutes, section 256.966 (1982), because a hospital's fiscal year ending in 1982 will be the first year subject to this part of the rule. After the first year it is necessary to use the adjusted base year cost in lieu of the allowable base year costs because that would reflect the amount by the eight percent cap for 1982 which would be used for a hospital fiscal year ending in 1983.

Item C. This item informs the affected parties that the Department will make the rate per admission determination.

It is reasonable to use the base year admissions in determining the rate year pass-through cost per admission to be consistent with how the allowable and adjusted base year costs per admission are determined.

Item D. This item informs the affected parties that the Department will make the rate per day determination. The need and reasonableness of using

the rate year pass-through cost per day, the base year day, and the adjusted base year cost per day after the initial year, is for the reasons cited in item C.

Item E. The need and reasonableness for the minimal particiaption provision is discussed on page 56, above.

Item F. The need and reasonableness for this provision is discussed on page 51, above.

Item G. The need and reasonableness for this provision is discussed on pages 42-44, above.

Item H. The need and reasonableness for this provision is discussed on pages 52-54, above.

Subpart 5. Four percent reduction. The need and reasonableness of this subpart is required under Laws of Minnesota 1982, Third Special Session, chapter 1, article 2, section 2, subdivision 4, paragraph (a), clause (4).

The foregoing is submitted in support of and as justification for the final adoption of the proposed rules.

The Department does not plan to use any "expert witnesses" from outside the Department to testify on its behalf at the public hearing.

Dated: February 7, 1985

Albert Hawyl for

LEONARD W. LEVINE

Commissioner

Minnesota Department of Human Services

JS1/01

Rules as Proposed (all new material)

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for all hospitals that participate in and are reimbursed directly 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.

9500.1095 STATUTORY AUTHORITY.

Parts 9500.1090 to 9500.1155 are authorized by Minnesota Statutes, section 256.969, subdivisions 2 and 6, and Laws of Minnesota 1983, chapter 312, article V, section 39. Parts 9500.1090 to 9500.1155 must be read in conjunction with Titles XVIII and XIX of the Social Security Act, Code of Federal Regulations, title 42, and Minnesota Statutes, chapters 256, 256B, and 256D.

9500.1100 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1090 to 9500.1155, the terms in subparts 2 to 48 have the meanings given them.

Subp. 2. **Adjusted base year cost per admission.** "Adjusted base year cost per admission" means allowable base year cost per admission cumulatively multiplied by the hospital cost index for years prior to the budget year.

Subp. 3. **Admission.** "Admission" means the act that allows the 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.

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

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 is adjusted for case mix and which excludes pass-through costs and outliers.

Subp. 6. **Ancillary service.** "Ancillary service" means inpatient hospital services that include laboratory, radiology, drugs, delivery room, operating room, therapy services, and other special items and services customarily charged for in addition to a routine service charge.

Subp. 7. **Appeals board.** "Appeals board" means the board which advises the commissioner on adjustments to a categorical rate per admission, rate per admission, or a rate per day.

Subp. 8. **Arithmetic mean cost per admission.** "Arithmetic mean cost per admission" means the number obtained by dividing the sum of a set of reimbursable inpatient hospital costs per admission by the number of admissions in the set.

Subp. 9. **Base year.** "Base year" means the hospital's fiscal year ending during calendar year 1981.

Subp. 10. **Budget year.** "Budget year" means the hospital's fiscal year for which a prospective reimbursement system is being determined.

Subp. 11. **Case mix.** "Case mix" means the distribution of admissions in the diagnostic categories.

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

Subp. 13. **Claims.** "Claims" means the information contained on the inpatient hospital invoices submitted to the department by a hospital to request reimbursement for inpatient hospital services provided to a recipient.

Subp. 14. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized representative of the commissioner.

Subp. 15. **Cost outlier.** "Cost outlier" means an admission whose reimbursable inpatient hospital cost exceeds the geometric mean cost per admission for diagnostic categories O and W under subpart 20, by three standard deviations.

Subp. 16. **Cost-to-charge ratio.** "Cost-to-charge ratio" means a ratio of a hospital's reimbursable inpatient hospital costs to its charges for inpatient hospital services.

Subp. 17. **Current year.** "Current year" means the hospital's fiscal year which occurs immediately before the budget year.

Subp. 18. **Day outlier.** "Day outlier" means an admission whose length of stay exceeds the geometric mean length of stay for a diagnostic category by three standard deviations.

Subp. 19. **Department.** "Department" means the Minnesota Department of Human Services.

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. Diseases and Disorders of the Nervous System	(1-35)
B. Diseases and Disorders of the Eye	(36-48)
C. Diseases and Disorders of the Ear, Nose, and Throat	(49-74)
D. Diseases and Disorders of the Respiratory System	(75-97, 99-102)
E. Diseases and Disorders of the Circulatory System	(103-145)
F. Diseases and Disorders of the Digestive System	(146-183, 185-190)
G. Diseases and Disorders of the Hepatobiliary System	

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	and Pancreas	(191-208)
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	(209-256)
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	(257-284)
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	(285-301)
K.	Diseases and Disorders of the Kidney and Urinary Tract	(302-333)
L.	Diseases and Disorders of the Male Reproductive System	(334-352)
M.	Diseases and Disorders of the Female Reproductive System	(353-369)
N.	Pregnancy, Childbirth, and the Puerperium	(370, 374-384)
C.	Newborns and Other Neonates with Conditions Originating in the Perinatal Period	(385-390)
P.	Diseases and Disorders of the Blood and Blood-Forming Organs and Immunity Disorders	(392-399)
Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms NEC	(400-414)
R.	Infectious and Parasitic Diseases (Systemic or Unspecified Sites)	(415-423)
S.	Mental Diseases and Disorders	(424-425, 427-429, 432)
T.	Substance Use and Substance Induced Organic Mental	

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	Disorders (Ages 0-20)	(433-438)
U.	Substance Use and Substance Induced Organic Mental Disorders (Ages over 21)	(433-438)
V.	Injury, Poisoning, and Toxic Effects of Drugs	(439-455)
W.	Burns	(456-460)
X.	Factors Influencing Health Status and Other Contacts with Health Services	(461-467)
Y.	Bronchitis and Asthma (Ages 0-1)	(98)
Z.	Bronchitis and Asthma (Ages 2-17)	(98)
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 0-1)	(184)
BB.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 2-17)	(184)
CC.	Cesarean section without cormorbidities and complications	(371)
DD.	Vaginal delivery with complicating diagnosis	(372)
EE.	Vaginal delivery without complicating diagnosis and Normal newborns	(373), (391)
FF.	Depressive neurosis	(426)
GG.	Psychosis	(430)
HH.	Childhood mental disorders	(431)
II.	Unrelated Operating room procedure	(468)
JJ.	Cases which could not be assigned to other diagnostic categories	(469-470)

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Subp. 21. **Discharge.** "Discharge" means a release of a recipient from a hospital.

Subp. 22. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the program established by Minnesota Statutes, section 256D.03.

Subp. 23. **Geometric mean cost per admission.** "Geometric mean cost per admission" means the nth root of the product of the reimbursable inpatient hospital costs per admission for n admissions.

Subp. 24. **Geometric mean length of stay.** "Geometric mean length of stay" means the nth root of the product of the number of days spent in a hospital for each admission for n admissions.

Subp. 25. **Hospital.** "Hospital" means an institution that, except for state-operated facilities, is approved to participate as a hospital under medicare.

Subp. 26. **Hospital cost index or HCI.** "Hospital cost index" or "HCI" means a single percentage annually multiplied by the adjusted base year cost per admission or the adjusted base year costs to adjust for inflation.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided under the supervision of a physician and furnished in a hospital for the care and treatment of a recipient. The inpatient hospital service may be furnished by a physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical assistance reimbursement.

Subp. 28. **Local agency.** "Local agency" means a county or multicounty agency authorized under Minnesota Statutes as the agency responsible for determining eligibility for medical assistance.

Subp. 29. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under Title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

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 9505.0540 [Emergency] cannot be provided on an outpatient basis.

Subp. 31. **Medicare.** "Medicare" means the federal health insurance program established under Title XVIII of the Social Security Act.

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

Subp. 33. **Operating costs.** "Operating costs" means the reimbursable inpatient hospital costs of a hospital excluding pass-through costs.

Subp. 34. **Outlier.** "Outlier" means a day outlier or a cost outlier.

Subp. 35. **Out-of-area hospital.** "Out-of-area hospital" means any hospital outside of Minnesota.

Subp. 36. **Pass-through costs.** "Pass-through costs" means reimbursable inpatient hospital costs not subject to the HCI.

Subp. 37. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to 9505.5020 [Emergency].

Subp. 38. **Prior year.** "Prior year" means the hospital's fiscal year immediately before the current year.

Subp. 39. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per admission, rate per admission, or rate per day, or some combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 40. **Readmission.** "Readmission" means an admission which occurs within seven days of a discharge, whose diagnostic category or a related diagnostic category is the same as that identified for that discharge.

Subp. 41. **Recipient.** "Recipient" means a person who has

applied to a local agency and has been determined eligible for medical assistance.

Subp. 42. **Reimbursable inpatient hospital costs.** "Reimbursable inpatient hospital costs" means those costs allowable under Title XVIII of the Social Security Act for inpatient hospital services.

Subp. 43. **Relative value.** "Relative value" means the reimbursable inpatient hospital cost per admission for all admissions in each diagnostic category in relation to the reimbursable inpatient hospital cost per admission of all admissions in all other diagnostic categories on a statewide basis.

Subp. 44. **Routine service.** "Routine service" means those inpatient hospital services included by a hospital in a daily room charge. Routine services are composed of two broad components: (1) general routine services, and (2) special care units including nursery care units, coronary care units, and intensive care units.

Subp. 45. **Second surgical opinion.** "Second surgical opinion" means the confirming or denying of the need for the proposed surgery by a recommended second physician as specified in part 9505.5030 [Emergency] and Minnesota Statutes, section 256B.503.

Subp. 46. **Total hospital admissions.** "Total hospital admissions" means the total number of acts that allow persons to officially enter a hospital during the base year to receive a service provided under the supervision of a physician and furnished in a hospital by a physician, or a vendor of an ancillary service prescribed by a physician.

Subp. 47. **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.

Subp. 48. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital to another.

9500.1105 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES.

The department shall use a prospective reimbursement system to reimburse hospitals for inpatient hospital services provided to recipients.

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. select all claims for all hospitals statewide for state fiscal years 1983 and 1984;

B. assign each claim from item A to the specific admission which generated the claim except as provided in item C;

C. exclude from item B the following claims:

(1) medicare crossover claims,

(2) claims submitted by out-of-area hospitals, and

(3) claims not reimbursed as of February 28, 1985;

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) establish the cost of routine services determined by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined in the base year,

(2) establish 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 the base year,

(3) establish the cost of services rendered by

interns and residents not in an approved teaching program for each admission in item B by multiplying the number of days for the appropriate routine services by the per diem cost identified in Worksheet D-2, Part I of the base year, and

(4) sum subitems (1) to (3) to determine the reimbursable inpatient hospital cost for each admission in item B;

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;

F. assign each admission to a diagnostic category;

G. identify outliers for each diagnostic category;

H. determine the statewide arithmetic mean cost per admission for all admissions by dividing the total reimbursable inpatient hospital cost for all admissions excluding outliers by the total number of admissions excluding outliers;

I. 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 by the total number of admissions in each diagnostic category excluding outliers; and

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

Subp. 2. **Redetermination of relative values.** The department shall redetermine the relative values of the diagnostic categories prior to the beginning of each state fiscal biennium. The redetermination of the relative values shall be based on claims from the two most recently completed state fiscal years reimbursed on or before March 1 of the second year of the biennium and the cost-to-charge ratio determined during the base year.

These redetermined relative values shall be the basis of reimbursement for the next biennium.

Subp. 3. **Publication of relative values.** The department

shall publish in the State Register the relative values of each diagnostic category at least 30 days prior to the start of a biennium.

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

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

A. determine reimbursable inpatient hospital costs for each hospital's base year admissions according to part 9500.1110, subpart 1, item D;

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 part 9500.1110, subpart 1, item G, and

(2) pass-through 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 outliers;

D. adjust item C for case mix as follows:

(1) assign each base year admission a diagnostic category as specified in part 9500.1110, subpart 1, items E and F,

(2) multiply each base year admission excluding outliers by the relative value of the diagnostic category assigned to that admission,

(3) sum the products determined in subitem (2),

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

(5) divide the cost per admission as determined in item C by subitem (4).

9500.1120 DETERMINATION AND PUBLICATION OF HOSPITAL COST INDEX (HCI).

Subpart 1. **Adoption of Health Care Costs.** The most recent

Health Care Costs published by Data Resources Incorporated (DRI) is incorporated by reference. The health care costs report is available through the minitex interlibrary loan system. The report is published monthly.

Subp. 2. **Determination of HCI.** For each calendar quarter the department shall determine the HCI as follows:

A. For each calendar quarter obtain from Health Care Costs published by Data Resources, Inc., inflation estimates for the following operating costs:

(1) salaries

(2) employee benefits

(3) medical fees

(4) raw food

(5) medical supplies

(6) pharmaceuticals

(7) utilities

(8) repairs and maintenance

(9) insurance (other than malpractice)

(10) other operating costs

B. During the fourth quarter of each calendar year, obtain data for operating costs as found in the aggregate of hospitals in Minnesota which indicate the proportion of operating costs attributable to each of item A, subitems (1) to (10). These proportions will be used in the determination of the HCI for the next calendar year.

C. Multiply each proportion for item A, subitems (1) to (10) by each subitem's inflation estimate.

D. Sum the products determined in item C and round the sum to one decimal place.

Subp. 3. **Publication of HCI.** The department shall publish the HCI in the State Register 30 days prior to the start of each calendar quarter. A hospital whose budget year starts during a given calendar quarter is subject to the HCI published 30 days prior to the start of that quarter.

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION.

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

budget year, each hospital shall submit to the department a written report of pass-through costs. 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 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. Depreciation			
B. Rents and leases			
C. Property taxes			
D. Property Insurance			
E. Interest			
F. Malpractice insurance			
G. TOTAL PASS-THROUGH COSTS (ITEMS A TO F)			

Pass-through costs are limited to items A to F 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.

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 to total reimbursable costs pursuant to part 9500.1115, item B, subitem (2)			

B. Pass-through costs as specified in subpart 1, item G multiplied by item A	_____	_____	_____
C. Number of base year admissions excluding outliers pursuant to part 9500.1115, item D, subitem (4)	_____	_____	_____
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 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 the hospital, the hospital shall pay to the commissioner the entire overpayment within 60 days of receiving the written notification from the commissioner.

Subp. 5. **Interest.** Interest charges must be assessed on underpayment or overpayment balances for pass-through cost adjustments outstanding after the deadlines. 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.

Subp. 6. **Effective date.** The categorical rate per

admission shall be effected for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1130 REIMBURSEMENT PROCEDURES.

Subpart 1. **Submittal of claims.** Claims must be submitted after the recipient is discharged.

Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved 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.

Subp. 4. **Adjustment to reimbursement.** Reimbursements made by the department shall be adjusted for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 [Emergency]. Adjustment to a hospital's account shall be by debit.

Subp. 5. **Rejection of claims.** Claims will not be reimbursed for a hospital's failure to:

A. obtain prior authorization;

B. provide documentation of a second surgical opinion;

C. receive admission certification; and

D. assign a claim to one of diagnostic categories A to II in part 9500.1100, subpart 20.

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)]

Subp. 7. **Reimbursement for transfers.** The department shall reimburse hospitals who discharge transfers and who admit transfers. Each hospital shall be reimbursed as follows:

Transfer = [(adjusted base year cost per admission) multiplied by (the relative value of the appropriate diagnostic

Reimbursement = category), divided by (the geometric mean length of stay of the diagnostic category) and multiplied by (the number of days of inpatient hospital services)]

In no case may a hospital receive a transfer reimbursement for a transfer that exceeds the adjusted base year cost per admission multiplied by the relative value of the appropriate diagnostic category unless the transfer is an outlier.

Subp. 8. **Reimbursement for admissions.** An admission and readmission to the same hospital shall be reimbursed with one categorical rate per admission and reimbursed for an outlier if appropriate. A readmission to a different hospital shall be reimbursed as a transfer as specified in subpart 7.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital 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 relative value of the appropriate diagnostic category;

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

(3) multiply the per day amount as determined in subitem (2) by 60 percent to establish the per day rate for the diagnostic category;

(4) subtract the number of inpatient days at three standard deviations for the diagnostic category as identified in part 9500.1110, subpart 1, item G from the actual number of inpatient days to establish the number of outlier days; and

(5) multiply the product determined in subitem (3) by the number of days determined in subitem (4).

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

(1) determine a statewide cost-to-charge ratio

according to hospitals' statewide base year medicare/medical assistance cost reports;

(2) multiply the hospital's billed charges by the statewide cost-to-charge ratio;

(3) subtract the cost at three standard deviations for the diagnostic category 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.

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

Subp. 10. **Reimbursement to out-of-area hospital.** The department shall reimburse out-of-area hospitals based on the lesser of billed charges or the out-of-area hospital categorical rate per admission. The department shall determine the out-of-area categorical rate per admission as follows in 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 hospital statewide by the number of admissions in each hospital's base year, excluding 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 outliers, to determine the statewide 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 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 outliers, to determine a statewide pass-through cost per admission;

G. the department shall determine the categorical

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rate per admission for an out-of-area hospital as follows:

Out-of-area Hospital Categorical Rate Per Admission	=	[(statewide 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 hospitals statewide which do not have admissions in the base year.** The department shall reimburse statewide hospitals which do not have admissions in the base year by using the statewide adjusted base year cost per admission as specified in subpart 10, item C, multiplied by the relative value of the appropriate diagnostic category plus the budget year pass-through cost per admission according to part 9500.1125, subpart 2. The pass-through cost per admission will be adjusted under part 9500.1125, subpart 4, and will be subject to part 9500.1125, subpart 5.

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

Subp. 12. **Payor of last resort.** A hospital may not submit a claim to the department until a final determination of the recipient's eligibility for potential third party payment has been made by a hospital. Any and all available third party benefits must be exhausted prior to billing medical assistance and the amounts collected must be shown on the claim.

9500.1135 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 exceed 15 percent of total hospital admissions according to the following schedule:

Percentage of Total Hospital Admissions Which are Medical

Assistance and General Assistance Medical Care	Increase in Adjusted Base Year Cost Per Admission
15-20 percent	1/4 percent for each percentage point above 15 percent
21-25 percent	1/2 percent for each percentage point above 20 percent
26-30 percent	3/4 percent for each percentage point above 25 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. In no case shall the disproportionate population adjustment exceed twice the HCI as determined in part 9500.1120.

9500.1140 APPEALS.

Subpart 1. **Appointment of appeals board.** The appeals board shall be appointed by the commissioner.

Subp. 2. **Composition of appeals board.** The appeals board shall consist of two public representatives, two representatives of the hospital industry, and one representative of the business or consumer community. Representatives shall serve for a period of two years.

Subp. 3. **Duties of appeals board.** The appeals board shall review a hospital's request that its reimbursement rate be changed and recommend to the commissioner what action should be taken on the request.

9500.1145 PROCEDURES OF APPEALS BOARD.

Subpart 1. **Notice of appeal.** A hospital that wants to appeal a rate must notify the department of its intent to appeal within 30 days of the effective date of the rate appealed or within 30 days of the change in circumstances which prompted the appeal. The notice of appeal must state the rate appealed and

the reasons for the appeal.

A. Within 90 days of the receipt of a notice of appeal, the board shall conduct a hearing.

B. The appeals board shall send a notice of hearing to the hospital at least 20 days before the hearing. The notice shall contain, at a minimum, the following:

(1) the time, date, and place for the hearing;

(2) the name, address, and telephone number of the department's representative to be contacted to discuss informal disposition of the dispute;

(3) notification that a party need not be represented by an attorney but may choose to be represented by an attorney or any other person of their choice; and

(4) a statement advising parties that failure to appear at the hearing will result in default.

Subp. 2. **Rights and obligations of appeals board.** The following are the rights and obligations of the appeals board:

A. A member of the appeals board shall be free of any personal, political, or economic association that would impair his or her ability to function in a fair and objective manner. Should a board member believe that he or she cannot comply with this rule, the member shall withdraw from hearing the appeal.

B. A member of the appeals board shall not communicate, directly or indirectly, with any person or party concerning any issue of fact or law relevant to a pending case except upon notice to all parties and opportunity for them to participate except as otherwise permitted by these rules.

C. Consistent with law and parts 9500.1090 to 9500.1155, the appeals board shall perform the following duties:

(1) Appoint one of its members to act as chairperson.

(2) Examine witnesses as necessary to make a complete record.

(3) Issue a written report to the commissioner regarding each appeal. The report shall contain findings of fact, conclusions, and a recommended disposition.

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(4) All actions of the appeals board shall be by majority rule of the board members present.

(5) Do all things necessary and proper to the performance of the foregoing.

Subp. 3. **Appeal rights.** A hospital may appeal a decision of the commissioner by serving a written notice of appeal with the commissioner within 30 days of the date of service of the decision appealed. The appeal shall be conducted under the contested case procedures of Minnesota Statutes, chapter 14 and the rules of the Office of Administrative Hearings.

9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS BEGINNING ON OR AFTER JULY 1, 1983, UNTIL JULY 28, 1985.

Subpart 1. **Purpose.** Under Minnesota Statutes, section 256.969, the annual increase in the cost per service unit for inpatient hospital services under medical assistance or general assistance medical care shall not exceed five percent for hospital rate years beginning during the 1985 biennium.

Subp. 2. **Definitions.** As used in this part, the following terms have the meanings given to them.

A. "Adjusted base year costs" means allowable base year costs cumulatively multiplied by the hospital cost index for a hospital's fiscal years prior to the budget year, and adjustments resulting from appeals.

B. "Allowable base year costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's base year medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total reimbursable costs; and

(3) add the lower of cost or charge limitations for costs disallowed on the medicare/medical assistance cost report as provided by Public Law Number 92-603, section 223,

inpatient routine service cost limitations, and Public Law Number 92-603, section 233.

C. "Minimal participation" means a hospital with fewer than 100 combined medical assistance and general assistance medical care admissions in the base year.

D. "Rate per admission" means the adjusted base year cost for each admission multiplied by the budget year HCI and adding the budget year pass-through cost per admission.

E. "Rate per day" means the allowable base year cost per day of inpatient hospital services multiplied by the budget year HCI and adding the budget year pass-through cost per day of inpatient hospital services.

Subp. 3. **Determination of allowable base year costs, allowable base year cost for each admission, and allowable base year cost per day.** The department shall determine allowable base year costs from the base year medicare/medical assistance cost report, using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determination following the steps outlined in items A to P:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part 1, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part 1, line 5);

C. reimbursable professional services (Worksheet E-5, Part 1, line 11);

D. net reimbursable inpatient hospital costs (subtract items B and C from item A);

E. total reimbursable costs (Worksheet A, column 7, line 84);

F. ratio of net reimbursable inpatient hospital costs to total reimbursable costs (item D divided by item E);

G. pass-through costs;

H. medical assistance pass-through costs (item F multiplied by item G);

I. routine service costs before limitation (Worksheet D-1, line 57);

J. reimbursable routine service costs (Worksheet D-1, line 61);

K. reimbursable routine service costs subject to limitation (subtract item J from item I);

L. allowable base year costs (subtract item H from item D and add item K);

M. base year admissions excluding medicare crossovers;

N. allowable base year cost for each admission (item L divided by item M);

O. base year patient days excluding medicare crossovers; and

P. allowable base year cost per day (item L divided by item O).

Subp. 4. **Determination of rate per admission and rate per day.** The department shall determine the rate per admission and rate per day according to items A to G.

A. For each hospital's budget year, each hospital shall submit to the department a written report of pass-through costs. 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 the start of each hospital's budget year and must include the following information:

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Depreciation	_____	_____	_____
(2) Rents and leases	_____	_____	_____
(3) Property taxes	_____	_____	_____
(4) License fees	_____	_____	_____
(5) Interest	_____	_____	_____
(6) Malpractice insurance	_____	_____	_____
(7) TOTAL PASS-THROUGH COSTS [subitems (1) to (6)]	_____	_____	_____

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Pass-through costs are limited to subitems (1) to (6) as defined 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.

B. The department shall determine the budget year pass-through cost per admission or per day, or both, from the submitted pass-through cost reports as specified in item A as follows:

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Ratio of net reimbursable inpatient hospital costs to total reimbursable costs [subpart 3, item F]			
(2) Pass-through costs as specified in [subpart 4, item A, subitem (7)]			
(3) Base year admissions [subpart 3, item M]			
(4) Pass-through cost per admission [subitem (2) divided by subitem (3)]			
(5) Base year patient days [subpart 3, item O]			
(6) Pass-through cost per day of inpatient hospital services [subitem (2)			

divided by subitem (5)]

C. The department shall determine the rate per admission for a budget year as follows:

Rate Per Admission = [(Adjusted base year cost for each admission) multiplied by (budget year HCI), plus (budget year pass-through cost per admission)]

D. The department shall determine the rate per day for a budget year as follows:

Rate Per Day = [(Adjusted base year cost per day of inpatient hospital services) multiplied by (budget year HCI), plus (budget year pass-through cost per day of inpatient hospital services)]

E. After the end of each budget year, the commissioner shall redetermine the rate per admission or rate per day, or both. The commissioner shall substitute actual pass-through costs as determined by medicare for budgeted costs in item B, subitem (2) for that year. If an adjustment indicates an overpayment to the hospital, the hospital shall pay the department the overpayment within 60 days of formal notification from the department. If the adjustment indicates an underpayment to the hospital, the department shall pay the hospital the underpayment within 60 days of formal notification from the department. Interest charges will be assessed according to part 9500.1125, subpart 5.

F. A hospital with minimal participation shall be reimbursed on a rate per day in lieu of a rate per admission unless the hospital elects to be reimbursed on a rate per admission basis. To obtain reimbursement on a rate per admission basis, the hospital shall submit a written request to the commissioner at least 30 days prior to the beginning of the budget year for which reimbursement is sought.

G. The department shall apply the disproportionate population adjustment as specified in part 9500.1135, substituting the term adjusted base year cost per admission with

a rate per admission or rate per day.

H. Reimbursement procedures are as specified in part 9500.1130, subparts 1 to 6.

I. Appeals must be made according to parts 9500.1140 and 9500.1145.

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

Subpart 1. **Purpose.** Under Minnesota Statutes 1982, section 256.966, the annual increase in the cost per service unit paid to any vendor under medical assistance or general assistance medical care shall not exceed eight percent for services provided from January 1, 1982, until part 9500.1150 becomes applicable.

Subp. 2. **Definitions.** As used in this part, the following terms have the meanings given them:

A. "Adjusted base year costs" means allowable base year costs cumulatively multiplied by the eight percent cap for a hospital's fiscal years prior to the rate year, and adjustments resulting from appeals.

B. "Allowable base year costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's base year medicare/medical assistance cost report with the following adjustments:

(1) subtract malpractice insurance costs that have been apportioned to medical assistance;

(2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total hospital costs; and

(3) add the lower of cost or charge limitations for costs disallowed on the medicare/medical assistance cost report as provided by Public Law Number 92-603, section 223, inpatient routine service cost limitations, and Public Law Number 92-603, section 233.

C. "Eight percent cap" means the limit on the annual cost increase per service unit under Minnesota Statutes, section

256.966.

D. "Rate per admission" means the allowable base year cost for each admission multiplied by the eight percent cap and adding the rate year pass-through cost per admission.

E. "Rate per day" means the allowable base year cost per day of inpatient hospital services multiplied by the eight percent cap and adding the rate year pass-through cost per day of inpatient hospital services.

F. "Rate year" means any hospital fiscal year that includes the period from January 1, 1982, until part 9500.1150 becomes applicable.

G. "Total hospital costs" means the costs identified in the hospital's base year medicare/medical assistance cost report, HCFA Form 2552, 1981 revision, Worksheet A, column 3, line 84.

Subp. 3. **Determination of allowable base year costs, allowable base year cost for each admission, and allowable base year cost per day.** The department shall determine allowable base year costs from the base year medicare/medical assistance cost report, using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to Q:

A. reimbursable inpatient hospital costs (Worksheet E-5, Part 1, line 13);

B. reimbursable malpractice insurance costs (Worksheet E-5, Part 1, line 5);

C. net reimbursable inpatient hospital costs (subtract item B from item A);

D. total hospital costs (Worksheet A, column 3, line 84);

E. malpractice insurance costs (Worksheet A, column 5, line 71);

F. net total costs (subtract item E from item D);

G. ratio of net reimbursable inpatient hospital costs to net total costs (item C divided by item F);

H. pass-through costs;

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I. medical assistance pass-through costs (item G mulitplied by item H);

J. routine service costs before limitation (Worksheet D-1, line 57);

K. reimbursable routine service costs (Worksheet D-1, line 61);

L. reimbursable routine service costs subject to limitation (subtract item K from item J);

M. allowable base year costs (subtract item I from item C and add item L);

N. base year admission excluding medicare crossovers;

O. allowable base year cost for each admission (item M divided by item N);

P. base year patient days excluding medicare crossovers; and

Q. allowable base year cost per day of inpatient hospital services (item M divided by item P).

Subp. 4. **Determination of rate per admission and rate per day.** The following data shall be determined:

A. The department shall determine the rate year pass-through costs per admission or per day of inpatient hospital services, or both, for the rate year as specified in part 9500.1150, subpart 4, item B.

B. The department shall multiply the allowable base year costs by the eight percent cap.

C. The department shall determine the rate per admission for a rate year as follows:

Rate Per Admission = [(Allowable base year cost for each admission) multiplied by (8 percent cap), plus (rate year pass-through cost per admission)]

In calculating the rate year pass-through cost per admission, the department shall use the total admissions from the hospital's base year.

After the initial year, adjusted base year costs are used in the rate per admission formula instead of allowable base year

costs.

D. The department shall determine the rate per day for a rate year as follows:

Rate Per Day = [(Allowable base year cost per day of inpatient hospital services) multiplied by (8 percent cap), plus (rate year pass-through cost per day of inpatient hospital services)]

In calculating the rate year pass-through cost per day of inpatient hospital services, the department shall use the total days of inpatient hospital services from the hospital's base year.

After the initial year, adjusted base year costs are used in the rate per day formula instead of allowable base year costs.

E. A hospital with minimal participation, as specified in part 9500.1150, subpart 4, item F, shall be reimbursed on a rate per day in lieu of rate per admission unless the hospital elects to be reimbursed on a rate per admission basis.

F. The department shall apply the disproportionate population adjustment as specified in part 9500.1135, substituting the term adjusted base year cost per admission with rate per admission or rate per day.

G. Reimbursement procedures are as specified in part 9500.1130, subparts 1 to 6.

H. Appeals must be made according to parts 9500.1140 and 9500.1145.

Subp. 5. **Four percent reduction.** Reimbursement for admissions is reduced four percent from January 1, 1983, through June 30, 1983, as provided in Laws of Minnesota 1982, Third Special Session, chapter 1, article 2, section 2, subdivision 4, paragraph (a), clause (4). Each rate per admission and each rate per day as determined under subpart 4 for each admission during the period from January 1, 1983, through June 30, 1983, shall be reduced by four percent.

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD711

Agency: Department of Human Services

Division:

Agency Contact: Richard Tester 296-9939

Minnesota Rules: Parts 9500.1090 to 9500.1155

Title: Proposed Rules Relating to Hospital Medical Assistance Reimbursement

Type of Rules: Permanent

Incorporations by Reference:

Rule Number:	Material Incorporated:
9500.1100	Health Care Financing Administration Form 2552, 1981 revision, published by Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, MN 55164
9500.1120	Health Care Costs, published by Data Resources Incorporated, 1750 K Street NW, Suite 300, Washington, D.C. 20006

Steven C. Cross
Revisor of Statutes

Susan M. Lentsch
Assistant Revisor
Phone: 296-0956
Date: February 7, 1985

EDITORIAL CHANGES TO RULES

PARTS:9500.1090 -.1155 RULE TITLE:Hospital Reimbursements DATE: 2-7-85

PAGE	LINE	DELETE	INSERT	POSITION
1	25	for		
1	26	years prior to the budget	through a hospital's current	
2	27		budget year HCI and the	the^relative
8	8		arithmetic mean of the	^reimbursable
8	10		arithmetic mean of the	^reimbursable
14	29		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.	commissioner.^
15	2^3		PART 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 which is apportioned to medical assistance. 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 shall be assessed according to part 9500.1125, subp. 5.	2^3

EDITORIAL CHANGES TO RULES

PARTS:9500.1090.1155 RULE TITLE:Hospital Reimbursements DATE:2-7-85

PAGE	LINE	DELETE	INSERT	POSITION
			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.	
15	1	effected	effective	
15	21		confirming	a^ second
16	10		readmissions	
17	18	E	G	
18	30		Subpart 1. Determination of disproportionate population adjustment.	^ the
19	15		Subp. 2. Limitation on disproportionate population adjustment.	costs.^ In
21	12	July 28, 1985	THE EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.	
21	22	for a hospital's fiscal year prior to the budget	through a hospital's current	
22	9	allowable	adjusted	
22	21	1 (one)	I (roman numeral one)	

EDITORIAL CHANGES TO RULES

PARTS:9500.1090-.1155 RULE TITLE:Hospital Reimbursements DATE:2-7-85

PAGE	LINE	DELETE	INSERT	POSITION
22	23	1 (one)	I (roman numeral one)	
22	32		except malpractice insurance costs	costs ^
22	33		except malpractice insurance costs	costs ^ (Item F)
25	21	formal	written	
25	24	formal	written	
25	35		subpart 1	9500.1135, ^
26	35^35		"Allowable rate period costs" means a hospital's reimbursable inpatient hospital costs as identified in a hospital's rate period medicare/medical assistance cost report with the following adjustments: (1) subtract malpractice insurance costs that have been apportioned to medical assistance; (2) subtract pass-through costs (except malpractice insurance costs) apportioned to medical assistance based on the ratio of net reimbursable inpatient hospital costs to total hospital costs; and	34^35
27	9	"Rate year" means any hospital	"Rate period" means any portion of a hospital's	^fiscal
27	10		any portion of	includes^the
27	24	1 (one)	I (roman numeral one)	
27	26	1 (one)	I (roman numeral one)	
27	36		except malpractice insurance costs	costs^
28	1		except malpractice insurance costs	costs^(item G)

EDITORIAL CHANGES TO RULES

PARTS:9500.1090-.1155 RULE TITLE:Hospital Reimbursements DATE:2-7-85

PAGE	LINE	DELETE	INSERT	POSITION
28	17^18		Determination of allowable rate period costs, allowable rate period cost for each admission, and allowable rate period cost per day. The department shall determine allowable rate period costs from the rate period medicare/ medical assistance cost report using data from the HCFA Form 2552 Worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to N: A. reimbursable inpatient hospital costs (Worksheet E-5, Part I, line 13); B. reimbursable malpractice insurance costs (Worksheet E-5, Part I, line 5); C. net reimbursable inpatient hospital costs (subtract item B from item A); D. total hospital costs (Worksheet A, column 3, line 84); E. malpractice insurance costs (Worksheet A, column 5, line 71); F. net total hospital costs (subtract item E from item D); G. ratio of net reimbursable inpatient hospital costs to net total hospital costs (item C divided by item F); H. pass-through costs except malpractice insurance costs; I. medical assistance pass-through costs except malpractice insurance costs (item G multiplied by item H); J. allowable rate period costs (subtract item I from item C); K. rate period admissions excluding medicare crossovers; L. allowable rate period cost for each admission (item J divided by item K);	17^18

EDITORIAL CHANGES TO RULES

PARTS:9500.1090-.1155 RULE TITLE:Hospital Reimbursements DATE:2-7-85

PAGE	LINE	DELETE	INSERT	POSITION
			M. rate period patient days excluding medicare crossovers; and N. allowable rate period cost per day of inpatient hospital services (item J divided by item M).	
28	11		admissions	
28	20	year	period	
28	22	year	period	
28	27	year	period	
28	28		Lesser of the	^ [(Allowable
28	30		or the allowable rate period cost for each admission	^plus
28	32 33	In calculating the rate year pass-through cost per admission, the department shall use the total admissions from the hospital's base year		
29	4		Lesser of the	^ [(Allowable
29	6		or the allowable rate period cost per day of inpatient hospital services	cap), ^plus
29	8-11	In calculating the rate year pass-through cost per day at inpatient hospital services, the department shall use the total days of inpatient hospital services from the hospital's base year		