Inpatient Hospital Rates Rebasing Report

Health Care Administration

April 2015

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Minnesota Department of **Human Services**

Legislative Report

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I. EXECUTIVE SUMMARY

The Minnesota Department of Human Services (DHS) created this report in response to Laws of Minnesota 2014, Chapter 312, Article 24, Section 10 which requires the DHS Commissioner to submit to the legislature by March 1, 2015 an Inpatient Hospital Rates Rebasing Report. This subject of this report is the Fee-for-Service (FFS) payment methodology for prospective payment system, or those hospitals paid under the Diagnostic Related Groups (DRGs). The methodology for the DRG hospitals was developed and modeled by excluding claims associated with out-of-state hospitals, critical access hospitals, long term care hospitals and rehabilitation hospitals.

During the 2014 Legislative session, DHS received authority to rebase fee-for-service inpatient hospital rates in the Minnesota Health Care Programs (MHCP) for the first time in seven years. The rebasing must be budget neutral and moves the rates from the current 2002 claims base to the 2012 claims base. DHS recognized that developing a new Medicaid payment method required significant analysis and modeling of data to maximize the State's available funding, maintain budget neutrality, and provide payments that are fair and equitable and in compliance with federal requirements. Expert technical assistance with the rebasing was secured through the Request for Proposal process.

The rebasing model outlined in this report is the result of over a year of work by DHS policy team members, provider stakeholders and contracted experts to analyze the current payment method, determine objectives for the new payment method and model pricing methods to assess the impact on plan recipients, providers and taxpayers. A full description of the final model is included in this report.

Summary of the old payment system issues

Minnesota's old fee-for-service payment system for inpatient hospital services is outdated, imprecise, systematically complex, noncompliant with upcoming federal requirements and lacks transparency.

Under the old payment system, hospitals' reimbursement rates were based on each hospital's costs and patient mix from 2002. As a result, the old rates fail to reflect over a decade of changes in hospital services and cost centers, mergers and acquisitions of hospitals by larger health care systems, and the significant movement of services from the inpatient to the outpatient setting.

The old payment system utilizes a hospital claims grouper that groups claims for the same services and conditions into a common Diagnostic Related Group (DRG). This grouper is more than eight versions behind the most current version. In addition, the older grouper supports a very limited number of DRGs available because it collapses multiple DRGs, which are meant to differentiate between types of admissions, into a single DRG. In other words, the old grouper treats most admissions as though they are the same without recognizing or adjusting for the severity of the patient's condition, the anticipated length of stay, and hospital resources required during the hospital stay. Consequently, it ensures that the Medical Assistance fee-for-service

system will overpay some hospitals and underpay others.

Using this outdated grouper with a formula based on each hospital's costs results in a payment system of imprecise rates, as many hospitals do not have sufficient admissions of certain types to allow a reasonably accurate rate to be developed. To overcome the issue of insufficient admissions for rate setting, multiple types of admissions were grouped together, losing the differences between types of admissions and their associated costs.

Moreover, by using each hospital's costs, the payment system does not control for efficiency or relativity of costs between hospitals rendering the same services, so the old payment system tends to overpay hospitals with higher costs and underpay lower cost hospitals, even if they rendered the exact same services. Lacking standardization of cost and service relativity, the programming for the old system reflects many unique and complex rules that adjust the claim information from the hospital, modify the actual resulting DRG into one of the small number of DRGs supported by the old system, and make multiple adjustments to the payment before the final payment is generated. These adjustments are not transparent to hospitals, mask the inherent inequity in the old payment system, and leave hospitals unable to determine whether an adjudicated claim was paid correctly.

Perhaps most importantly, the old payment system and the grouper it uses will not comply with new federal requirements that go into effect October 1, 2015. On that date, the Centers for Medicare and Medicaid Services (CMS) will require all providers and payers, including each state's Medicaid program, to comply with the tenth version of the International Classification of Diseases (ICD-10) coding standards. Because the old grouper is generations behind current versions and combines multiple types of admissions and services into a larger, less precise DRG, it is unable to comply with ICD-10 standards. These standards require even greater specificity and precision in coding and paying for variations in patient acuity, services provided, complexity of care and anticipated costs for each service. To ensure that Minnesota's Medical Assistance program remains eligible to receive federal matching funds, the old payment system must be replaced with a more refined, updated and sophisticated grouper and reimbursement formula.

All Patient Refined Diagnostic Related Groups based payments

The rebased inpatient hospital payment method involves the design and implementation of inpatient prospective payment systems using the All Patient Refined Diagnostic Related Groups (APR-DRG) patient classification model. This payment method enhances DHS' ability to appropriately reimburse inpatient hospital services commensurate with the resources used, the severity of the illness and the patient's risk of mortality. The new method will also establish compliance with federal ICD-10 requirements. DHS is using APR-DRG version 31 and national standardized relative weights, rather than using a non-standardized method based on each hospital's costs.

The modeled rate methodologies were evaluated against the following criteria:

- **Equity of payment among providers**: The method should generate fairer payments across hospitals and types of care. The recommended APR-DRG payment method is calculated by multiplying a hospital base rate by a DRG relative weight. The relative weights are determined using average costs from many hospitals to ensure similar

payment for similar services, regardless of where those services are provided.

- **Predictability and stability of resulting payments:** The method should generate stable, predictable payments to enable DHS and the providers to manage their budget. The recommended payment methodology would allow hospitals to accurately estimate payments.
- **Ability to recognize differences in resource requirements:** The method should recognize the wide differences in resource requirements for inpatient hospital services in Minnesota's Medicaid population. The APR-DRG system is nationally recognized for its ability to capture resource use and patient characteristics across the spectrum of the populations covered by Medicaid Programs.
- **Incentives for providers to use resources most efficiently:** Because the method pays a standard rate rather than a facility specific rate, the method should encourage hospital efficiency by rewarding hospitals that increase efficiency while continuing to provide quality care. The APR-DRG system incorporates a single standardized base rate. This encourages hospitals to better manage their resources.
- **Incentives to promote access to high quality care, including recognition of potentially preventable events:** The proposed method should promote and maintain beneficiary access to care. It should also recognize and address extreme and unpredictable cases/costs in which the standard DRG payment differs greatly from the level of resources expended by the hospital by incorporating outlier payments whenever a hospital's estimated loss is above a predetermined threshold. The APR-DRG system can be adapted to compute additional payment amounts for extremely high cost cases or cases with very long inpatient stays.
- **Simplicity of program administration:** The payment method should be efficient to administer. A payment system that is relatively standardized will be easier for providers and DHS to implement, understand, administer and maintain. The APR-DRG system is an updated version of the base DRG system that has been used by Medicare for many years and has been widely adopted by payers other than Medicare, and previously used by DHS.
- **Transparency:** The payment method should engender trust from hospital administrators, hospital clinicians, legislators and Medicaid program administrators. Given the long history of DRGs, the APR-DRG system should be familiar to hospitals and is straightforward in its mechanics. By using national weights and streamlined adjustments, it will be easier for anyone to calculate the rates.
- **Forward compatible:** The method must be compatible with future requirements, including ICD-10, as well as current and future CMS requirements and state initiatives. The APR-DRG system is fully compatible with ICD-10 coding. In addition, due to its widespread adoption by states, it is very likely to be updated in response to any future changes in law or CMS policy.

Minnesota Specific Configurations

DHS configured the APR-DRG model to meet Minnesota's state specific needs in the following ways:

Base Rate: The standard base rate payment for discharges on or after November 1, 2014 is set at

$5,376.02 with the labor portion adjusted by the FFY 2014 Medicare Inpatient Prospective Payment System wage index that applies to each hospital. The wage index takes into account reclassifications but does not include the Frontier adjustment. Setting the base rate at this level keeps total payments budget neutral to 2012.

Relative Weights: DHS is using national standardized relative weights for each DRG. The development of the national relative weights actually included data from many Minnesota hospitals. Analysis indicates a high correlation between the national standardized values and the Minnesota specific relative weights used in previous rate setting methodologies. Thus, the national weights are a valid, reliable method.

Payments for High Cost Cases: The new rate methodology incorporates a cost outlier payment rate to account for inpatient stays that greatly exceed the costs of an average stay. The claim outlier threshold is equal to the base DRG payment plus $70,000 in fixed losses. Once the threshold has been met, additional payment is based on a fixed percentage of the costs that exceed the threshold.

Payments for Transfers: Payments for stays that are split between two facilities are pro-rated based on the standard Medicare Inpatient Prospective Payment System (IPPS) transfer methodology. Payment is equal to the standard DRG base payment divided by the average length of stay multiplied by one plus the claim length of stay.

Policy Adjusters: DHS has applied four policy related adjustments to the DRG base payments. These adjusters will mitigate payment reductions associated with these services, but are subject to future review based on additional information such as:

- The impact of the more detailed coding that occurs in the APR-DRG system,
- The necessity of the adjustment as other inpatient and outpatient services evolve and:
- More permanent solutions are developed that include all aspects of hospital payments, including Disproportionate Share Hospital (DSH) payments.

The adjusters are targeted to services that are integral the Medical Assistance program and have a long history of legislative support.

Mental Health – Temporary adjustments were made to each of the four severities of illness (SOI) subclasses for every mental health DRG. The adjuster values are:

SOI 1 = 2.25 – This means payment increased by that factor
(2.25 times the rate it would have otherwise been).
SOI 2 = 2.05
SIO 3 = 1.70
SIO 4 = 1.55

Pediatric – Two policy adjustment values are applied to pediatric services. The values of the policy adjusters differ and are dependent on whether the service is delivered in a licensed children's hospital or to a patient under the age of 18 in a non-children's hospital.

Children's Hospital	=	1.60
Non-Children's Hospital	=	1.15

Non-Metro Obstetrics – An adjustment equal to 1.35 is applied to obstetrics services

(DRG 560 only) whenever that service is delivered in a hospital located outside the seven metro county area.

The policy adjusters are mutually exclusive and are applied in the order listed above. For example, a hospital providing inpatient mental health care for child would be paid using the mental health adjuster only; the pediatric adjuster would not be applied to the pediatric mental health claim.

Finally, the legislatively required current payment adjustments of a $5 add-on for newborn screening and the $3,528 payment limit for Cesarean sections are retained, as these are still required under current law.

The DRG base payment is comprised of the hospital DRG Base Rate multiplied by the DRG Relative Weight multiplied by the value of any applicable Policy Adjustor. A more detailed description of the rate components is included on page 20.

Additional payment considerations for 2014 and 2015

In addition to requiring that the total aggregate payment amounts in the new payment system are budget neutral to 2012, the legislation also directs DHS to hold aggregate payment increases or decreases to individual hospitals to a five percent limit. For the 2014 rate year, DHS was able to limit the loss to 3.2 percent and still remain within the budget neutrality limits. The chart in Appendix B shows the impact to each affected hospital of the rate setting methodology before and after the five percent limits are applied.

Appendix C also shows the hospital specific impacts of payments to non-children's hospitals being increased by 10 percent as a result of changes to Minnesota Statutes 256.969 subdivision 3c that were effective November 1, 2014. The result, when combined with the policy adjusters and the five percent limits noted above is that no hospital has a decrease in payments compared to their 2012 payments for the same claims.

2013 claims model validation summary

The simulated payment model using 2012 claims was validated using 2013 claims. The results of that validation are summarized in the table below. Changes in payment by service include the effects of the policy adjusters but do not account for the limits on payment increases and decreases or the 10 percent increase discussed above.

The simulated payment model shows a one percent decrease in total payments when applied to 2013 claims. DHS, based on consultation with the contracted vendor, recommends not adjusting for this decrease given that the more accurate coding in the new system may result in a slight natural increase in relative weights (and total payments) within the claims. This is a change that cannot be accounted for when using past claims experience in the model, as those claims were coded to the old payment system.

Claim Year	Case Mix Index	Legacy Pay to Cost Ratio (percentage)	New Pay to Cost Ratio (percentage)	Percentage Change in Total Payments			
				Mental Health	Obstetrics	Pediatric	
						Children's	Non-Children's
2012	0.936	65.9	65.9	(4.2)	(13.8)	12.3	1.6
2013	0.919	65.7	65.1	(7.4)	(15.0)	17.9	3.3

The Department of Human Services (DHS) has recommended modernizing the state's methodology related to Disproportionate Hospital Share (DSH) payments made to hospitals. Although there are changes to total payments for service lines based on 2013 claims that may need to be addressed, DHS recommends the policy adjusters be re-examined after the changes to DSH payments have been made so that all parts of the payment system are taken into consideration before refining the system further. This is discussed further in the next section.

Payments in future years

Proposals to modify DSH payments and payments to critical access hospitals have been recommended by DHS, in consultation with the Minnesota Hospital Association (MHA). Disproportionate Hospital Share payments are intended to help ensure particular hospitals, typically Children's hospitals, hospitals that serve high volumes of Medicaid patients, or hospitals that provide important services to the Medicaid population, do not suffer large losses compared to their costs due to treating Medicaid and uninsured patients. Currently DSH payments are set based only on Medicaid volume in each facility and included in the payment for each claim. Over the next few months DHS will examine new DSH payment methodologies that could be used to address the payment reductions that are currently being mitigated by the policy adjusters, as well as other areas that may be beneficial to Medical Assistance. If approval to adjust the DSH payments is received, the results of any changes will be included in the second report that is due back to the legislature in 2016.

As the rate setting methodology moved from payments based on facility specific costs to rates based on costs for services as measured across many hospitals, facilities that incur the higher costs of maintaining the infrastructure to provide specialty or lower volume services may not always be adequately reimbursed. This is illustrated by the magnitude and inverted structure of the mental health policy adjusters which are set higher for lower acuity services and lower for higher acuity services.

There are two potential reasons that required putting the policy adjusters in place in that way. First, the old rate structure used an older CMS-DRG classification system that lacked the ability to properly classify higher acuity cases, resulting in the majority of the volume of cases falling into the lower acuity subclasses in the new system. In addition, the DRGs were further compressed under the old system into a small number of DRGs, so the old system did not distinguish between complex cases involving high levels of resources and those cases that are more straightforward and require lower levels of resources. This issue may resolve somewhat as hospitals are appropriately reimbursed for the higher acuity cases and coding to the new system improves.

The other reason for the structure of the policy adjusters may be that hospitals are holding lower acuity patients in non-mental health beds until the appropriate outpatient or inpatient mental health placement becomes available or until other non-medical issues such as adequate housing are addressed.

Hospital stakeholders have indicated this occurs when patients present to their facility and they in turn try to find appropriate inpatient or outpatient services, which are currently insufficient in many areas of the state. Recognizing that many of these patients do not have high medical needs that require inpatient level of care, but rather could be more efficiently and effectively managed in a non-hospital setting, the new hospital payment system should take this into account.

Optimally, the new system should not be set up to "over pay" the service rate for these types of admissions. Instead, the system should eventually be designed to incent treatment at an appropriate level of need in an appropriate setting. Multiple initiatives have been proposed to make improvements within the existing mental health continuum of care, but the rebased system will need to temporarily recognize the lack of sufficient inpatient and outpatient mental health services and mental health crisis services. Other initiatives such as Health Care Homes, In-Reach Care Coordination, Targeted Case Management, and the evolving work of the Integrated Health Partnerships are also designed to help connect MA enrollees with needed medical and social services. These services may also help avoid hospital admissions through more proactive, person-centered care plans.

In addition, those hospitals that receive the most complex and high cost patents, such as patients who have been civilly committed and who would otherwise be placed in a regional treatment center to receive care, use of DSH payments is an appropriate payment method to target additional funds to those hospitals.

Similarly, certain hospitals may incur higher infrastructure costs to maintain the separate capacity to do certain types of transplants. Because transplant services are relatively low volume services the infrastructure may not be used enough to recoup the full costs via the base rate DRG payments. This is another instance in which DSH funds could be targeted to hospitals to help them offset the higher costs of offering the low volume, high cost service.

DHS continues to work with our technical experts to develop a cost-based payment methodology for critical access hospitals that is more comprehensive and stable. Analysis indicated a much wider than anticipated variation in payments related to costs for the critical access hospitals. As a result, a single percentage of cost system that is budget neutral would create large and likely harmful swings in reimbursement to these small, but necessary facilities. DHS has also recommended the development of a higher level of cost reimbursement for critical access hospitals and will develop that system if approved by the legislature. In the meantime, the rates for critical access hospitals remain unchanged from the 2012 payment system.

II. LEGISLATION

Laws of Minnesota 2014, Chapter 312, Article 24, Section 10 require that the Commissioner of the Department of Human Services submit to the legislature by March 1, 2015 an Inpatient Hospital Rates Rebasing Report.

Sec. 10.

[Coding removed] Report required.

(a) The commissioner shall report to the legislature by March 1, 2015, and by March 1, 2016, on the financial impacts by hospital and policy ramifications, if any, resulting from payment methodology changes implemented after October 31, 2014, and before December 15, 2015.

(b) The commissioner shall report, at a minimum, the following information:

(1) case-mix adjusted calculations of net payment impacts for each hospital resulting from the difference between the payments each hospital would have received under the payment methodology for discharges before October 31, 2014, and the payments each hospital has received or is expected to receive for the same number and types of services under the payment methodology implemented effective November 1, 2014;

(2) any adjustments that the commissioner made and the impacts of those adjustments for each hospital;

(3) any difference in total aggregate payments resulting from the validation process under calendar year 2013 claims; and

(4) recommendations for further refinement or improvement of the hospital inpatient payment system or methodologies.

III. BACKGROUND

During the 2014 Legislative session, DHS received authority to rebase FFS inpatient hospital rates for the Minnesota Health Care Programs (MHCP) and achieve compliance with federal regulations related to claims processing. The Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Final Rule requires all providers, payers, health plans, clearinghouses and vendors (all HIPAA covered entities) to begin using International Classification of Diseases 10-Procedure Codes (ICD-10 PCs) for inpatient hospital settings on transactions for dates of service and inpatient discharges on and after October 1, 2015.

DHS's ability to fully implement APR-DRGs and ICD-10 procedure codes is dependent on system changes for its Medicaid Information Systems (MMIS). It is anticipated that system changes will be completed during 2015. Once fully implemented, claims in the system, will be reprocessed from November 1, 2014 going forward.

Mandatory Diagnostic Coding Changes
The International Classification of Diseases (ICD) is a system for coding diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases, as classified by the World Health Organization and is used world-wide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. Providers and payers use ICD codes to classify, store and retrieve diagnostic or procedural information, manage electronic health records and process claims.

The Administrative Simplification provision under Section 1104 of the Patient Protection and Affordable Care Act of 2010 (ACA) is designed to improve the standards for electronic transactions mandated by the Health Insurance Portability and Accountability Act (HIPAA). Its goal is to reduce administrative costs by adopting a set of operating rules for each transaction and to create as much uniformity in implementing electronic standards as possible. The Act's Administrative Simplification provision requires covered entities including health plans, health care clearinghouses and providers to upgrade to new standards in electronically conducting certain administrative transactions.

Two of the key building blocks to achieve Administrative Simplification compliance are HIPAA 5010 and ICD-10. The combined changes of HIPAA 5010 and ICD-10 impact all payers and providers. HIPAA 5010 requirements modernize the standards that regulate electronic transactions. These upgrades primarily impact health information systems and technology and are essential to transitioning to ICD-10.

The conversion from ICD-9 to ICD-10 is significant for DHS and providers. It requires more rigorous coding and documentation. The transition from ICD-9 to ICD-10 will increase the number of allowable codes by 800 percent. For example, under ICD-9, an angioplasty was represented by one code. Under ICD-10, an angioplasty could be represented with one of 854 codes. The addition of more codes in ICD-10 will affect reimbursement by offering more specific diagnosis reporting. This increased specificity will result in:

- fewer claim rejections and denials due to non-specific diagnoses;
- fewer requests for supporting clinical documentations;

- more precise pricing structure, and
- more timely reimbursements.

All-Patient Refined –Diagnostic Related Groups (APR-DRGs)
DRGs, developed by 3M, are designed to provide a measure of the amount and intensity of the resources devoted to an episode of inpatient care. Developed in the 1960s, DRGs are used to measure the services used by a patient during a stay in the hospital.

There are many versions of DRG groupings. The first version to be put into widespread use was the basic version used by Medicare. Although CMS has refined the DRG system over time, the CMS and MS-DRG Systems are not refined enough to accurately measure the resources used for neonatal or obstetrics services because they are used primarily for the Medicare population. DHS was using a CMS-DRG system in the old payment methodology.

In response to the need to better measure resources used by non-Medicare patients, the All-Patient or AP-DRG system was developed. The AP-DRG system provides a better method of measuring newborn and pediatric inpatient services, as well as better accounting for severity and acuity across all admissions.

However the AP-DRG system, like the MS-DRG system lacks the ability to capture key aspects of both the patients being treated and the severity of illness that is being treated. The All-Patient Refined or APR-DRG system was developed to address these needs. Today, more than twenty states are either using or considering use of the APR-DRG system when setting payment rates for inpatient hospital care for their Medicaid programs.

APR-DRGs provide a better measure of the costs and resources used in inpatient care for the full range of the population covered by Medicaid including, newborns, children, the disabled and the elderly. In addition, APR-DRGs incorporate a measure of the severity of the illness of the patient being treated and the patient's risk of mortality. In the APR-DRG system, each DRG group has been expanded to include four subclasses that are used to describe the variation in the patient's level of illness and the patient's risk of mortality. The subclasses are labeled numerically from one to four to indicate a minor, moderate, major or extreme severity of illness or risk of mortality.

In addition to being a more refined system for measuring resource use and patient characteristics, the APR-DRG system, like all DRG systems, is also easily adaptable to state specific payment rate setting methodologies. The new payment system incorporates the APR-DRG system.

IV. INPATIENT HOSPITAL RATES REBASING

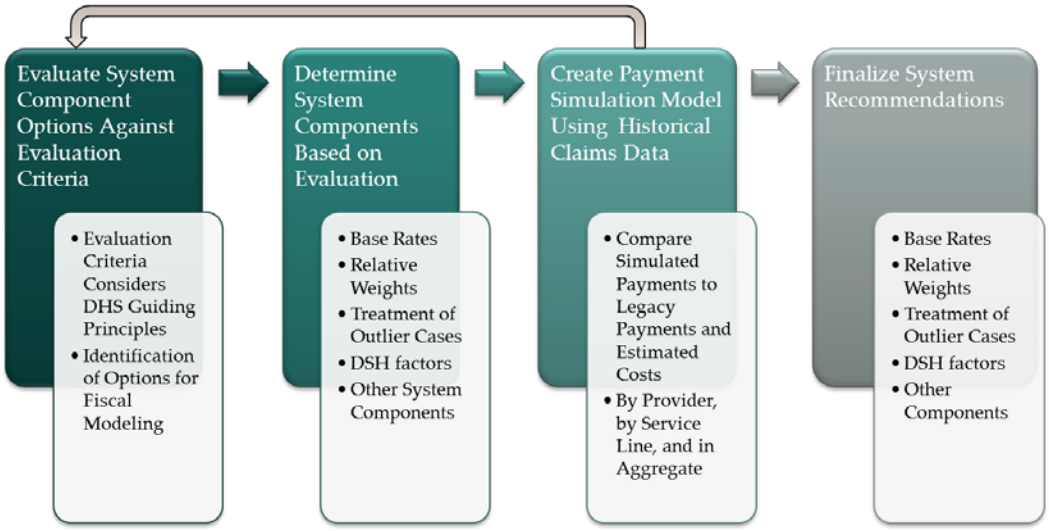
Modeling Process

DHS sought expert technical assistance for the development of a new Medicaid payment model through a Request for Proposal (RFP) process. DHS developed and published an RFP for Analytic Services to assist with the ICD-10 Conversion of Inpatient Hospital Payment Rates. This RFP was published on November 27, 2013 with a final submission of December 30, 2013.

The RFP outlined the state's intent to use the 3M All Patient Refined Diagnostic Related Group (APR-DRG) grouper for its payment methodology. It also outlined the intent to achieve compliance with ICD-10 in conjunction with the rebased rates.

DHS selected Navigant Consulting, Inc. to provide assistance in the development of its new inpatient payment system using the 3M APR-DRG Group classification system in compliance with ICD-10. The following diagram outlines the Design Framework for the project.

Project Design Framework



A preliminary matrix of key design components was established to identify and define the design components related to the inpatient payment methodology development and the preliminary options available for each of those components. The key design components developed and analyzed included:

- **Base Rates:** Standardization of hospital base rates was analyzed from multiple perspectives including but not limited to wage areas, major diagnostic categories, and hospital type.
- **Relative Weights:** Analysis was done to evaluate the impact of adopting the 3M standardized national weights. Analysis was also done using Minnesota specific claims to validate the national weights.
- **Outlier Payment Policy:** Analyzed options for outlier policy adjustors including day outliers, high cost outliers, and low cost outliers.
- **Transfer Payment Policy:** Analyzed an approach similar to Medicare's policy for transfer out claims and post-acute transfer policy (transfer to a non-acute hospital, long term care, or rehabilitation setting).
- **Payment for Specialty Services:** Evaluated payment for specialty services including, but not limited to mental health, rehabilitation and transplant services.
- **Targeted Policy Adjustors:** Evaluated the projected impact of the implementation of APR-DRGs on certain hospital types and services lines including, but not limited to neonatal, obstetrics, pediatrics, traumas centers, critical access hospitals and severity of illness levels.
- **Budget neutrality:** Evaluated and defined the included services and providers and analyzed the impact within a fixed target of total 2012 aggregate payments. The finalized system was also run against 2013 claims to validate budget neutrality to 2013 aggregate payments.
- **Transitional corridor:** Analyzed and incorporated facility specific aggregate payment rate limits of increases or decreases of no more than 5 percent.

DHS recognized that the new payment model would impact multiple stakeholders. Each stakeholder entity had their own perspective on the components of a successful payment model. DHS engaged key stakeholders in multiple forums throughout the entire project. Stakeholder insight into the payment models and the potential impact to multiple groups resulted in additional reworking of the models and ongoing feedback from the stakeholders. Key stakeholders engaged throughout the project include:

1. Minnesota Hospital Association (MHA) Leaders – DHS met regularly to obtain input from MHA Leaders on the simulation models and components.
2. Minnesota Hospital Association Members – DHS and its expert consultants led several MHA sessions including:
    a. April l 22, 2014 – Inpatient DRG Project Overview
    b. September 11, 2014 – Inpatient DRG Project. Discussion of payment system aspects and steps for further development

c. November 18, 2014 – Disproportionate Share Payment Meeting
d. February 4, 2015 – Inpatient Hospital Rebased Payment Model released.

3. Individual MHA member organizations including major trauma centers, safety net hospitals, transplant centers and children's facilities met separately with DHS.
4. DHS staff attended a number of MHA meetings throughout the process to inform and update hospital executives and financial staff.
5. DHS staff and MHA staff provided updates to all interested legislators.

A payment simulation model for analyses and calculations to support both International Classification of Diseases–9 (ICD-9) and ICD–10 payment models was developed. The baseline model was built using APR-DRG version 31 with 1,256 valid APR-DRGs including 112 neonatal DRGs.

The payment simulation model provided DHS with the ability to interactively evaluate the fiscal impacts of the payment parameters under consideration by comparing payments under the new methodology to payments under the previous methodology, and also to the cost of claims within a budget neutral framework. Multiple models were developed and analyzed using varying base rates, cost outlier thresholds, and policy adjusters. An analysis of the impacts to non-metro providers compared to metro providers was also conducted. All of the models focused on aggregate data at the service line level or similar groups of hospitals (e.g. non-metro versus metro hospitals). Impacts to specific hospitals were not evaluated until the final simulation model had been selected. This was done to ensure the basic framework of the new payment model was applied fairly and consistently across all providers.

The following data were included in the modeling datasets:

a. 2012 Fee For Service (FFS) claims for inpatient acute, including psychiatric, care services at in-state and out-of-state Local Trade Area (LTA) providers
b. APR-DRG relative weights based on Version 31 of the APR-DRG grouper without collapsing, expansion or modification
c. Disproportionate Payment Adjustments (DPA), other payment adjustment that applied during the base year
d. Calculations for every claim in the dataset using the new APR-DRG system pricing logic.

The DRG payment simulation model excluded:

a. Rehabilitation distinct part units
b. Freestanding rehabilitation providers
c. Long-Term Acute Care (LTAC) providers
d. Psychiatric services currently paid under per diem rates
e. Out-of-state non-LTAC providers
f. Medicare cross over claims
g. Non-Citizen and refugee programs which are very small state and federally funded programs

h. “Ungroupable” DRG claims (total of 3 claims)
i. $0 paid claims under the current system.

Findings

Multiple payment models were considered as DHS analyzed the data and the simulation remodeling impacts.

Results were summarized by:

- Hospital Type
- APR-DRG and Severity of Illness Classifications
- Service line – Mental Health, Neonate, Normal newborn, Obstetrics – Cesarean, Obstetrics – all other services, Transplant, Trauma, Other pediatric Children Providers, Other pediatric Non Children Providers, Other adult

In the final payment simulation model, data was analyzed within the current systems payment and the new systems payment by cost and service line. The current system and estimated new system simulated payments broken out by service line are reflected in the table below. The changes noted in the table and the charts below illustrate the budget neutral rebased rates and do not reflect the impact of the temporary five percent gain or loss limit for each hospital or the ten percent added to the rates of all non-children’s hospitals resulting from the sunset of that rate reduction.

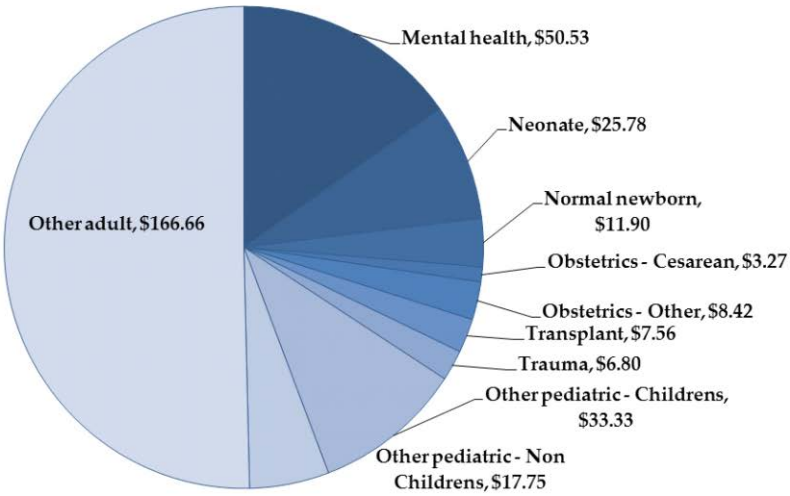
APR-DRG Service Line Impact – Summary
(before transition and buyback factor impacts)

APR-DRG Service Line	Current System Payments	Estimated New System Payments	Percentage Change in Payment
Mental health	$50,530,289	$48,424,632	(4.2%)
Neonate	$25,784,466	$26,207,434	1.6%
Normal newborn	$10,706,500	$5,345,691	(50.1%)
Obstetrics - Cesarean	$3,273,070	$2,510,549	(23.3%)
Obstetrics - all other services	$8,419,059	$7,259,810	13.8%
Transplant	$7,555,708	$4,550,574	(39.8%)
Trauma	$6,795,420	$8,650,587	27.3%
Other pediatric Children Providers	$33,326,246	$37,435,954	12.3%
Other pediatric Non Children Providers	$17,752,111	$18,039,079	1.6%
Other adult	$166,658,586	$172,350,569	3.4%

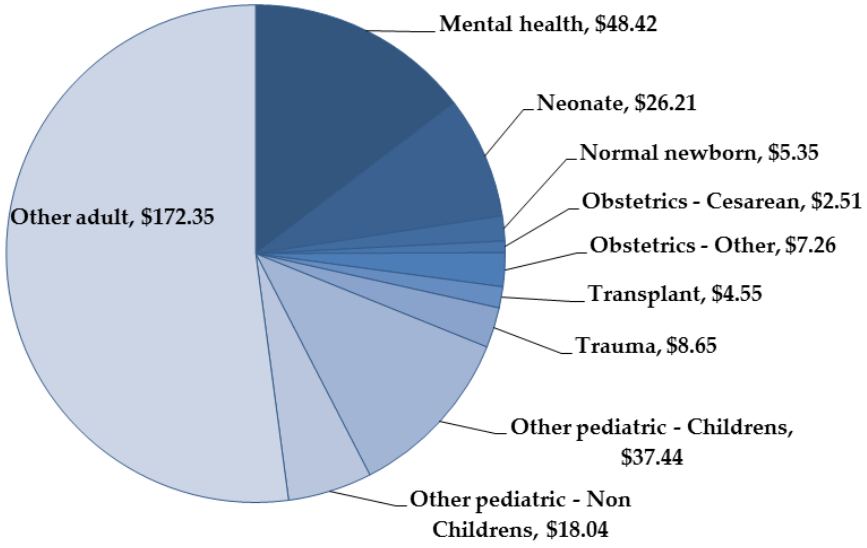
The impact on payment distribution of the final budget neutral payment model is depicted in the charts included below.

Calendar Year 2012 Claims Payment Data by APR-DRG Service Line

Current System Payments - $330.8 (In Millions)



New System Payments - $330.8 (In Millions)



New Payment Methodology

Payment Rate Structure for DRG Hospitals

The Minnesota inpatient hospital payment system for the Medical Assistance Program is generally defined in state statute. To be eligible for payment, inpatient hospital services must be medically necessary, and if required, have the necessary prior approval from the Department. Payment rates for large general hospitals that are not rehabilitation or long term hospitals are based on the 3M All Patient Refined Diagnosis Related Grouper (APR-DRG) to reflect a per discharge payment schedule.

Components of the Payment Rate Calculation

APR-DRG Base Rate – This is a standardized per discharge dollar amount that forms the basis for the beginning of the payment calculation. The base rate is the same for all hospitals and every payment. The base rate is multiplied by several factors to arrive at the final payment amount.

Wage Index – Payments to each hospital are adjusted to reflect the cost of labor within the geographic area in which the hospital is located. CMS sets the wage area adjustment factors, or indices, each year. Individual hospitals may petition CMS to be "reclassified" into a wage area that is different from the one in which they are physically located. The wage index is made up of a labor and non-labor portion which is also set by CMS.

Relative Weights – The standardized base rate amount is multiplied by a relative weight factor that reflects the severity of the patient being treated and complexity of the services delivered.

Policy Adjusters – DHS is using policy adjusters to increase the base rate payment amount for mental health services, pediatric services and some obstetric services.

Disproportionate Share Hospital Payment Adjustment – APR-DRG base rate payments to hospitals that treat a large number of Medical Assistance enrollees are augmented with a Disproportionate Share Hospital adjustment factor.

Outlier and/or Transfer Payment Adjustment – Payment rates are also adjusted for very high cost cases or when a patient is transferred between treating hospitals or from a hospital to a non-hospital post-acute care setting.

All of these adjustments and add-ons make up the APR-DRG Basic Base Payment Rate. Once the Basic Base Payment Rate has been determined, it is further adjusted to account for payments from other sources.

The adjusted payment is then increased by 10 percent to reflect the rate increase to all non-children's hospitals that became effective November 1, 2014. The increased adjusted payment is then multiplied by a transitional factor to ensure that aggregate payments to each hospital stay within a five percent increase or 3.2 percent decrease from the 2012 payment amounts. Finally, the payment amount is increased by two percent to account for the statewide assessment levied on all non-Medicare hospital services.

In addition to the APR-DRG Basic Base Rate payments, one-time annual lump sum supplemental payments are made to certain qualifying safety net hospitals and to teaching hospitals that are in addition to the payments they receive under the DRG payment system.

ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM
Basic Base Payment Rate

1. DRG BASE RATE

(Wage Index **x** Labor Related Portion **+** Non-labor Related Portion) →

- Wage Index > 1.000 → 68.8% of Labor-Related Portion is Adjusted for Area Wages
- Wage Index ≤ 1.000 → 62% of Labor-Related Portion is Adjusted for Area Wages

2. DRG BASE PAYMENT

(DRG Base Payment) **+** (High Cost Outlier) **x** (DRG Weight) **x** (Minnesota Policy Adjuster) **x** (10% Rateable Adjustment) → DRG Base Payment

3. DRG BASE PAYMENT TRANSFER ADJUSTMENT

- Claim Length of Stay + 1 ≥ DRG Average Length of Stay → Unadjusted DRG Base Payment
- Claim Length of Stay + 1 < DRG Average Length of Stay → DRG Per Diem Payment Rate

4. CEASEREAN SECTION LIMIT

Ceaserean Section Limit Applied $3528 ↓

(Basic Base Payment **+** Outlier Payment **x** DSH Factor)

5. HIGH COST OUTLIER PAYMENT

Outlier Payment = (Claim Cost) **-** (Outlier Threshold) **x** (Marginal Factor)

Outlier Threshold = DRG Payment + $70,000
Marginal Cost Factor = 50%

6. DISPROPORTIONATE SHARE PAYMENT

(DRG Base Payment) **+** (High Cost Outlier Payment) **x** (Disproportionate Share Payment Factor)

7. PROVIDER TAX ADD-ON

(DRG Base Payment **+** High Cost Outlier Payment **+** DSH Payment) **x** 1.02%

8. COMPLETE CLAIM PRICING FORMULA

(DRG Base Payment **+** High Cost Outlier Payment **+** DSH Payment) **x** (Transitional Adjustment) **x** (1.02%)

ALL RATES ARE NET OF THIRD PARTY LIABILITY AND PATIENT LIABILITY

Payment Rate Components

The new payment methodology includes the following components:

1. **DRG Base Rates:** Statewide standardized base rate amount of $5,376.02 with labor portion adjusted by FFY 2014 IPPS wage index (with reclassifications without Frontier Adjustment). Statewide standardized amount set such that statewide aggregate simulated total claim payments are adjusted for budget neutrality.
2. **Relative Weights:** Based on 3M's version 31 APR-DRG standard national weights.
3. **Policy Adjustors:** These policy adjustors are mutually exclusive and applied in the order noted below.
    a. Mental Health DRG policy adjusters for SOI levels 1/2/3/4 are 2.25/2.05/1.70/1.55 to achieve at least statewide average cost coverage.
    b. Other Pediatric policy adjuster for non-children's providers is 1.15, set to make service line budget neutral.
    c. Other Pediatric policy adjuster for children's providers is 1.60, set to make each provider equal in total payments between current and new system.
    d. Non-metro provider APR-DRG 560 (vaginal delivery) policy adjuster of 1.35, set to make service budget neutral.
    e. $5 newborn screening add-on required under current law.
    f. $3,528 payment limit applied for Cesarean section DRG 540 claims required under current law.
4. **Basic Base Payments:** Calculated by multiplying the DRG base rate by the DRG relative weight and the policy adjuster when applicable.
5. **Disproportionate Share Hospital Payment Adjustment (DPA):** Calculated using the statewide average of the number of Medical Assistances days per year for all hospitals and the number of Medicaid Assistance days for the hospital being paid. The DPA factor is unique to each hospital. Base payments are multiplied by the DPA factor.
6. **Outlier Payment Policy:** Calculated using following:
    a. Claim outlier threshold equal to base DRG payment plus $70,000 fixed loss threshold.
    b. Claim outlier costs calculated by multiplying claim charges by FFY 2012 Medicare outlier CCRs for that hospital.
    c. Claim outlier payment calculated based on 50% of outlier costs exceeding outlier threshold for all DRGs.
7. **Transfer Payment Policy:** Based on the Medicare Inpatient Prospective Payment System which pro-rates the full payment amount by a standard transfer methodology when a patient is discharged to another facility. The transfer payment is equal to the DRG base payment divided by the DRG average length of stay, multiplied by one plus the claim length of stay (up to the full DRG base payment).

8. **Ten Percent Increase and Transition Factor:** Payments are adjusted for the ten percent payment increase for all non-children's hospitals. The transitional factor is applied by hospital at the claim level. This factor adjusts the payment to ensure that aggregate payments to each hospital stay within limits of a five percent increase or a 3.2 percent decrease from the 2012 aggregate payments to the hospital.
9. **Provider Tax Assessment Adjustment:** Calculated as:

   (Basic Base payment + outlier payment + DSH payment - TPL payment - Patient liability)

   Multiplied by (10% increase * Transition Factor * 2%)

Rate Validation

Payments generated under the current methodology were recalculated applying the recommended rebased payment methodology to 2013 claims in order to validate the rates and to ensure that the proposed payment methodology remained budget neutral. This is outlined in the table below. The 2012 and 2013 payments outlined below do not reflect the impact of the temporary five percent gain or loss limit for each hospital or the 10 percent added to the rates of all non-children's hospitals resulting from the sunset of that rate reduction.

Validation of Rates and Budget Neutrality

APR-DRG Service Line	Total Current System Payments Calendar Year 2012 Claims		Preliminary System Payment Estimates Calendar Year 2013 Claims	
	Claims Payment Data	Simulated Payments New APD-DRG System without Transitional Adjustment	Claims Payment Data	Simulated Preliminary Estimated Claims Payments
Mental health	$ 50,530,289	$ 48,424,632	$ 53,989,647	$ 50,003,575
Neonate	25,784,466	26,207,434	35,787,371	36,058,914
Normal newborn	10,706,500	5,345,691	12,382,717	6,021,767
Obstetrics - Cesarean	3,273,070	2,510,549	5,959,908	4,820,313
Obstetrics - all other services	8,419,059	7,259,810	14,091,284	11,972,147
Transplant	7,555,708	4,550,574	3,719,245	2,777,923
Trauma	6,795,420	8,650,587	7,570,878	8,633,046
Other pediatric Children Providers	33,326,246	37,435,954	39,602,682	46,690,225
Other pediatric Non Children Providers	17,752,111	18,039,079	18,332,398	18,939,775
Other adult	166,658,586	172,350,569	179,529,326	181,480,800
Analytical Dataset Total	**$ 330,801,455**	**$ 330,774,879**	**$ 370,965,456**	**$ 367,398,487**

Impact on Hospital Rates

The rate validation exercise demonstrates that the aggregate payments remain relatively stable over two years of claims experience. The impact of the new rate methodology on individual hospitals varies considerably. Table 4 of Appendix C summarizes the impacts of the new payment system on each affected facility.

The first section of the table summarizes each hospital's total number of discharges and the computed case mix as measured using the new DRG grouper before and after the policy adjusters are applied. The table also lists the CY 2012 total payments under the current system and computes a payment to cost ratio that is then applied to the payments to arrive at estimated total costs. The current system payment to cost ratio and estimated costs in this section of the table were computed using a method of cost estimating which maps billed charges to specific cost centers in a standardized way. Individual hospitals may map charges differently when completing their cost reports. Therefore, a payment to cost ratio calculated by a hospital using their own methodology may be larger or smaller than the estimated ratios and costs shown in the table. However, the use of the standardized cost estimation methodology results in standardized costs that can be used to rank or compare hospitals within the model. For example, the payment to cost ratios for Healtheast St. Johns (49.3) and Healtheast Woodwinds (79.3) shown in the table probably do not match the ratios reflected on the hospital's filed cost reports. However the values in the table can be used to determine relative cost coverage between hospitals and to provide a good general description of magnitude of the cost coverage in each facility.

The next section of the table, labeled "Estimated Impact – Before Transition and Buyback" shows the impacts of applying the new payment methodology to each hospital's 2012 claims once the claims have been grouped by the new APR-DRG grouper. This section shows the value of the total payments using the new payment system, the change in total payments from the old system both in dollars and as a percentage and computes a new payment to cost ratio using the same standardized cost estimating methodology used before.

The third section of the table takes the estimated payments under the new system as computed in the previous section and applies the Transition factor. The Transition factor is the factor applied to the aggregate facility specific payments for each hospital to ensure that total facility specific payments do not increase by more than 5 percent or decrease by more than 3.2 percent when compared to the hospital's actual 2012 payments.

The last section of the table applies the readmission buyback factor. The Readmission Buyback factor is equal to 1.10 for all non-children's hospitals and 1.0 for children's hospitals.

The last two columns in Table 4 show the total change in aggregate payments for each facility between actual 2012 payments under the old system and estimated payments (using the same claims) under the new system after the transition and readmission factors are applied. Hospitals within the table are presented in order of the percentage change in total payments from greatest increase to greatest decrease in total payments under the new system compared to their 2012 payments. The impacts reflect over a decade of changes in hospital services and cost centers, mergers and acquisitions of hospitals by larger health care systems, and the significant movement of services from the inpatient to the outpatient setting. Many health systems have consolidated certain types of services to certain hospitals within their system, which will change the case mixes within the hospitals across their system. As a hospital's case mix changes, so will their payments. This is particularly evident with hospitals that over the past decade have become "regional hubs", such as the hospitals in Mankato, Bemidji, and St. Cloud. Taking on more high cost services and complex cases within their areas, combined with larger volumes of MA patients result in increased payments for these facilities.

Future Considerations

The rebasing of the inpatient hospital payment rates identified the following additional areas for payment reform in order to ensure that hospital rates are aligned with state and federal policy objectives by:

1. Revising the Disproportionate Share Hospital (DSH) payments
2. Establishing a redistribution process for DSH funds
3. Revising Critical Access Hospital (CAH) rates and eliminating settlements
4. Revising rates for vaginal and Cesarean Section (C-Section) deliveries
5. Simplifying claims payment for Rehabilitation and Long Term hospitals
6. Ensuring regular rebasing of hospital costs and rates

Disproportionate Share Hospital (DSH) Payments are made to hospitals that provide a high volume of uncompensated care to Medical Assistance and uninsured patients. DSH payments to hospitals are limited at the facility level to the hospital's uncompensated costs for treating Medicaid patients and uninsured patients. This payment limit is referred to as the facility specific DSH limit. Effective for payments made in calendar year 2011, CMS requires states to accurately determine each DSH hospitals' facility specific DSH limit. CMS will not provide federal matching dollars for any DSH payment amounts that exceed the facility specific limit. The enforcement of this rule requires DHS to redistribute excess DSH funds to other eligible hospitals or to lose the federal funding associated with the DSH funds that cannot be fully paid out to DSH hospitals. Changes to the DSH methodology will also relieve small rural hospitals from the significant expense of filing CMS mandated DSH audit reports when the DSH funding they receive is not commensurate with the cost of completing the required audit. DHS also recommends significantly reducing or eliminating DSH payments to local trade area hospitals. Minnesota hospitals receive little to no DSH payments from our border states.

The Centers for Medicare and Medicaid Services (CMS) created the critical access designation to ensure that rural beneficiaries would have access to acute care hospital services. Nearly six in ten hospitals across Minnesota are designated critical access hospitals by CMS. In 2012, MHCP recipients recorded over 2,500 admissions at 81 federally designated CAH , almost all of which were located in Minnesota. During the rebasing of the inpatient hospital rates, it was noted that the CAHs have lower patient volumes and generally treat patients with lower complexity. While the use of a cost based rate maintained stable payments to these providers, variation in cost across critical access hospitals are much greater than expected. Revising the methodology will provide the stability in payments necessary to ensure access in rural areas. The methodology would have high level cost-based payments that are tiered based on a set of factors that include geographic distance from other hospitals, cost efficiency, and types of services provided. Because payments will be at a high level of cost reimbursement, payments would be made at the time the claim is processed and would not be subject to settle-up payments in future years. DHS also proposes to revise the outpatient payment methodology to eliminate the estimated cost based payments and the step to settle the estimated interim payments to actual costs. The settle-up process is resource-intensive for hospitals and DHS, and results in relatively small payments to or from DHS. The settle-up cannot occur until at least two years after the claims have been

paid, and for hospitals that end up owing money, these payments can be disruptive to their financial stability.

The current blended payment rate and limits on hospital payments for vaginal and cesarean deliveries do not reduce Medicaid C-section rates nor do they produce a rate that recognizes complex deliveries and surgical births. The current rates do not support the effective evaluation of potential policy adjustments for obstetric services especially those delivered in rural areas. Legislation has been proposed to remove the blended payment rate and statutory limits on deliveries and C-sections.

Rates for long term and rehabilitation hospitals were not impacted by the rebasing, however, because the system is being modified to incorporate a new claims grouper, the programming associated with the payments for these hospitals must be updated to reflect the conversion to ICD-10. The rates will be set to a rate that is equal to the rates paid to these facilities in 2012, however, DHS proposes to incorporate all rate reductions that applied to these hospitals through 2012 into the final rates. This is the same thing that was done for DRG and critical access hospitals. By incorporating all previous rate reductions, the rates are more transparent to providers and streamlined and easier to maintain going forward.

Finally, the rebasing exercise has demonstrated clearly the need for regular rebasing of hospital rates and costs. Updated hospital costs, patient mix, and relative values are essential to ensure hospital payment rates are fair and accurately reflect current data. The new inpatient payment system provides more streamlined methods to increase or decrease hospital payments in the future based on policy adjusters and service line adjustments. Assuming the proposal to revise DSH factors is authorized, that will be an additional method available to the legislature on an ongoing basis.

V. Conclusion

DHS has developed a payment methodology that meets the requirements set forth in Minnesota Statutes 256.969 subdivision 2b. The proposed APR-DRG methodology incorporates Medicare cost and payment principles. The cost and charge data used to develop the methodology was limited to 2012 Medical Assistance covered claims from Minnesota and local trade area hospitals that are not critical access hospitals, long-term hospitals or rehabilitation hospitals. The value of the base rate payments and adjustments are budget neutral to the aggregate cost of the calendar year 2012 payments.

The proposed methodology also applies the required transition period payment corridors that limit aggregate hospital specific payment increases or decreases to 5 percent. DHS was able to limit aggregate hospital specific payment decreases to 3.2 percent while still remaining with the budget neutral aggregate payments across all hospitals. Given the significant changes to some hospitals between the 2002 to 2012 base years and the unknown impacts associated with the ICD-10 conversion, there could be benefit to extending these payment corridors until the next scheduled rebasing. An alternative could also be to gradually increase the corridors by a fixed percentage starting in 2016. For example, the corridors could be increased from 5 percent to 10 percent for discharges occurring on or after July 1, 2016.

DHS applied four policy adjustments to the base rate payments. The adjusters are targeted to services that are integral the Medical Assistance program and have a long history of legislative support, and address key services within the MA program, such as mental health, pediatric services, and obstetrics.

DHS validated the payment rate methodology by simulating the payment amounts produced when the new methodology was applied to the calendar year 2013 inpatient claims from Minnesota and local trade area hospitals that are not critical access, long-term or rehabilitation hospitals. The model produced payments that were consistent with the 2012 claims used in the model simulations.

DHS continues to work collaboratively with stakeholders on developing new payment methodologies for Disproportionate Share Hospital payments, payments for critical access hospitals, payments for obstetric services and payments for rehabilitation and long term hospitals. By doing so, DHS will be able to address certain areas where gaps remain such as hospitals that provide high cost mental health services to highly complex patients, high volume transplant centers, rural obstetric hospitals that perform C-sections, and hospitals that have seen marked increases in their Medicaid patient volume over the past decade.

Appendixes

Appendix A: Acronyms

ACA Affordable Care Act
ALOS Average length of stay
APR-DRG: All Patient Refined Diagnosis Related Group System
CAH: Critical access hospital
CCR: Cost-to-charge ratio
CMI: Case-mix index
CY: Calendar year
DPA: Disproportionate patient adjustment
DPP: Disproportionate patient percentage
DRG: Diagnosis-related group
DSH: Disproportionate share hospital
FFY: Federal fiscal year
GME: Graduate medical education
HCO: High-cost outlier
HCUP: Healthcare Cost and Utilization Project
HIPPA: Health Insurance Portability and Accountability Act
ICD-9-CM: International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM: International Classification of Diseases, Tenth Revision, Clinical Modification
IME: Indirect medical education
IPF: Inpatient psychiatric facility
IPPS: [Acute care hospital] Inpatient Prospective Payment System
IRF: Inpatient rehabilitation facility
LOS: Length of stay
LTC-DRG: Long-term care diagnosis-related group
LTCH: Long-term care hospital
MDC: Major diagnostic category
RY: Rate year
SFY: State fiscal year

Appendix B: Glossary

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

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

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

Base year. "Base year" means a hospital's fiscal year or years that is recognized by Medicare from which cost and statistical data are used to establish rates.

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

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

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

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

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

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

Fixed-loss amount. “Fixed-loss amount” means the amount added to the base DRG payment to establish the outlier threshold amount.

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

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

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

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

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare.

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

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

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

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

Low-Medicaid-volume Hospital. "Low-Medicaid-volume hospital" means a Minnesota or local trade area hospital with less than twenty Medical Assistance admissions in the base year.

Marginal cost factor. "Marginal cost factor" means a percentage of the estimated costs recognized above the outlier threshold amount.

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

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a hospital that is not located in a Metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

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

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

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota, excluding local trade area hospitals.

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

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

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

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

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

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

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

Rate year. "Rate year" means a calendar year from January 1 through December 31 in which the discharge occurred.

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

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

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

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

Transitional Period. “Transitional period” applies to the initial period of time for APR-DRG Hospitals and CAH Hospitals in Minnesota or local trade areas for discharges occurring on or after November 1, 2014 until June 30, 2016.

Wage Index. “Wage index” means an adjustment factor applied to the base rate to compensate for differences in hospital wage levels among geographic areas. The factor reflects the relative hospital wage level within the geographic area of the hospital compared to the national average hospital wage level. For areas with frontier state status the “Pre-floor Wage Index” is used.

Appendix C

Inpatient APR-DRG Payment Simulation Model

Minnesota Department of Human Services

Proposed Inpatient APR-DRG Payment Model

Design Component	Description
Model claims data	CY 2012 Minnesota Medicaid inpatient acute and psychiatric FFS claims data from in-state and out-of-state LTA hospitals. Excludes COS values that are not 001, 014 or 073, Medicare dual eligibles, Major Program Codes that are not EH or MA, ungroupable DRG claims, LTAC claims, rehabilitation provider claims, $0 paid claims, CAH claims and out-of-state non-LTA provider claims.
DRG classification version	3M APR-DRG version 31.
Proposed new system target expenditures	New inpatient system funding pool based on CY 2012 claim allowed amounts, including readmission reductions, with adjustments to reflect the current payment system.
DRG base rates	Based on statewide standardized amount of $5,376.02 with labor portion adjusted by FFY 2014 Medicare IPPS wage index (with reclassifications, without Frontier Adjustment). Statewide standardized amount set such that statewide aggregate simulated total claim payments are equal to current system payments.
Relative weights	Based on 3M's version 31 APR-DRG "standard" national weights.
Base payments	Calculated by multiplying the DRG base rate by the DRG relative weight.
Outlier payments	Calculated using following: - Claim outlier threshold equal to base DRG payment plus $70,000 fixed loss threshold - Claim outlier costs calculated by multiplying claim charges by FFY 2012 Medicare outlier CCRs. - Claim outlier payment calculated based on 50% of outlier costs exceeding outlier threshold for all DRGs.
Transfer payments	Based on the Medicare IPPS pro-rated standard transfer methodology for discharge status of '02', '05', and '65'. Transfer payment equal to the DRG base payment divided by the DRG average length of stay, multiplied by one plus the claim length of stay (up to the full DRG base payment).
DSH payments	Calculated by multiplying the sum of the base payments and outlier payments by revised DPA factors, which are based on hospital FYE 2012 Medicare cost report data extracted from the HCRIS dataset. Statewide average MIUR is 14.69% and the provider standard deviation MIUR is 10.67%.
Assessment payments	Calculated as: (Base payment + outlier payment + DSH payment - TPL payment - Patient liability) * 2%
Policy adjusters	- Temporary mental Health DRG policy adjusters for SOI levels 1/2/3/4 are 2.25/2.05/1.70/1.55 to achieve at least statewide average cost coverage. - Temporary "Other Pediatric" policy adjuster for non-children's providers is 1.15, set to make service line budget neutral. - Temporary "Other Pediatric" policy adjuster for children's providers is 1.60, set to make each provider at least budget neutral. - Non-metro provider APR-DRG 560 policy adjuster of 1.35, set to make the DRG budget neutral for these providers. - $5 newborn screening add-on. - $3,528 payment limit applied for Cesarean section DRG 540 claims (before DSH).

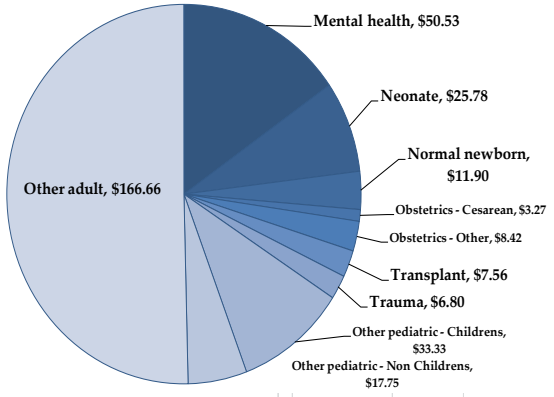
Table 2: Service Line Summary

Minnesota Department of Human Services

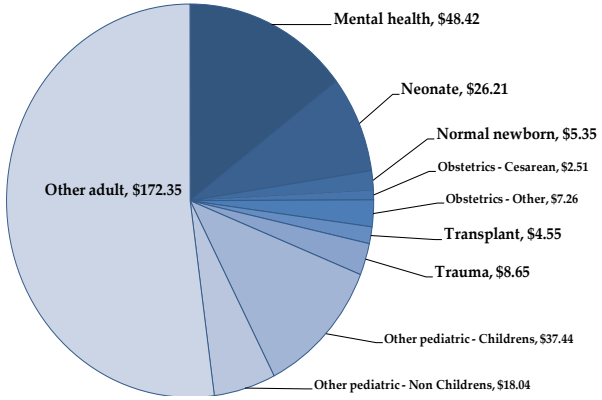
Proposed Inpatient APR-DRG Payment Model

	Calendar Year 2012 DRG Model FFS Claims Data					Simulated Payments Under New APR-DRG System - Before Transitional Adjustment or Buyback					
Policy Adjuster Categories	CY 2012 Discharges	APR-DRG CMI	Estimated Cost	Total Legacy System Payments	Legacy System Estimated Pay-to-Cost Ratio	Temporary Policy Adjuster	Simulated New System Payments	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage	Policy Adjuster Comment
1. Mental Health:											
SOI level 1	2,810	0.388	$ 21,300,047	$ 18,508,410	86.9%	2.25	$ 15,769,472	74.0%	$ (2,738,938)	-14.8%	
SOI level 2	3,512	0.550	39,839,814	27,438,590	68.9%	2.05	26,372,548	66.2%	(1,066,043)	-3.9%	
SOI level 3	469	0.835	6,428,802	3,552,341	55.3%	1.70	4,298,792	66.9%	746,451	21.0%	
SOI level 4	101	1.700	2,958,844	1,030,948	34.8%	1.55	1,983,821	67.0%	952,873	92.4%	
Mental Health Total	6,892	0.520	$ 70,527,507	$ 50,530,289	71.6%		$ 48,424,632	68.7%	$ (2,105,657)	-4.2%	
2. Neonate	1,113	2.475	$ 35,438,311	$ 25,784,466	72.8%	1.00	$ 26,207,434	74.0%	$ 422,968	1.6%	
3. Normal newborn	6,651	0.125	15,711,297	10,706,500	68.1%	1.00	5,345,691	34.0%	(5,360,809)	-50.1%	$5 screening add-on
4. Obstetrics - Cesarean (1)	707	0.643	6,410,099	3,273,070	51.1%	1.00	2,510,549	39.2%	(762,521)	-23.3%	Payment limit of $3,528 before DSH
5. Obstetrics - all other services	2,987	0.362	15,258,749	8,419,059	55.2%	Non-Metro: 1.35	7,259,810	47.6%	(1,159,249)	-13.8%	Applied to Non-Metro DRG 560 only
6. Transplant	50	9.588	7,176,887	7,555,708	105.3%	1.00	4,550,574	63.4%	(3,005,134)	-39.8%	
7.Trauma	464	2.443	12,063,225	6,795,420	56.3%	1.00	8,650,587	71.7%	1,855,167	27.3%	
8. Other pediatric DRGs - Children's providers	1,854	1.276	34,694,764	33,326,246	96.1%	1.60	37,435,954	107.9%	4,109,708	12.3%	Age 17 and under; excludes above categories
9. Other pediatric DRGs - Non-children's providers	2,186	1.002	24,221,647	17,752,111	73.3%	1.15	18,039,079	74.5%	286,968	1.6%	Age 17 and under; excludes above categories
10. Other adult DRGs	20,001	1.264	280,509,947	166,658,586	59.4%	1.00	172,350,569	61.4%	5,691,983	3.4%	
CY 2012 Analytical Dataset Total	**42,905**	**0.936**	**$ 502,012,433**	**$ 330,801,455**	**65.9%**		**$ 330,774,879**	**65.9%**	**$ (26,576)**	**0.0%**	

Current System Payments - $330.8 (in millions)



New System Payments - $330.8 (in millions)



*Estimated Costs and Pay-to-Cost Ratios for individual service lines may differ from hospital reported data due to the standardized method used to estimate costs.

Table 3: Transition Factor Summary

Minnesota Department of Human Services

Proposed Inpatient APR-DRG Payment Model

Estimated Payment Change Range	Number of Providers	CY 2012 Discharges	APR-DRG CMI	Estimated Cost	Total Legacy System Payments	Legacy System Estimated Pay-to-Cost Ratio	Simulated New System Payments	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage
	Calendar Year 2012 DRG Model FFS Claims Data						Simulated Payments Under New APR-DRG System - Before Transitional Adjustment or Buyback			
Metro-Area Providers:										
25%+ Increase	7	2,122	1.009	$ 21,944,347	$ 11,246,703	51.3%	$ 15,021,211	68.5%	$ 3,774,508	33.6%
15% - 25% Increase	5	7,309	1.002	81,123,144	42,492,460	52.4%	51,432,955	63.4%	8,940,495	21.0%
5% - 15% Increase	5	3,156	0.970	37,529,982	22,293,286	59.4%	25,126,811	67.0%	2,833,526	12.7%
5% Decrease - 5%Increase	8	9,570	1.083	139,226,766	107,341,543	77.1%	107,575,022	77.3%	233,478	0.2%
5% - 15% Decrease	10	11,297	0.947	138,059,437	98,394,123	71.3%	87,479,286	63.4%	(10,914,836)	-11.1%
15% - 25% Decrease	6	3,252	1.060	47,508,119	28,428,366	59.8%	23,551,064	49.6%	(4,877,303)	-17.2%
25%+ Decrease	1	58	0.438	836,652	594,794	71.1%	351,226	42.0%	(243,569)	-41.0%
Metro Subtotal	**42**	**36,764**	**1.008**	**466,228,447**	**310,791,275**	**66.7%**	**310,537,574**	**66.6%**	**(253,701)**	**-0.1%**
Non-Metro Providers:										
25%+ Increase	1	700	0.684	$ 4,878,652	$ 2,478,715	50.8%	$ 3,217,930	66.0%	$ 739,215	29.8%
15% - 25% Increase	1	186	0.693	1,215,283	579,178	47.7%	676,892	55.7%	97,715	16.9%
5% - 15% Increase	3	1,701	0.533	8,199,715	4,840,546	59.0%	5,363,152	65.4%	522,606	10.8%
5% Decrease - 5%Increase	4	654	0.489	4,195,366	2,206,780	52.6%	2,194,210	52.3%	(12,570)	-0.6%
5% - 15% Decrease	9	2,285	0.436	14,030,534	8,053,851	57.4%	7,321,610	52.2%	(732,241)	-9.1%
15% - 25% Decrease	5	615	0.415	3,264,436	1,851,111	56.7%	1,463,511	44.8%	(387,599)	-20.9%
25%+ Decrease	0	-		-	-	N/A	-	N/A	-	N/A
Non-Metro Subtotal	**23**	**6,141**	**0.502**	**35,783,986**	**20,010,180**	**55.9%**	**20,237,305**	**56.6%**	**227,125**	**1.1%**
CY 2012 Analytical Dataset Total	**65**	**42,905**	**0.936**	**$ 502,012,433**	**$ 330,801,455**	**65.9%**	**$ 330,774,879**	**65.9%**	**$ (26,576)**	**0.0%**

Note: Provider counts rolled up by Medicare ID. As such a general acute provider with a distinct part unit would count as one provider in this summary.

Table 4: Facility Specific Description

*Estimated Costs and Pay-to-Cost Ratios for individual hospitals may differ from hospital reported data due to the standardized method used to estimate costs.

Minnesota Department of Human Services
Inpatient APR-DRG Payment Simulation Model
Provider Impact - Transition Year 1

Sorted by Payment Change % Before Transition and Buyback

		Calendar Year 2012 DRG Model Data						Estimated Impact - Before Transition and Buyback			
Medicare Provider Number	Hospital Name	CY 2012 Discharges	APR-DRG Case Mix - Unadjusted	APR-DRG Case Mix - With Policy Adjustments	Estimated Costs	Current System Total Payments	Legacy System Estimated Pay-to-Cost Ratio	New System Total Payments	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage
240196	Phillips Eye Institute	2	0.910	0.980	$ 28,424	$ 4,267	15.0%	$ 11,453	40.3%	$ 7,186	168.4%
430016	Avera Mckennan Hospital & University Health Center	251	1.007	1.279	2,419,105	1,012,207	41.8%	1,711,962	70.8%	699,755	69.1%
520087	Gundersen Luth Med Ctr	109	1.526	1.586	1,672,357	663,200	39.7%	1,016,653	60.8%	353,453	53.3%
240056	Ridgeview Medical Center	220	0.676	0.680	1,423,555	631,938	44.4%	831,511	58.4%	199,573	31.6%
240093	Immanuel-St Josephs-Mayo Health System	700	0.684	0.760	4,878,652	2,478,715	50.8%	3,217,930	66.0%	739,215	29.8%
350011	Sanford Medical Center Fargo	954	1.228	1.281	10,607,169	5,510,126	51.9%	7,091,828	66.9%	1,581,702	28.7%
430095	Avera Heart Hospital Of South Dakota Llc	10	3.968	3.968	249,121	138,733	55.7%	177,887	71.4%	39,154	28.2%
240019	Smdc Medical Center	576	0.624	1.068	5,544,617	3,286,232	59.3%	4,179,917	75.4%	893,685	27.2%
240057	Abbott Northwestern Hospital Inc	2,141	1.028	1.155	25,669,470	11,975,368	46.7%	14,956,627	58.3%	2,981,259	24.9%
240063	St Joseph'S Hospital	963	0.862	1.035	10,130,431	5,419,316	53.5%	6,697,019	66.1%	1,277,703	23.6%
240036	St Cloud Hospital	1,715	0.913	0.995	16,249,348	9,286,331	57.1%	11,187,427	68.8%	1,901,097	20.5%
240001	North Memorial Health Care	1,909	1.148	1.213	23,264,307	12,705,389	54.6%	14,955,146	64.3%	2,249,757	17.7%
240078	Fairview Southdale Hospital	581	0.930	1.022	5,809,588	3,106,057	53.5%	3,636,735	62.6%	530,679	17.1%
240030	Douglas County Hospital	186	0.693	0.712	1,215,283	579,178	47.7%	676,892	55.7%	97,715	16.9%
243300	Gillette Childrens Specialty Hospital	427	1.430	2.104	11,992,975	8,416,192	70.2%	9,652,115	80.5%	1,235,923	14.7%
240040	University Medical Center-Mesabi/ Mesaba Clinics	319	0.522	0.725	2,428,578	1,211,030	49.9%	1,384,490	57.0%	173,460	14.3%
240100	North Country Regional Hospital	1,123	0.586	0.612	5,713,339	3,370,483	59.0%	3,807,300	66.6%	436,816	13.0%
240002	St Mary's Medical Center	1,168	1.156	1.174	12,634,600	7,606,274	60.2%	8,547,303	67.6%	941,029	12.4%
350019	Altru Hospital	255	1.066	1.096	2,933,863	1,341,022	45.7%	1,501,228	51.2%	160,206	11.9%
240210	Healtheast St John'S Hospital	987	0.670	0.674	7,539,965	3,718,767	49.3%	4,041,674	53.6%	322,907	8.7%
240141	Fairview Northland Regional Hospital	162	0.469	0.482	842,652	482,142	57.2%	516,853	61.3%	34,711	7.2%
240101	St Marys Regional Health Center	416	0.415	0.441	1,643,724	987,920	60.1%	1,038,999	63.2%	51,079	5.2%
240047	St Lukes Hospital	757	0.819	0.952	5,400,325	4,170,883	77.2%	4,372,569	81.0%	201,686	4.8%
430090	Sioux Falls Surgical Hospital Llp	1	0.886	0.890	7,633	4,152	54.4%	4,350	57.0%	198	4.8%
240084	Virginia Regional Medical Center	138	0.417	0.425	698,900	308,980	44.2%	323,462	46.3%	14,482	4.7%
350070	Essentia Health-Fargo	284	1.037	1.044	2,756,875	1,503,567	54.5%	1,552,780	56.3%	49,213	3.3%
240071	District One Hospital	173	0.398	0.434	730,661	448,838	61.4%	458,678	62.8%	9,840	2.2%
240066	Lakeview Memorial Hospital	68	0.582	0.602	380,711	229,260	60.2%	231,960	60.9%	2,700	1.2%
240044	Winona Health Services	203	0.514	0.652	1,730,685	739,422	42.7%	747,893	43.2%	8,471	1.1%
243302	Childrens Health Care - Minneapolis	1,898	1.601	2.206	43,409,759	43,001,035	99.1%	43,254,927	99.6%	253,892	0.6%
240038	United Hospital	1,744	0.732	0.819	15,535,887	8,863,468	57.1%	8,887,994	57.2%	24,526	0.3%
430027	Sanford Usd Medical Center	147	1.385	1.423	2,227,292	1,214,781	54.5%	1,213,185	54.5%	(1,596)	-0.1%
240004	Hennepin County Medical Center	4,601	1.060	1.156	69,190,095	48,274,679	69.8%	47,965,756	69.3%	(308,923)	-0.6%
240052	Lake Region Healthcare Corporation	210	0.510	0.650	1,353,309	789,259	58.3%	755,678	55.8%	(33,581)	-4.3%
240207	Fairview Ridges Hospital	667	0.612	0.619	4,273,436	2,637,635	61.7%	2,504,238	58.6%	(133,397)	-5.1%
240132	Unity Hospital	945	0.755	0.757	8,176,720	4,558,748	55.8%	4,313,762	52.8%	(244,986)	-5.4%

Table 4: Facility Specific Description (continued)

*Estimated Costs and Pay-to-Cost Ratios for individual hospitals may differ from hospital reported data due to the standardized method used to estimate costs.

Minnesota Department of Human Services
Inpatient APR-DRG Payment Simulation Model
Provider Impact - Transition Year 1

Transition Year 1 Ceiling:	**5.0%**
Transition Year 1 Floor:	**-3.2%**

Sorted by Payment Change % Before Transition and Buyback

		Estimated Impact - Transition Year 1 before Buyback					Estimated Impact - Transition Year 1 with Buyback				
Medicare Provider Number	Hospital Name	Transition Factor	Payments After Adjustment	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage	Readmission Buyback Factor	Payments After Adjustment	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage
240196	Phillips Eye Institute	0.3912	$ 4,481	15.8%	$ 213	5.0%	1.10	$ 4,928.66	17.3%	$ 661	15.5%
430016	Avera Mckennan Hospital & University Health Center	0.6208	1,062,786	43.9%	50,579	5.0%	1.10	1,169,064	48.3%	156,857	15.5%
520087	Gundersen Luth Med Ctr	0.6850	696,408	41.6%	33,207	5.0%	1.10	766,048	45.8%	102,848	15.5%
240056	Ridgeview Medical Center	0.7980	663,546	46.6%	31,607	5.0%	1.10	729,900	51.3%	97,962	15.5%
240093	Immanuel-St Josephs-Mayo Health System	0.8088	2,602,662	53.3%	123,947	5.0%	1.10	2,862,928	58.7%	384,213	15.5%
350011	Sanford Medical Center Fargo	0.8158	5,785,513	54.5%	275,387	5.0%	1.10	6,364,065	60.0%	853,939	15.5%
430095	Avera Heart Hospital Of South Dakota Llc	0.8189	145,671	58.5%	6,939	5.0%	1.10	160,239	64.3%	21,506	15.5%
240019	Smdc Medical Center	0.8255	3,450,522	62.2%	164,290	5.0%	1.10	3,795,574	68.5%	509,342	15.5%
240057	Abbott Northwestern Hospital Inc	0.8407	12,574,036	49.0%	598,668	5.0%	1.10	13,831,440	53.9%	1,856,072	15.5%
240063	St Joseph'S Hospital	0.8497	5,690,457	56.2%	271,141	5.0%	1.10	6,259,503	61.8%	840,187	15.5%
240036	St Cloud Hospital	0.8716	9,750,962	60.0%	464,631	5.0%	1.10	10,726,058	66.0%	1,439,727	15.5%
240001	North Memorial Health Care	0.8920	13,339,990	57.3%	634,601	5.0%	1.10	14,673,989	63.1%	1,968,600	15.5%
240078	Fairview Southdale Hospital	0.8968	3,261,424	56.1%	155,367	5.0%	1.10	3,587,566	61.8%	481,510	15.5%
240030	Douglas County Hospital	0.8984	608,120	50.0%	28,942	5.0%	1.10	668,932	55.0%	89,754	15.5%
243300	Gillette Childrens Specialty Hospital	0.9156	8,837,477	73.7%	421,285	5.0%	1.00	8,837,477	73.7%	421,285	5.0%
240040	University Medical Center-Mesabi/ Mesaba Clinics	0.9184	1,271,516	52.4%	60,486	5.0%	1.10	1,398,668	57.6%	187,637	15.5%
240100	North Country Regional Hospital	0.9295	3,538,885	61.9%	168,402	5.0%	1.10	3,892,774	68.1%	522,290	15.5%
240002	St Mary's Medical Center	0.9344	7,986,600	63.2%	380,326	5.0%	1.10	8,785,260	69.5%	1,178,986	15.5%
350019	Altru Hospital	0.9379	1,408,002	48.0%	66,980	5.0%	1.10	1,548,802	52.8%	207,780	15.5%
240210	Healtheast St John'S Hospital	0.9661	3,904,662	51.8%	185,894	5.0%	1.10	4,295,128	57.0%	576,360	15.5%
240141	Fairview Northland Regional Hospital	0.9795	506,257	60.1%	24,115	5.0%	1.10	556,883	66.1%	74,741	15.5%
240101	St Marys Regional Health Center	0.9984	1,037,337	63.1%	49,416	5.0%	1.10	1,141,070	69.4%	153,150	15.5%
240047	St Lukes Hospital	1.0000	4,372,569	81.0%	201,686	4.8%	1.10	4,809,826	89.1%	638,943	15.3%
430090	Sioux Falls Surgical Hospital Llp	1.0000	4,350	57.0%	198	4.8%	1.10	4,784.88	62.7%	633	15.2%
240084	Virginia Regional Medical Center	1.0000	323,462	46.3%	14,482	4.7%	1.10	355,808	50.9%	46,828	15.2%
350070	Essentia Health-Fargo	1.0000	1,552,780	56.3%	49,213	3.3%	1.10	1,708,058	62.0%	204,491	13.6%
240071	District One Hospital	1.0000	458,678	62.8%	9,840	2.2%	1.10	504,546	69.1%	55,708	12.4%
240066	Lakeview Memorial Hospital	1.0000	231,960	60.9%	2,700	1.2%	1.10	255,156	67.0%	25,896	11.3%
240044	Winona Health Services	1.0000	747,893	43.2%	8,471	1.1%	1.10	822,682	47.5%	83,260	11.3%
243302	Childrens Health Care - Minneapolis	1.0000	43,254,927	99.6%	253,892	0.6%	1.00	43,254,927	99.6%	253,892	0.6%
240038	United Hospital	1.0000	8,887,994	57.2%	24,526	0.3%	1.10	9,776,793	62.9%	913,325	10.3%
430027	Sanford Usd Medical Center	1.0000	1,213,185	54.5%	(1,596)	-0.1%	1.10	1,334,503	59.9%	119,723	9.9%
240004	Hennepin County Medical Center	1.0000	47,965,756	69.3%	(308,923)	-0.6%	1.10	52,762,332	76.3%	4,487,653	9.3%
240052	Lake Region Healthcare Corporation	1.0110	763,991	56.5%	(25,268)	-3.2%	1.10	840,390	62.1%	51,131	6.5%
240207	Fairview Ridges Hospital	1.0196	2,553,322	59.7%	(84,314)	-3.2%	1.10	2,808,654	65.7%	171,018	6.5%
240132	Unity Hospital	1.0230	4,412,979	54.0%	(145,769)	-3.2%	1.10	4,854,277	59.4%	295,529	6.5%

Table 4: Facility Specific Description (continued)

*Estimated Costs and Pay-to-Cost Ratios for individual hospitals may differ from hospital reported data due to the standardized method used to estimate costs.

Minnesota Department of Human Services
Inpatient APR-DRG Payment Simulation Model
Provider Impact - Transition Year 1

Sorted by Payment Change % Before Transition and Buyback

		Calendar Year 2012 DRG Model Data						Estimated Impact - Before Transition and Buyback			
Medicare Provider Number	Hospital Name	CY 2012 Discharges	APR-DRG Case Mix - Unadjusted	APR-DRG Case Mix - With Policy Adjustments	Estimated Costs	Current System Total Payments	Legacy System Estimated Pay-to-Cost Ratio	New System Total Payments	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage
240020	Cambridge Medical Center	388	0.502	0.667	2,718,363	1,762,174	64.8%	1,653,817	60.8%	(108,357)	-6.1%
240053	Park Nicollet Methodist Hospital	977	0.797	0.806	9,033,175	4,931,523	54.6%	4,602,626	51.0%	(328,896)	-6.7%
240069	Owatonna Hospital	301	0.401	0.517	1,877,868	1,029,035	54.8%	959,362	51.1%	(69,674)	-6.8%
240064	Grand Itasca Clinic And Hospital	142	0.566	0.588	762,515	508,575	66.7%	473,285	62.1%	(35,290)	-6.9%
240006	Olmsted Medical Center	213	0.296	0.322	1,107,531	538,400	48.6%	498,329	45.0%	(40,071)	-7.4%
240088	Rice Memorial Hospital	312	0.423	0.570	2,017,929	1,079,944	53.5%	996,990	49.4%	(82,954)	-7.7%
240104	St Francis Regional Medical Center	345	0.595	0.605	2,798,795	1,326,021	47.4%	1,213,844	43.4%	(112,177)	-8.5%
240117	Austin Medical Center	336	0.404	0.526	1,905,479	1,111,454	58.3%	1,017,360	53.4%	(94,094)	-8.5%
240075	Essentia Health St Joseph'S Medical Center	447	0.583	0.748	3,658,860	2,027,116	55.4%	1,837,566	50.2%	(189,549)	-9.4%
240014	Northfield Hospital	147	0.326	0.354	581,209	329,623	56.7%	295,944	50.9%	(33,679)	-10.2%
354004	Prairie St. John's	193	0.554	1.076	1,043,376	1,207,959	115.8%	1,073,745	102.9%	(134,214)	-11.1%
240080	University Of Minnesota Medical Center, Fairview	3,333	1.272	1.469	59,448,638	45,677,246	76.8%	40,531,539	68.2%	(5,145,707)	-11.3%
240076	Buffalo Hospital	189	0.370	0.389	1,021,723	503,516	49.3%	446,564	43.7%	(56,952)	-11.3%
244xxx	PrairieCare LLC	82	0.418	0.913	861,873	497,549	57.7%	438,715	50.9%	(58,834)	-11.8%
240115	Mercy Hospital	1,487	0.844	0.957	15,185,899	9,821,184	64.7%	8,593,612	56.6%	(1,227,572)	-12.5%
240106	Regions Hospital	2,880	0.961	1.116	34,519,160	25,974,082	75.2%	22,553,385	65.3%	(3,420,697)	-13.2%
240187	Hutchinson Area Health Care	198	0.434	0.708	1,097,420	926,188	84.4%	796,211	72.6%	(129,978)	-14.0%
240010	Mayo Clinic - Saint Marys Hospital	1,680	1.435	1.573	33,986,809	20,386,198	60.0%	17,235,946	50.7%	(3,150,252)	-15.5%
240050	Fairview Lakes Health Services	210	0.469	0.473	1,099,938	678,259	61.7%	567,889	51.6%	(110,370)	-16.3%
240214	Maple Grove Hospital	507	0.442	0.444	2,820,495	1,616,102	57.3%	1,343,459	47.6%	(272,643)	-16.9%
240043	Naeve Hospital	210	0.367	0.383	952,746	522,478	54.8%	426,068	44.7%	(96,409)	-18.5%
240166	Fairmont Medical Center	90	0.522	0.540	514,841	312,057	60.6%	246,399	47.9%	(65,659)	-21.0%
240018	Fairview Red Wing Hospital	96	0.568	0.579	812,526	421,115	51.8%	330,658	40.7%	(90,456)	-21.5%
240059	Regina Medical Center	82	0.453	0.470	398,918	279,863	70.2%	216,725	54.3%	(63,138)	-22.6%
240061	Mayo Clinic - Methodist Hospital	478	0.991	0.994	7,259,845	3,881,541	53.5%	2,998,707	41.3%	(882,834)	-22.7%
240022	Sanford Regional Hospital Worthington	137	0.289	0.305	585,405	315,599	53.9%	243,661	41.6%	(71,937)	-22.8%
520004	Franciscan Skemp La Crosse Hsptl	34	0.702	0.789	241,870	201,491	83.3%	155,108	64.1%	(46,383)	-23.0%
240213	Healtheast Woodwinds Hospital	343	0.625	0.626	2,099,163	1,664,776	79.3%	1,249,954	59.5%	(414,822)	-24.9%
354005	Richard P. Stadter Psych Center	58	0.438	0.931	836,652	594,794	71.1%	351,226	42.0%	(243,569)	-41.0%
	CY 2012 Analytical Dataset Total	**42,905**	**0.936**	**1.066**	**$ 502,012,433**	**$ 330,801,455**	**65.9%**	**$ 330,774,879**	**65.9%**	**$ (26,576)**	**0.0%**

Note: Provider totals summed up by Medicare ID in this schedule. As such, a general acute provider with a distinct part unit with separate NPIs would be combined.

Table 4: Facility Specific Description (continued)

*Estimated Costs and Pay-to-Cost Ratios for individual hospitals may differ from hospital reported data due to the standardized method used to estimate costs.

Minnesota Department of Human Services
Inpatient APR-DRG Payment Simulation Model
Provider Impact - Transition Year 1

Transition Year 1 Ceiling:	**5.0%**
Transition Year 1 Floor:	**-3.2%**

Sorted by Payment Change % Before Transition and Buyback

		Estimated Impact - Transition Year 1 before Buyback						Estimated Impact - Transition Year 1 with Buyback				
Medicare Provider Number	Hospital Name	Projected Transition Payments Under New System	Transition Factor	Payments After Adjustment	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage	Readmission Buyback Factor	Payments After Adjustment	New System Estimated Pay to Cost Ratio	Estimated Payment Change	Estimated Payment Change Percentage
240020	Cambridge Medical Center	1,674,066	1.0314	1,705,747	62.7%	(56,427)	-3.2%	1.10	1,876,322	69.0%	114,148	6.5%
240053	Park Nicollet Methodist Hospital	4,684,946	1.0372	4,773,844	52.8%	(157,678)	-3.2%	1.10	5,251,229	58.1%	319,706	6.5%
240069	Owatonna Hospital	977,584	1.0383	996,105	53.0%	(32,930)	-3.2%	1.10	1,095,716	58.3%	66,680	6.5%
240064	Grand Itasca Clinic And Hospital	483,146	1.0402	492,311	64.6%	(16,264)	-3.2%	1.10	541,542	71.0%	32,967	6.5%
240006	Olmsted Medical Center	511,480	1.0458	521,152	47.1%	(17,248)	-3.2%	1.10	573,267	51.8%	34,867	6.5%
240088	Rice Memorial Hospital	1,025,947	1.0485	1,045,344	51.8%	(34,600)	-3.2%	1.10	1,149,879	57.0%	69,934	6.5%
240104	St Francis Regional Medical Center	1,259,720	1.0575	1,283,641	45.9%	(42,381)	-3.2%	1.10	1,412,005	50.5%	85,983	6.5%
240117	Austin Medical Center	1,055,881	1.0575	1,075,858	56.5%	(35,596)	-3.2%	1.10	1,183,443	62.1%	71,990	6.5%
240075	Essentia Health St Joseph'S Medical Center	1,925,760	1.0679	1,962,337	53.6%	(64,779)	-3.2%	1.10	2,158,571	59.0%	131,455	6.5%
240014	Northfield Hospital	313,142	1.0782	319,087	54.9%	(10,536)	-3.2%	1.10	350,996	60.4%	21,373	6.5%
354004	Prairie St. John's	1,147,561	1.0890	1,169,309	112.1%	(38,651)	-3.2%	1.10	1,286,239	123.3%	78,280	6.5%
240080	University Of Minnesota Medical Center, Fairview	43,393,384	1.0909	44,215,856	74.4%	(1,461,390)	-3.2%	1.10	48,637,442	81.8%	2,960,196	6.5%
240076	Buffalo Hospital	478,341	1.0915	487,425	47.7%	(16,092)	-3.2%	1.10	536,167	52.5%	32,651	6.5%
244xxx	PrairieCare LLC	472,672	1.0978	481,622	55.9%	(15,927)	-3.2%	1.10	529,784	61.5%	32,235	6.5%
240115	Mercy Hospital	9,330,125	1.1063	9,507,113	62.6%	(314,071)	-3.2%	1.10	10,457,825	68.9%	636,640	6.5%
240106	Regions Hospital	24,675,378	1.1148	25,142,513	72.8%	(831,569)	-3.2%	1.10	27,656,765	80.1%	1,682,683	6.5%
240187	Hutchinson Area Health Care	879,879	1.1260	896,533	81.7%	(29,655)	-3.2%	1.10	986,186	89.9%	59,998	6.5%
240010	Mayo Clinic - Saint Marys Hospital	19,366,888	1.1449	19,733,435	58.1%	(652,763)	-3.2%	1.10	21,706,778	63.9%	1,320,580	6.5%
240050	Fairview Lakes Health Services	644,346	1.1561	656,536	59.7%	(21,722)	-3.2%	1.10	722,190	65.7%	43,931	6.5%
240214	Maple Grove Hospital	1,535,297	1.1644	1,564,324	55.5%	(51,778)	-3.2%	1.10	1,720,756	61.0%	104,654	6.5%
240043	Naeve Hospital	496,354	1.1870	505,743	53.1%	(16,735)	-3.2%	1.10	556,317	58.4%	33,840	6.5%
240166	Fairmont Medical Center	296,454	1.2259	302,060	58.7%	(9,997)	-3.2%	1.10	332,266	64.5%	20,209	6.5%
240018	Fairview Red Wing Hospital	400,059	1.2328	407,636	50.2%	(13,479)	-3.2%	1.10	448,399	55.2%	27,285	6.5%
240059	Regina Medical Center	265,870	1.2500	270,906	67.9%	(8,957)	-3.2%	1.10	297,996	74.7%	18,134	6.5%
240061	Mayo Clinic - Methodist Hospital	3,687,464	1.2530	3,757,379	51.8%	(124,161)	-3.2%	1.10	4,133,117	56.9%	251,577	6.5%
240022	Sanford Regional Hospital Worthington	299,819	1.2538	305,503	52.2%	(10,096)	-3.2%	1.10	336,053	57.4%	20,454	6.5%
520004	Franciscan Skemp La Crosse Hsptl	191,416	1.2575	195,048	80.6%	(6,442)	-3.2%	1.10	214,553	88.7%	13,062	6.5%
240213	Healtheast Woodwinds Hospital	1,581,537	1.2892	1,611,441	76.8%	(53,335)	-3.2%	1.10	1,772,585	84.4%	107,809	6.5%
354005	Richard P. Stadter Psych Center	565,054	1.6393	575,764	68.8%	(19,030)	-3.2%	1.10	633,341	75.7%	38,546	6.5%
	CY 2012 Analytical Dataset Total	**$ 330,061,958**		**$330,832,730**	**65.9%**	**$31,275**	**0.0%**		**$358,706,763**	**71.5%**	**$27,905,307**	**8.4%**

Note: Provider totals summed up by Medicare ID in this schedule. As such, a general acute provider with a distinct part unit with separate NPIs would be combined.