STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO RULES OF THE MINNESOTA DEPARTMENT OF HUMAN SERVICES GOVERNING IMPATIENT HOSPITAL REIMBURSEMENT UNDER MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE, PARTS 9500.1090 to 9500.1155

STATEMENT OF NEED AND REASONABLENESS

Minnesota Rules, parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for inpatient hospital services under the Medical Assistance (MA) and General Assistance Medical Care (GAMC) Programs. The reimbursement system established by these rules promotes cost containment without negative effects on patient care, by offering financial incentives for efficient and economical hospital operations. Minnesota Statutes, section 256.969 subdivision 2, mandates that inpatient hospital reimbursement under the MA and GAMC Programs be based upon a diagnostic classification. These rules contain definitions of terms; provisions governing the determination of relative values; determination of allowable base year cost per admission; determination of the annual cost index; determination of reimbursement rates; reimbursement procedures; and appeal procedures.

In 1983 the Legislature directed the Commissioner of Human Services to promulgate temporary and permanent rules to implement Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39 which establish a prospective reimbursement system for MA and GAMC inpatient hospital services. In response to the legislative mandate, the Department published 12 MCAR sections 2.05401-2.05403 (Temporary) in the State Register on August 1, 1983. The temporary rule became effective on October 1, 1983. The temporary rule was continued in effect for an additional 180 days under Minnesota Statutes, section 14.35. It was again continued in effect until August 1, 1985.

To develop permanent rules, the Department worked closely with hospital representatives. A modified diagnosis related groups (DRGs) reimbursement system similar to the Medicare Program was implemented. The permanent rules were adopted on August 1, 1985 and amended on March 24, 1987.

Since adopting these rules and the amendments to them, the Department has identified some additional areas of the rules that need to be amended. The need for these amendments arises from inconsistencies with the related Admission Certification rule, parts 9505.0500 to 9505.0540 (Rule 48), which outlines the procedures to be followed in order to be eligible for reimbursement under parts 9500.1090 to 9500.1155. To avoid confusion, it is imperative that Rule 48 be read in conjunction and consistent with these rules.

The department solicited the opinion of an advisory committee before and during the preparation of the proposed amendments to the rules. The committee was composed of representatives from the Minnesota Medical Association, Minnesota Hospital Association, Council of Hospital Corporations, and individual hospitals. The committee also included the medical review agent and utilization review specialists. (See appendix A for committee membership.) The committee met on December 2, 1987, February 4, 1988, and March 4, 1988 to review the amendments proposed by the department. Members of the committee supported the department's desire to address these concerns.

The proposed amended rules, designated as, parts 9500.1095 to 9500.1155 are hereby affirmatively presented by the Department as required by Minnesota Statutes, section 256.969 and in accordance with the provisions of the Minnesota Administrative Procedures Act, Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings.

Part 9500.1090. PURPOSE AND SCOPE

It is necessary to replace 9500.1155 subpart 5 with 9500.1155 subpart 6 in order to correct a typographical error. This amendment is reasonable because Laws of Minnesota 1982, Third Special Session, chapter 1, article 2, section 2, subdivision 4, paragraph (a), clause (4) require that the 4% reduction rule apply only to medical assistance reimbursement.

Part 9500.1095. STATUTORY AUTHORITY

It is necessary to inform providers and recipients that this rule should be read in conjunction with the admission certification rule, i.e. parts 9505.0500 to 9505.0540 (Rule 48). This amendment is reasonable because providers must follow the procedures set forth in and obtain the approvals required under the admission certification rule (Rule 48) before they can be reimbursed under these rules for inpatient hospital services provided by them.

Part 9500.1100. DEFINITIONS

The proposed amendments to the definitions are necessary to clarify the meaning of terms which may be subject to multiple interpretations, and to be consistent with medical usage, statutes and other related rules.

Subp. 20. Diagnostic categories. The definition of "diagnostic categories" has been amended to be consistent with the definition of diagnostic category in the admission certification rule (Rule 48). There is no change in the meaning of this term. This amendment is necessary and reasonable because the present rule must be read in conjunction with Rule 48 (refer to SNR for part 9500.1095), and consistent definitions minimize the risk of confusion for providers and recipients.

Subp. 21a. Foreseeable complication. It is reasonable and necessary to delete this definition because the text of the rule that it related to has been deleted (refer to 9505.1130 subparts 7 and 8).

Subp. 27. Inpatient hospital services. It is necessary to amend this subpart to include the term "hospital" to be consistent with the definition in Rule 48. It is reasonable that services which are medically necessary may be furnished by the hospital as well as the physician or other vendor during a recipient's inpatient hospital stay. It is necessary to clarify that inpatient hospital services are those provided after the recipient is admitted to the hospital and hospital services are made available to the recipient on a continuous 24-hour-a-day basis. This amendment is reasonable because it is consistent with common medical usage and with parts 9505.0170 to 9505.0475 (Rule 47), which govern provider eligibility to receive medical assistance payments.

Subp. 29. Medical assistance or MA. The amendment is necessary because it identifies the funding programs that come under the purview of this rule and clarifies that GAMC is one of the funding sources and is included in all references to MA throughout this rule. Minnesota Statutes, section 256D.03, subd. 7(b) requires the department to establish standards for reimbursement in the GAMC program that conform to procedures established for the Medical Assistance program. It is reasonable to use one term in order to delete unnecessary words in a reference frequently repeated in the rule. It is necessary and reasonable to exclude part 9500.1155 subpart 6 from this definition because the 4% reduction rule does not apply to the GAMC program. It is also necessary and reasonable to amend this definition because it is consistent with 9505.0500 to 9505.0540 (Rule 48).

Subp. 42. Readmission. It is necessary to broaden the time frame for readmissions because of the complexity of medical care and the potential for fragmented care caused by the incentive to discharge and readmit, which is inherent in the per admission prospective payment system. The extended time frame also serves as a safeguard against unnecessary, inappropriate or underutilization of services. A broader time frame allows more thorough detection of such occurrences. The amendment is also reasonable because it is consistent with the definition of readmission in parts 9505.0500 to 9505.0540 (Rule 48) and the Medicare prospective payment system which expanded the review of readmissions from 7 to 15 days.

Subp. 50. Transfer. This amendment is necessary to clarify that a transfer is a situation in which a recipient is transported directly from one hospital to another with no change in the level of care provided. The word "directly" has the meaning given to it in the American Heritage Dictionary (The American Heritage Dictionary, Second College Edition, 1985), i.e. without intervening persons, conditions, or agencies; immediate. A direct transfer occurs when the hospital codes the recipient's disposition status as discharged to another hospital. It is reasonable because not all recipients treated for inpatient hospital services receive the entire treatment for an episode in one hospital.

Although direct transfers are technically readmissions, it is necessary and reasonable to differentiate them from readmission situations in which a change in the level care between discharge and readmission has occurred for purposes of coding claims and retaining consistent data and for record keeping within the hospital.

Part 9500.1130. REIMBURSEMENT PROCEDURES

Subp. 4. Adjustment to reimbursement. It is necessary to clarify the criteria used for determining adjustments to reimbursement. It is reasonable to refer to parts 9505.0500 to 9505.0540 (Rule 48) as standards for determining the appropriateness of utilization because they include the admission certification process, criteria for determining medical necessity, transfers and readmissions.

It is necessary and reasonable to inform the providers of the methods that the Department will use for recovery and adjustment and to refer to part 9505.0520 to 9505.0540 which set forth the methods of adjusting reimbursement.

Subp. 5. Rejection of claims. It is necessary to clarify when claims will not be reimbursed for Medicare eligible recipients. The amendment is reasonable because services which have been certified as medically necessary under the Medicare

program are exempt from the MA admission certification process. This is reasonable and necessary because Medicare has established an admission certification process which is essentially similar to the MA process. Similarly, the denial of inpatient hospital services under Medicare also means a denial of the service under MA because there has already been a determination that the services are not medically necessary. This amendment is also reasonable because it is consistent with the provision for exclusion from admission certification in part 9505.0520, subp. 2, item B (Rule 48).

Subp. 7. Reimbursement for transfers. It is necessary to clarify transfer reimbursement criteria for providers. It is reasonable that the amendment delete the existing criteria for transfer situations because more comprehensive criteria related to transfer situations have been added to part 9505.0540, subparts 3 - 6 (Rule 48). These criteria address transfer situations, and referrals to different hospitals. (Refer to SNR for part 9505.0540, subparts 3 to 6.)

Subp. 8. Reimbursement for readmissions. It is necessary to clarify the criteria used by the department for reimbursing providers for readmissions to the same or different hospital. It is reasonable that the amendment delete all criteria currently in this rule regarding readmission situations as comprehensive criteria for readmissions have been added in part 9505.0540, subparts 3 to 6 (Rule 49) establishing standards for admission certification in readmissions situations and thereby making them eligible for payment under parts 9500.1100-9500.1155 (Rule 54).

The readmissions criteria were developed by a special task force composed of hospital utilization review professionals, the medical review agent and the Department. The establishment of readmission criteria was necessary because the present payment system creates an incentive for hospitals to discharge and readmit patients, thereby collecting additional payments. However, hospitals should be financially indifferent to discharging and readmitting recipients because those are medical decisions. The present criteria served as a foundation for the amended criteria, which is more comprehensive and easier to implement. The criteria are designed to encompass all circumstances that may arise in readmission situations and to serve as a screen for physician review. The readmission criteria differentiate between readmissions which will be considered as second admissions and for which the provider will be paid separately, readmissions which will be considered as continuous with the first admission and for which the provider will be eligible for only one DRG payment, and readmissions which will be considered as transfers and for which the provider will be eligible for a transfer payment. The readmission criteria will function as safeguards against unnecessary or inappropriate use of medical assistance services, excess payments and under-

utilization such as fragmented care and premature discharge as required by Minnesota Statutes, section 256B.04, subdivision 15. (See also SNR for part 9505.0540, subp. 3 to 6.)

The Department will not present expert witnesses to testify concerning the provisions of these proposed rules on behalf of the department.

September 7, 1988

Julie Brunner

for SANDRA GARDEBRING, Commissioner
Department of Human Services