STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED AMENDMENTS TO THE RULES OF THE MINNESOTA DEPARTMENT OF HUMAN SERVICES ESTABLISHING PROCEDURES FOR DETERMINING INPATIENT HOSPITAL PAYMENT RATES UNDER THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS; MINNESOTA RULES, PARTS 9500.1090 TO 9500.1140

STATEMENT OF NEED AND REASONABLENESS

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INTRODUCTION

Minnesota rules, parts 9500.1090 to 9500.1140 establish a prospective payment system for inpatient hospital services under the Medical Assistance (MA) and General Assistance Medical Care (GAMC) programs. The amendments to the rules are proposed in order to conform the current rules to changes that have occurred in state and federal legislation. The amendments also reorganize the rules to make the proposed rules more understandable. If adopted, the proposed rules will update Minnesota rules, parts 9500.1090 to 9500.1140.

BACKGROUND

The Medicaid program was enacted in 1965 by Congress under Title XIX of the Social Security Act. This created a cooperatively financed and administered MA program for the needy. The federal government establishes broad compliance guidelines for state MA programs and provides 55% of the funding. The GAMC program is entirely state funded and regulated. In the interests of administrative ease and uniformity it is generally modelled after the MA program.

Prior to 1980, federal law required states to pay for inpatient hospital services under the MA program on a reasonable cost related basis. Basically, reasonable cost included all direct and indirect costs that were deemed to be necessary and proper for the delivery of inpatient hospital services.

A major drawback to a reasonable cost based system was that it offered few incentives for hospitals to contain costs. In essence, hospitals had the opportunity to be reimbursed for whatever they spent to provide care as long as those expenditures were for covered MA services and within a wide range of allowable costs. The result was unacceptably high rates of inflation that did not relate to increases in other sectors of the economy.

To allow flexibility and innovation to the states, Congress enacted the Omnibus Reconciliation Act of 1980, section 962 and of the Omnibus Budget Reconciliation Act of 1981, section 2173. These laws made significant changes to the provisions of the Social Security Act relating to payment of MA inpatient hospital services. Congress removed the reasonable cost requirement and established criteria that payment rates for inpatient hospital services must be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated hospitals to provide services in conformance with applicable state and federal laws, regulations, and quality, and safety standards. This requirement is commonly referred to as the Boren amendment. The legislation also specified that the methods and standards for an inpatient hospital payment system must take into

account other factors. These requirements are contained at Code of Federal Regulations, title 41, parts 447.250 to 447.255 and include:

1. establishing appeal procedures to allow hospitals to have their rates administratively reviewed;
2. establishing uniform cost reporting and audit requirements;
3. assuring that payments in aggregate for services are not greater than the amount that would be paid under the Medicare principles of reimbursement;
4. assuring that the rates do not exceed customary charges; and
5. providing the public with an opportunity to review and comment on significant changes to the state's methods for determining payment rates prior to implementation.

In 1983, the Minnesota Legislature directed the department to promulgate temporary and permanent rules to implement Laws of Minnesota 1983, chapter 312, article 5, sections 9 and 39 which established a prospective payment system for MA and GAMC inpatient hospital services. In response to the legislation, the department promulgated 12 Minnesota Code of Agency Rules 2.05401 to 2.05403 which became effective on October 1, 1983. The temporary rule was effective until August 1, 1985.

The temporary rule established a single hospital specific payment rate regardless of the patient's diagnosis. The rate represented an average allowable cost of the inpatient hospital services provided by a hospital during the base year of 1981 as increased for inflation. One of the major assumptions under a single payment system is that the case mix of inpatient hospital services provided in the base year will remain fixed in future years. This assumption is unlikely in the hospital industry which experiences continued changes in technology and physician practice patterns. A hospital that changes its case mix of services could either be penalized or receive a windfall. In response to this problem, Minnesota Laws 1984, chapter 534, section 20 mandated that inpatient hospital payments be based upon diagnostic classifications.

The department implemented a payment system based on diagnostic related groups (DRGs) under Minnesota Rules, parts 9500.1090 to 9500.1155 which were effective August 1, 1985. Under this system, inpatient hospital services are divided into diagnostic categories. Each category represents a broad clinical category differentiated from all others based on the body system and the cause of disease. Patients are assigned to a diagnostic category depending on the principal diagnosis, secondary diagnoses, presence or absence of operating room procedures, age, sex, and discharge status. Under the system, hospital payments are related to the treatment provided to each patient. These rules,

with minor modifications after August 1, 1985 are still in effect.

PROPOSED AMENDMENTS

In the development of the proposed rule amendments, the department complied with the procedures required by the Administrative Procedure Act, Minnesota Statutes, chapter 14, the rules of the Attorney General and internal department policies to assure maximum public participation. Public input was requested through a Notice of Solicitation of Outside Information or Opinions that was published August 27, 1990 in the State Register (15 S.R. 528). The department also established an advisory committee that consisted of members and staff of the Council of Community Hospitals, the Minnesota Hospital Association, the Minnesota Medical Association, the Minnesota Psychiatric Society, the County Directors Association, the Legal Aid Society, the Office of Ombudsman for Older Minnesotans and individual hospitals. Eight advisory committee and three technical advisory subcommittee meetings were held. In addition, the department was required by 1990 legislation at Minnesota Statutes, section 256.9695, subdivision 4 to contract for a study of the inpatient hospital payment system. The results and recommendations of the study that was conducted by the Peat Marwick Compass consulting group are attached as exhibit 1.

Authority for the adopted rules as well as the proposed amendments is established by Minnesota Statutes, sections 256.9685 to 256.9695. The proposed rules are based on a major redraft of statutes in 1989 as amended in 1990, 1991 and 1992. These laws established a refined DRG payment system for inpatient hospital services under the MA and GAMC programs to be effective with the implementation of the upgrade to the Medicaid Management Information System (MMIS). Currently, the payment system is based on hospital specific cost as adjusted for diagnosis. The statutory changes did not alter this. Rather they align payments more accurately to the service that is delivered and the hospital's cost. To accomplish this, the law includes a number of changes to the rate setting and payment systems that are primarily based on updating cost, reducing the averaging range inherent in the rates and improving the rate setting precision. These changes include the items listed below and the terms used are defined at part 9500.1100.

- Rebasing each hospital's cost data to a more recent year and every two years thereafter.
- Adjusting payments for admissions that result in long stays.
- Increasing the number of routine and ancillary cost categories.
- Expanding the number of diagnostic categories.
- Including total operating dollars in the relative

values.

- o Equating the relative value data year with the cost data year.
- o Excluding property costs from the relative values.
- o Establishing rehabilitation distinct part rates separately from other hospital rates.
- o Creating cost outliers for all diagnostic categories.
- o Calculating day outlier per diems on a cost basis.
- o Allowing the outlier percentage rate to be chosen.
- o Instituting diagnostic categories for neonatal per diem rates.
- o Setting property rates prospectively.

Although the changes listed above do not result in major conceptual differences from the current system, the rebasing of the cost to a more recent year will result in a redistribution of the existing monies. Rebasing of the system also results in budget neutrality. The rates of some hospitals will be reduced because their costs have increased slower than allowable inflation from the existing 1981 base year. Efficiencies have been achieved through means such as compressing services into a shorter length of stay, reductions in acuity or other cost saving measures. These hospitals are currently overpaid when compared to cost. The rates of other hospitals will be increased because they are currently underpaid when compared to cost. This redistribution of monies will be much larger initially than it will be in the future because there is at least a six year change in base years and considerable pressures were exerted on the industry during that period to contain cost. Rebasing will then continue on a one or two year basis so the change in rates will be limited.

A general explanation of the principles and conceptual characteristics of the rate setting and payment systems is presented because the proposed rules are mathematically complex and it is difficult to interpret the ramifications of the methodology. For example, the Medicare DRG based prospective payment per admission system is sometimes thought of as similiar to the MA/GAMC system. Although similiar in payment approach, comparability is lost primarily because Medicare produces limited flat rates for all hospitals within a group while MA/GAMC results in rates based on hospital specific cost.

The MA rate setting system essentially uses all base year allowable MA/GAMC costs within a hospital and divides by the corresponding admissions to develop an average cost per admission. The costs are then statistically sorted between payments associated with outliers and payments associated with the admission. Thus, the two parts encompass the whole and the amount associated with the admission or outlier payment is budget neutral to the hospital. Payment through a per admission average

rate, however, may result in the perception that all costs are not paid. For example, the days between the average length of stay and outlier status tend to be viewed as uncompensated when, in fact, these costs are built into the data from which the per admission rate is derived. Also, the dollars that are viewed as uncompensated in outlier payments due to a reduction from cost follows the same methodology and are added back to the admission payment. Although a per day payment system would be based on the same historical costs, a per admission payment is used because incentives for long stays are reduced and utilization review activities are simplified.

Although the total costs are included due to the facility specific nature of the system, paying based on an average will result in losses on some admissions and gains on other admissions. As a result, it is important that the system does not create disincentives to view payments in total as opposed to the parts. Hospital staff, for example, will look at the outlier payment or the admission payment for a particular patient as low compared to the cost of the stay. Hospitals have sophisticated computer systems that enable the expected payment to be compared to cost or charges on a daily basis. The desire of the payor to eliminate averaging within the hospital is further reinforced because many departments and units within hospitals are treated as cost centers. Transplants, rehabilitation units and children's mental health are examples of services that individually might not appear financially viable due to their variance in cost from the average. Therefore, these aspects of hospital operations must be accounted for in the design of the payment system due to the potential effect that it could have on patient access if financial viability was viewed on an admission basis. Although discrimination based on diagnosis would be contrary to law, it is easier to avoid any incentives of this nature than it would be to monitor and enforce.

To minimize the effect of this wide range in averaging and to target payments more closely to a claim specific basis, the DRG is used. The DRG is simply an allocation device that allows multiple payments from the average rate. Increasing the number of DRGs decreases the range in averaging, but the number of DRGs is budget neutral to a hospital under a hospital specific cost system. This is because the effects of payments through DRG relative values are standardized in rate setting by dividing the hospital's average rate by the hospital's weighted average relative value. This is referred to as the case mix index. The optimum would be to have as many DRGs as possible and further break downs within the DRG by variables such as patient age and eligibility. However, the number of historical admissions in a group is a limiting factor and if the break downs are too fine, claim coding for financial maximization may occur. This is also difficult to monitor and enforce.

The rebasing of rate setting data to a more recent year effective the earlier of the upgrade to the MMIS or July 1, 1992 is required by Minnesota Statutes, section 256.9695, subdivision 3. However, since payments cannot be made with rebased data until the MMIS is completed, the law also provides for a methodology that compensates for an effective date of July 1, 1992 after the MMIS is completed. A prospective method rather than a retrospective approach is used to avoid federal problems with the state plan. Also, because some hospital rates are decreased, it was determined that rules should be in place prior to implementation since the laws could not be written with the required specificity at the time. Basically, the method of compensating for the timing difference occurs by adding or subtracting the change resulting from rebasing to or from the rebased rates for the same period of time that the MMIS is delayed from July 1, 1992. This is further adjusted for dissimilar methods of rate setting.

9500.1090 PURPOSE AND SCOPE.

It is necessary to inform the affected parties that the proposed amendments to adopted rule parts 9500.1190 to 9500.1140 will be used by the department to establish a prospective payment system for inpatient hospital services under both the MA and GAMC programs. It is reasonable to inform affected parties because the rule sets forth standards and administrative requirements that hospitals and the department must follow.

Throughout the rules, the term "payment" has been substituted for the word "reimbursement". This is necessary because Minnesota Statutes, section 256.9685 to 256.9695 refers to a "payment system" rather than a "reimbursement system". The term "payment" is reasonable because it connotates an established amount while the term "reimbursement" infers a settlement to expenses.

It is not necessary to specify that all parts of the rule also apply to GAMC when MA is stated because the definition of Medical Assistance includes GAMC as required by Minnesota Statutes, section 256.9686, subdivision 7.

It is not necessary to specify that payment rates are to be segregated by eligibility status because the definition of diagnostic category has the same effect.

It is necessary to specify that these rules do not govern payments to state owned hospitals in order to avoid any misunderstandings about applicability. This is reasonable because state hospital payments are governed by Minnesota Statutes, section 245.474.

It is necessary that federal law has supremacy when there is a conflict between state and federal law as provided by Minnesota Statutes, section 256.9685, subdivision 2. This is reasonable because failure to conform to federal requirements results in the loss of the federal share of MA payments.

9500.1095 STATUTORY AUTHORITY.

It is necessary to inform affected parties that these rules must be read in conjunction with the federal statutes and regulations and other department rules governing the administration of MA so that affected parties are fully informed. It is reasonable because the provisions cited govern related aspects of MA and GAMC that require compliance.

9500.1100 DEFINITIONS.

Subpart 1. Scope. This subpart is necessary to clarify that the definitions apply to rule parts 9500.1090 to 9500.1140. The definitions are reasonable in order to provide a common frame of reference and understanding.

Subpart 1a. Accomodation service. This term is necessary because it describes the types of routine inpatient services provided by hospitals. The definition is reasonable because the cost of each accomodation is different and the rate establishment methodology would, otherwise, be repetitive for each type of service.

Subpart 2. Adjusted base year operating cost. This term is necessary because it describes the allowable base year operating cost as adjusted by the hospital cost index through the rate year. The definition is reasonable because the operating part of hospital rates must be adjusted annually for cost changes as required by Minnesota Statutes, section 256.969, subdivision 1. The words "per day" are added so that the definition can also be used in conjunction with per day rates.

Subpart 3. Admission. This term describes the process by which a person becomes an inpatient of a hospital. The additional language that describes the time of birth as an admission is necessary because claims for rate establishment and payment are separated between mother and baby. The additional language is reasonable because it establishes a time that the claim separation begins.

Subpart 4. Admission certification. This definition is deleted because its use in the rules is as a reference that is self-explanatory.

Subpart 4a. Aid to families with dependent children. This

definition is deleted because its use in the rules is as a reference that is self-explanatory and it is a function of other rules that are to be read in conjunction with this rule.

Subpart 5. Allowable base year operating cost. This term is necessary because it describes a major component of the payment rates. The words "per day" are added so that the definition can also be used in conjunction with per day rates. It is reasonable to delete references to outlier cost inclusion because the formula for rate establishment has the same effect.

Subpart 6. Ancillary services. This term describes the types of non-routine inpatient services provided by hospitals. The definition is necessary because it depicts inpatient service costs that are used in the rate establishment methodology. The identification of additional ancillary services is reasonable because they increase the specificity of establishing the cost of individual claims that are used in establishing rates.

Subpart 7. Appeals board. This definition is deleted because the appeals language at Minnesota Statutes, section 256.9695 does not include any provisions for an appeals board. The statutory language that had required an appeals board was eliminated by 1989 session laws, chapter 282.

Subpart 8. Arithmetic mean cost per admission. This definition is deleted because it is no longer necessary. The relative value establishment methodology includes the mathematical iteration that results in the same and a more understandable effect as using this definition.

Subpart 8a. Arithmetic mean length of stay. This definition is deleted for the reasons given at existing part 9500.1100, subpart 8.

Subpart 9. Base year. This term describes the period of time from which information is used to establish rates. The changes are necessary as they are required by Minnesota Statutes, section 256.9686, subdivision 2. The changes are reasonable because a historical period of data is necessary to establish rates.

Subpart 10. Budget year. This definition is deleted because it was applicable to a rate establishment methodology that has been superseded by Minnesota Statutes, section 256.969, subdivision 2b and 2c.

Subpart 11. Case mix index. This term describes a standard measure of inpatient service intensity. The changes are necessary as they are required by Minnesota Statutes, section 256.9686, subdivision 3. The changes are reasonable because they are more descriptive of the effect.

Subpart 12. Categorical rate per admission. This definition is deleted because it is redundant with the self-explanatory nature of part 9500.1128, subpart 2.

Subpart 12a. Charges. This term describes the price the hospital has established for services rendered. It is necessary as it is required by Minnesota Statutes, section 256.9686, subdivision 4. It is reasonable because costs are derived from charges in the rate establishment methodology.

Subpart 13. Claims. This definition is deleted because its use in the rules is self-explanatory.

Subpart 14. Commissioner. This definition is unchanged.

Subpart 15. Cost outlier. This term describes an admission that has been determined to be atypical in cost. The changes are necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. The changes are reasonable because it identifies the point at which additional payments are made.

Subpart 16. Cost to charge ratio. This term describes a statistical term used in Medicare cost reporting. The changes are necessary due to other definitional changes. The changes are reasonable in order to be consistent throughout the rules.

Subpart 17. Current year. This definition is deleted because it was applicable to a rate establishment methodology that has been superseded by Minnesota Statutes, section 256.969, subdivision 2b and 2c.

Subpart 18. Day outlier. This term describes an admission that has been determined to be atypical in length of stay. The changes are necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. The changes are reasonable because they identify the point at which additional payments are made.

Subpart 19. Department. This definition is unchanged.

Subpart 20. Diagnostic Categories. This definition is deleted due to its replacement at part 9500.1100, subparts 20a to 20g.

Subpart 20a. Diagnostic categories. This term describes the types of inpatient hospital services that are included together in groups for payment purposes.

DRGs were originally developed by Yale University's Center for Health Studies in the late 1960's to monitor the quality of care and to perform utilization review in a hospital. In 1975, the Health Care Financing Administration, which oversees the Medicare and Medicaid programs, began working with Yale to develop the

DRGs for payment purposes. Under the system 23 Major Diagnostic Categories (MDCs) were created based on organ systems because medicine is practiced primarily according to specialities based on organ systems.

The MDCs were limited to those variables that are descriptive of the patient's clinical condition and that are available on most discharge abstracts. The variables include factors such as principal diagnosis, secondary diagnoses, surgical procedures, age, sex, and discharge status. Subgroups of cases within the MDCs were examined to determine whether the proposed distinctions were clinically sensible and whether the cases in each group were medically similar. After modification through time this process has resulted in the development of the 492 mutually exclusive classification system of diagnosis related groups. Therefore, these MDCs correspond to medical specialities and the DRGs correspond to services that are clinically coherent and homogeneous.

The purpose of DRGs is to distribute the payment of services based on the cost of service and thus, better targeting of payments to the service rendered. It is not intended to contain cost since the number of categories used is budget neutral to the hospital. Although the assignment of fewer DRGs to a category would result in increased payment specificity, it is limited due to the number of admissions that exist for each DRG, the extent of cost difference and the desire to avoid coding situations that artifically increase or decrease payments.

The diagnostic categories are no longer a direct reflection of DRGs under Medicare because MA/GAMC service and cost have different levels of effect due to the differences in eligibility groups. This is reasonable because it allows flexibility and more accurate payments. Medicare, for example is not concerned with multiple categories of neonate services, while MA is. Age break-downs are another example of an MA concern that Medicare does not have. The assignment to program area from base year data is unchanged from current rules.

Subpart 20b. Diagnostic categories eligible under the medical assistance program. The establishment of a category based on MA eligibility is unchanged. The change in assignment of DRGs to the diagnostic categories is necessary to reduce the cost variation within categories. This is reasonable because the result is that payments are more closely aligned to the cost of providing the service.

Subpart 20c. Medical assistance covered diagnostic categories under the aid to families with dependent children program. The establishment of a category based on AFDC eligibility is unchanged. The change in assignment of DRGs to the diagnostic categories is necessary to reduce the cost variation within

categories. This is reasonable because the result is that payments are more closely aligned to the cost of providing the service.

Subpart 20d. Diagnostic categories for persons eligible under the general assistance medical care program. The establishment of a category based on GAMC eligibility is unchanged. The change in assignment of DRGs to the diagnostic categories is necessary to reduce the cost variation within categories. This is reasonable because the result is that payments are more closely aligned to the cost of providing the service.

Subpart 20e. Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part. The establishment of a category for rehabilitation hospitals and distinct parts is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 12. This is reasonable because the cost variation between rehabilitation admissions and general acute care admissions is large. The change in assignment of DRGs to the diagnostic categories is necessary to reduce the cost variation within categories. This is reasonable because the result is that payments are more closely aligned to the cost of providing the service. The absence of differentiation by eligibility group is necessary to maximize the number of proposed categories. This is reasonable because the number of rehabilitation admissions are limited.

Subpart 20f. Diagnostic categories for neonatal transfers. The establishment of a category for neonatal transfers is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 13. This is reasonable because these admissions are paid on a per day basis and are required to be excluded from the data used to set per admission rates. The change in assignment of DRGs to the diagnostic categories based on weight from the current neonatal categories is necessary to reduce the cost variation within categories. This is reasonable because the result is that payments are more closely aligned to the cost of providing the service. The absence of differentiation by eligibility group is necessary to maximize the number of proposed categories. This is reasonable because the number of neonatal transfer admissions are limited.

Subpart 20g. Additional DRG requirements. It is necessary to establish additional requirements because all aspects of assignment to a diagnostic category are not a function of the DRG. This is reasonable so that other variables are taken into account.

Item A. The grouper specification is necessary in the interest of clarity. This is reasonable because it has been moved from current part 9500.1110, subpart 1, item E.

Item B. The change in discharge status is necessary so that grouping is based on services. This is reasonable because services are a better function of cost than the discharge status. This change affects burns transferred, neonates died or transferred and chemical dependency that have left against medical advice. For transfers, this is reasonable because a separate payment methodology already accounts for the differences. For neonates, this is reasonable because a separate specialty group already account for the differences. For chemical dependency, payment through the State's Consolidated Chemical Dependency Treatment Fund accounts for payment other than leaving against medical advice because it is not considered treatment.

Item C. It is necessary to remove the rehabilitation code (v57) prior to grouping so that all diagnosis do not group to the same DRG. This is reasonable because the need to use the code does not exist and it would be self-defeating when a separate specialty group category has been established for rehabilitation.

Subpart 21. Discharge. This definition is deleted as its use in the rules is self-explanatory.

Subpart 22. General assistance medical care. This definition is unchanged.

Subpart 23. Geometric mean cost per admission. This definition is deleted because the math of the relative value establishment methodology along with the definitions of day and cost outliers have the same effect. Also, setting the trim points at X standard deviations beyond a specified type of mean is unnecessary because the type of mean is integral to the formula and is not interchangable.

Subpart 24. Geometric mean length of stay. This definition is deleted for the same reasons given at part 9500.1100, subpart 23.

Subpart 24a. Health Care Financing Administration. This definition is deleted as it does not appear in the rules.

Subpart 25. Hospital. This term describes the facility types that are subject to these rules. The changes are necessary as they are required by Minnesota Statutes, section 256.9686, subdivision 6. The changes are reasonable because they depict the type of facility that is capable of providing inpatient services.

Subpart 26. Hospital cost index or HCI. This phrase describes the method by which costs are updated from the base year to the rate year. The changes are necessary in order to conform with language at Minnesota Statutes, section 256.969, subdivision 1. and has no affect on the definition. The changes are reasonable

in order to be consistent with the proposed definition of allowable base year operating cost.

Subpart 26a. Inpatient hospital costs. This phrase describes the costs that are used in the rate establishment methodology. The definition is necessary and the exclusion of Medicare adjustments is necessary in order to be consistent with the requirements at Minnesota Statutes, section 256.969, subdivisions 2b and 2c which concern the costs to include in rate establishment. The definition is reasonable because the costs that will form the basis for inpatient rates need to be related to an inpatient stay. The disregard of Medicare adjustments is reasonable because they do not relate to the MA program.

Subpart 27. Inpatient hospital service. This phrase describes the services that are subject to these rules. The definition is necessary in order to be consistent with the requirements at Minnesota Statutes, section 256.969, subdivisions 2b and 2c which concern the services to include in rate establishment. The definition is reasonable because the services that will form the basis for inpatient rates need to be related to an inpatient stay. The inclusion of outpatient services that immediately precede a stay is necessary to avoid the unbundling of a stay for additional payment. This inclusion is reasonable because, in retrospect, the patient would have been admitted immediately. The deletions are necessary and reasonable in the interest of simplification as the words did not add to the understanding of the phrase.

Subpart 28. Local agency. This definition is deleted as it does not appear in the rules.

Subpart 28a. Local trade area hospital. This phrase describes locations of hospitals outside of Minnesota. The definition is necessary in order to comply with the requirements of Minnesota Statutes, section 256.969, subdivisions 17 and 18. The geographic designation is reasonable because it defines an area that is commonly accepted and identifiable as a border region.

Subpart 29. Medical assistance. This term describes the programs under which services are provided that are subject to these rules. The changes are necessary and reasonable as it is required by Minnesota Statutes, section 256.9686, subdivision 7 and do not change the effect.

Subpart 30. Medically necessary. This definition is deleted as it does not appear in the rules.

Subpart 30a. Medically needy. This definition is deleted as it does not appear in the rules.

Subpart 31. Medicare. This definition is unchanged.

Subpart 32. Medicare crossover. This term describes patients that are simultaneously eligible for coverage under both Medicare and MA. The definition is necessary because payments are coordinated due to the Medicare deductible, coinsurance, and other amounts not covered by Medicare that are covered by MA. The changes are reasonable in the interest of simplification as the words do not add to the understanding of the term. The addition of the limitation to Part A Medicare is necessary because a patient can also be eligible for non-inpatient services under Medicare Part B after Part A exhausts. It is reasonable to add this limitation to assure that only inpatient services are coordinated.

Subpart 33. Metropolitan statistical area hospital. This phrase describes the location of hospitals under a federal census identification. The additional language is necessary because metropolitan statistical area status is subject to change. This is reasonable because, without the additional words, rates might need to be recalculated within a rate year and therefore, the prospective nature of the system would be lost.

Subpart 33a. Minnesota supplemental aid. This definition is deleted as it does not appear in the rules.

Subpart 34. Nonmetropolitan statistical area hospital. This phrase is the complement to part 9500.1100, subpart 33. The change is necessary and reasonable for the reasons at part 9500.1100, subpart 33.

Subpart 35. Operating costs. This phrase is unchanged in effect. The changes are necessary to be consistent with the proposed definition of property costs and because the definition of reimbursable inpatient hospital costs has been deleted. The changes are reasonable in order to be consistent throughout the rules.

Subpart 36. Outlier. This definition is deleted as it is no longer necessary due to the definitions at part 9500.1100, subparts 15 and 18.

Subpart 37. Out of area hospital. This phrase describes locations of hospitals outside of Minnesota. The definition is necessary in order to comply with the requirements of Minnesota Statutes, section 256.969, subdivisions 17 and 18. The geographic designation is reasonable because it defines an area that is the complement to part 9500.1100, subpart 28a.

Subpart 38. Property costs. This term describes the complement to part 9500.1100, subpart 35. The definition is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 2c and other definitional changes. The changes are reasonable in order to be consistent throughout the rules.

Subpart 39. Prior authorization. This definition is deleted because its use in the rules is as a reference that is self-explanatory.

Subpart 40. Prior year. This definition is deleted as it does not appear in the rules.

Subpart 41. Prospective reimbursement system. This definition is deleted because it is not used in the rules in a manner that requires a definition.

Subpart 41a. Rate year. This term describes the period of time that rates are in effect. The definition is necessary due to the requirements of Minnesota Statutes, section 256.9686, subdivision 8. It is reasonable because it specifies the period of time that rates will remain in effect.

Subpart 42. Readmission. This definition is deleted because its use in the rules is as a reference that is self-explanatory.

Subpart 43. Recipient. This definition is deleted because its use in the rules in self-explanatory and it is a function of other rules that are to be read in conjunction with this rule.

Subpart 43a. Recipient Resources. This definition is deleted because its use in the rules in self-explanatory and it is a function of other rules that are to be read in conjunction with these rules.

Subpart 44. Reimbursable inpatient hospital costs. This definition is deleted because it does not appear in the rules.

Subpart 44a. Rehabilitation distinct part. This term describes a unit of a hospital that has a specific designation under Medicare. The definition is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 12. It is reasonable in order to use a common definition.

Subpart 45. Relative value. This term describes a scale of cost and payment differences among the diagnostic categories. The definition is necessary due to the requirements of Minnesota Statutes, section 256.9686, subdivision 9. It is reasonable to include costs in excess of trim points so that all allowable operating costs are included and because the outlier is also subject to the relative values.

Subpart 46. Routine services. This definition is deleted because it has been replaced with more specificity by part 9500.1100, subpart 1a.

Subpart 47. Second surgical opinion. This definition is deleted because its use in the rules is as a reference that is self-

explanatory.

Subpart 47a. Supplemental security income. This definition is deleted as it does not appear in the rules.

Subpart 48. Total hospital admissions. This definition is deleted as it does not appear in the rules.

Subpart 49. Total reimbursable costs. This definition is deleted as it does not appear in the rules.

Subpart 50. Transfer. This term describes the situation in which the treatment of a patient for the same diagnosis and occurrence takes place in two or more hospitals. The changes are necessary because the revised MMIS defines hospitals and hospital sub-units by seven and nine digit provider numbers. The change that has an effect on hospitals is the use of nine digits to define the movement of a patient to a rehabilitation distinct part as a transfer. This change is reasonable because separate treatment of rehabilitation distinct parts from the hospital has been established in the rate setting system and thus, the payment system must also differentiate between the two entities. In effect, the result of a separate rate makes it necessary to define it as a separate hospital for payment purposes.

Subpart 51. Trim point. This term describes the threshold where an admission becomes an outlier. The changes are necessary due other definitional changes. The changes are reasonable in order to be consistent throughout the rules.

Subpart 52. Usual and customary. This definition is deleted because it has been replaced by part 9500.1100, subpart 12a.

9500.1105 BASIS OF PAYMENT FOR INPATIENT HOSPITAL SERVICES.

This part is necessary in order to establish the information from which payment rates are derived. It is reasonable to delete the first sentence because it is not necessary to the function of the rules.

Subpart 1. Reporting requirements.

Item A. It is necessary to specify the information that is needed from hospitals in order to establish rates. The October 1 reporting date is reasonable because it is prevalent throughout Minnesota Statutes, section 256.969 when data from the hospital is needed. This date is also reasonable so that the rates can be set by the next December 1. Disregarding untimely information is necessary because it is required by Minnesota Statutes, section 256.969, subdivision 4a and it is reasonable so that the rates can be set by the next December 1.

Subitem (1) It is necessary to report Medicare audited cost report information because the information is needed to supplement the electronic data that is obtained from the federal government and used for rate setting. It is reasonable to require this information only from local trade area hospitals because these hospitals use a different Medicare fiscal intermediary that does not automatically send the department a copy of the report.

Subitem (2) It is necessary to report the decision on separate payment for certified registered nurse anesthetist services in order to meet the requirements of Minnesota Statutes, section 256.969, subdivision 10. The irrevocable nature of the decision is reasonable because once the charge is removed from the UB-82 billing form, the ability to find the base year cost to put back into the rates is also lost.

Subitem (3) It is necessary to identify rehabilitation distinct part claims because Minnesota Statutes, section 256.969, subdivision 12 requires these units to have separate rates. It is reasonable to have the claims identified by the hospital because the department's computer system cannot differentiate these admissions from other admissions to a hospital. This information, however, will no longer be required when the base year is a year in which the hospital submits separate claims.

Subitem (4) It is necessary to report the outlier percentage decision due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. It is reasonable to request the information so that hospitals are given a choice before a fixed determination is made.

Subitem (5) It is necessary to report Medicare audited cost report information in order to implement property rates as required by Minnesota Statutes, section 256.969, subdivision 2c. It is reasonable to request the information from the hospitals because the department does not obtain the cost reports from Medicare until they are audited which can be two years after submission. The information is only necessary prior to a rebased rate year because property rates are changed when operating rates are changed.

Subitem (6) It is necessary to report the low income utilization information in order to meet the federal requirements as provided by Minnesota Statutes, section 256.969, subdivision 9. It is reasonable to request the information from hospitals because it is non-routine data and the department does not collect it in any other manner.

Subitem (7) It is necessary to report Medicare adjustments because rates are based on the cost finding methods and allowable costs of the Medicare program in effect during the base year as

required by Minnesota Statutes, section 256.969, subdivisions 2b and 2c. This is reasonable because some information in the cost report may be under appeal with Medicare for a long period of time or an adjustment to the cost report may be subsequently made. The changes would need to be made part of the rate setting system.

Item B. It is necessary to report this information due to the requirements of Minnesota Statutes, section 256.969, subdivision 4a. It is reasonable to use the February first date because the information is extensive and the data needs to be checked and put into correct formats for rate setting. The information is also available to the hospital by that date.

Subpart 2. Establishment of base years.

Item A. It is necessary to establish base years to be consistent with Minnesota Statutes, section 256.969, subdivision 3a. It is reasonable to establish the base year as the time period specified because it is the year closest to the rate year for which audited cost report information was available from the Medicare program when work began to implement these rules. However, delays in the MMIS also delayed implementation due to the requirements of Minnesota Statutes, section 256.9695, subdivision 3 and thus, the data is older than desired. In order to avoid a duplication of effort, this difference is remedied under item D with a larger change in base years than usual. In the future, the chosen base year will be the most recent data that allows for the establishment of rates in a timely manner. It is reasonable to set a minimum of twelve months of data for each hospital because the rates are derived from average data and are in effect for a year. The definition of base year at Minnesota Statutes, section 256.9686, subdivision 2 also specifies a fiscal year. The inclusion of closed hospitals is based on the need for this data in the relative values because the patients would go to a different hospital as a result of the closing of a hospital.

Item B. It is necessary to provide a separate base year time period for Children's hospitals in order to comply with Minnesota Statutes, section 256.969, subdivisions 2b and 2c which require that rates are to be based on Medicare cost finding and allowable costs. The separate base year is reasonable because their base year data has never been fully audited by the Medicare program due to the low Medicare volume. Establishing the base year two years ahead of other hospitals is reasonable because the department has contracted for these audits and data for the base year used by other hospitals is no longer readily accessable. The difference in base years, however, is temporary because item D provides for Children's hospitals to be updated slower until the base years of other hospitals are within the same time period. In the future, the department's audits will be put on

the same schedule as the Medicare audits.

Item C. It is necessary to provide a separate base year time period for a long term hospital because the base year data did not reflect the costs and case mix of the designation until the year specified. Establishing the base year two years ahead of other hospitals is reasonable because the hospital would be subject to cash flow problems until a case mix appeal could be initiated. The difference in base years, however, is temporary because item D provides for a long term hospital to be updated slower until the base years of other hospitals are within the same time period.

Item D. It is necessary to provide for an updating of the base year data every two years or, at the commissioner's option, every year due to the requirements of Minnesota Statutes, section 256.969, subdivisions 2b and 2c. This is reasonable so that the payment system adjusts for changes in hospital cost patterns. The necessity of using various updated time frames for the rebasing is explained under items A to C. The differences are reasonable so that all hospitals are put into the same base year period.

9500.1110 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES.

Subpart 1. Determination of relative values.

Item A. It is necessary to derive relative value determinations from data within each hospital's base year as required by Minnesota Statutes, section 256.969, subdivision 2. Local trade area hospital data are included due to the requirements of Minnesota Statutes, section 256.969, subdivision 17 and the treatment of out of area hospital data is unchanged. This is also required by Minnesota Statutes, section 256.969, subdivision 18.

Item B. It is necessary to add the word "charges" due to the requirements of Minnesota Statutes, section 256.969, subdivision 2b which specifies that the data must reflect MA covered services. This is reasonable because some items on a claim may not be allowable in rate setting. The assignment of claims to admissions is not necessary due to the addition of item D.

Subitem (1) This subitem is unchanged and is consistent with Minnesota Statutes, section 256.969, subdivision 2.

Subitem (2) It is necessary to delete out of area hospitals because the proposed language at part 9500.1100, subpart 1, item A has the same effect. This is reasonable because the proposed rules do not result in a change. The proposed language is

necessary due to Minnesota Statutes, section 256.969, subdivision 2 and reasonable because a transfer does not represent the cost of a full admission. Requiring the stay to be less than the average length of stay is necessary because neonatal transfers in the base year were paid on a transfer rate basis indefinitely and did not revert to a per admission stay at the average length of stay. This is reasonable so that neonatal transfers that are currently paid a per day rate are not eliminated from the data.

Subitem (3) The changes are necessary due to Minnesota Statutes, section 256.969, subdivision 2 which reference paid claims during the base year. The changes are reasonable so that the claims will coincide with the base year.

Subitem (4) The exclusion is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 11.

Subitem (5) This exclusion is necessary due to the requirements of Minnesota Statutes, section 256.969, Subdivision 2b. The October date is reasonable because this allows rates to be established in a timely manner. Failure to establish a date prior to the rate year could result in changes to the rates during the year and a loss of the prospective nature of the system.

Subitem (6) This exclusion is necessary due to Minnesota Statutes, section 256.9685, subdivision 1, which require services to meet medical necessity requirements and 256.969, subdivision 2, which references paid claims during the base year. Non-covered days occur when the length of stay is longer than is medically necessary and thus, it is reasonable to reduce the charges on the claim accordingly. It is reasonable to use the ratio non-covered days to total days to reduce the charges because it results in an even distribution of charges which, in the absence of direct identification, is the only practical method.

Item C. It is necessary to split base year claims between mothers and babies so that the data for relative values and rates can also be split for payment during the rate year. It is reasonable to pay the claims separately because different diagnoses and thus, different DRGs are applicable to each stay. Without the split, base year rates would not be accurate and rate year payments would not be correctly aligned to the service provided because either the mother or baby's principal diagnosis would take precedence over the other. This procedure will not be necessary when the base year is a year in which the hospital has submitted separate claims.

Subitem (1) It is reasonable to split the room charges in this manner because it is essentially direct identification of charges to the mother and babies.

Subitem (2) It is reasonable to split ancillary charges in this manner although ancillary services tend to benefit both mother and baby. This is because the weighting for accomodation services is sensitive to the need for ancillary services due to accomodation type and amount of ancillary services due to length of stay.

Subitem (3) It is reasonable to include any subsequent base year stay because, during the base year, a new admission occurred when the mother was discharged, but during the rate year it will be paid as one admission.

Item D. It is necessary to combine claims into admissions because payments are made based on the average rate per admission. This is reasonable because multiple claims, as in the case of readmissions and interim payments for long stays, may exist for the same admission.

Item E. The changes are necessary in order to be consistent with the proposed definition of operating costs and to have relative value time periods consistent with the base year. The claims contain data regarding inpatient hospitalization billed charges as opposed to cost information. Therefore, the billed charges must be converted to costs to accurately reflect the relative costliness of an admission among the diagnostic categories. It is reasonable to use base year charges and base year Medicare cost report data because that is the year used to establish the allowable cost per admission. That cost report recognizes the Medicare cost finding and allowable cost principles. Subitems (1) to (5) provide the methodology under which the charges for an admission will be converted to cost.

Subitem (1) The claim for an admission indicates the amount of accomodation charges for routine services. It is necessary to multiply the appropriate days times the appropriate cost because this will, after summing, determine the total accomodation cost for an admission. It is reasonable to replace the ratio multiplication methodology with a per day methodology because the cost report data includes a per diem and not a ratio. It is reasonable to sum the products because the proposed method contains multiple accomodations while the current method has one.

Subitem (2) The claim for an admission indicates the amounts of ancillary service charges by type of service. It is necessary to multiply those amounts by the appropriate ancillary service cost to charge ratio because this will determine the ancillary service cost. It is reasonable to sum the products because the proposed method contains multiple ratios while the current method has one.

Subitem (3) The changes are necessary to be consistent with the proposed definition of operating costs. The changes are reasonable because they do not effect the formula.

Subitem (4) It is necessary to include the costs of malpractice insurance as an operating cost due to the requirements of Minnesota Statutes, section 256.969, subdivision 1. It is reasonable to establish a methodology of allocating the cost to inpatient claims because the cost report does not identify an inpatient cost separately and the cost in the accomodation and cost to charge ratios do not include it. It is necessary to develop a ratio that results in the MA part of inpatient services because, in the absence of direct identification, it is the best indicator that is readily available. It is reasonable to apply the ratio to the malpractice cost so that the MA inpatient portion can be identified. It is necessary to reduce the malpractice cost by 8.5 percent because the Medicare cost finding principals have taken that amount and automatically assigned it to the general and administration account. This is reasonable because that cost has therefore already been included and double payments are avoided.

Subitem (5) The changes are necessary to be consistent with the proposed definition of operating costs. The changes are reasonable because they do not affect the formula.

Subitem (6) It is necessary to adjust the base year cost to the rate year by the HCI due to the requirements of Minnesota Statutes, section 256.969, subdivisions 1 and 2b. This is reasonable so that all numbers that affect payments reflect current values.

Item F. The changes are necessary to be consistent with the proposed definition of operating costs and in the interest of clarity. The deletions are reasonable because they have been, in effect, moved to part 9500.1100, subparts 20a to 20i. It is reasonable to not assign the costs to the neonatal transfer diagnostic category because these admissions are paid on a per day basis and the assignment is included at part 9500.1116.

Items F. to I. It is necessary to delete the items so that the costs associated with outlier payments are not excluded and thus, total operating costs are included in the relative values as provided by Minnesota Statutes, section 256.969, subdivision 2. This is reasonable due to the definition of relative value at Minnesota Statutes, section 256.9686, subdivision 9, and because the relative values with an outlier exclusion would only partially reflect the cost of a stay. Including outlier costs is also necessary because outlier rates and payments have been changed under the proposed rules to include relative values in their determination.

Item G. The deletions are necessary in order to be consistent with the proposed definition of operating costs and for the reasons given at existing items F to I.

Item H. The deletions are necessary in order to be consistent with the proposed definition of operating costs and for the reasons given at existing items F to I.

Item I. This item is unchanged except for the rounding requirement. This is necessary in the interest of specificity. This is reasonable as it also has no effect because the case mix index is balanced against this with five digits.

Item J. It is necessary to determine the average length of stay in order to implement the transfer rates as required by Minnesota Statutes, section 256.969, subdivision 14. The methodology and rounding requirement is reasonable because the average length of stay for transfer rates is currently calculated in this manner.

Item K. It is necessary to determine day outlier trim points in order to implement day outlier rates as required by Minnesota Statutes, section 256.969, subdivision 8. The methodology and rounding requirement is reasonable because trim points are currently calculated in this manner.

Item L. It is necessary to determine cost outlier trim points in order to implement cost outlier rates as required by Minnesota Statutes, section 256.969, subdivision 8. The methodology and rounding requirement is reasonable because trim points are currently calculated in this manner.

Subpart 2. Redetermination of relative values. The deletions are necessary because the information was applicable to a relative value establishment methodology that has been superseded by Minnesota Statutes, section 256.969, subdivision 2. The proposed language is necessary due to the same statute. It is reasonable to allow diagnostic category changes as long as rates are also recalculated because the result is budget neutral due to the interaction between the relative values and the case mix index.

Subpart 3. Publication of relative values. This subpart has been deleted due its replacement at part 9500.1110, subpart 2.

9500.1115 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER.

Subpart 1. Minnesota and local trade area hospitals. The changes are necessary in order to be consistent with the proposed definition of adjusted base year operating cost. Local trade area hospital data are included due to the requirements of Minnesota Statutes, section 256.969, subdivision 17.

Item A. It is necessary to convert the base year charges to allowable cost under the Medicare principles due to the

requirements of Minnesota Statutes, section 256.969, subdivision 2a. It is reasonable to use the same method used to determine the relative values because this develops base year cost under the requirement. This is also reasonable because the data used for rate setting must reflect the relative value data as required by Minnesota Statutes, section 256.969, subdivision 3a. It is necessary to adjust the ancillary ratios if separate payment for certified registered nurse anesthetist services is elected so that the method results in cost. This is reasonable so that the hospital's rates are accurate and double payment does not result.

Item B. It is necessary to determine the costs associated with outlier payments because these costs will be paid in addition to the payment per admission. This change is reasonable due to Minnesota Statutes, section 256.969, subdivision 2 which requires their exclusion from the cost per admission and it avoids double payment. The existing language has been deleted because it has been replaced by the proposed item C. It is necessary to delete the cost exclusion because the costs have already been removed from the accomodation and ancillary ratios within the costing process.

Subitem (1) It is necessary to find the cost of cost outliers associated with outlier payments because these costs will be paid in addition to the payment per admission. This is reasonable due to Minnesota Statutes, section 256.969, subdivision 2 which requires their exclusion from the cost per admission and it avoids double payment. It is necessary to exclude cost outlier status for a partially denied stay because an accurate method of allocating the cost to the denied days is not available. This is reasonable because it is not clear that medically necessary costs are greater than cost outlier status.

Subitem (2) It is necessary to determine the costs associated with day outlier payments because these costs will be paid in addition to the payment per admission. This is reasonable because Minnesota Statutes, section 256.969, subdivision 2 requires their exclusion from the cost per admission and it avoids double payment. The formula also results in the same effect and replaces the existing formula at part 9500.1110, subpart 1, item I.

Item C. It is necessary to subtract the cost associated with outlier payments because these costs will be paid in addition to the payment per admission. This is reasonable because Minnesota Statutes, section 256.969, subdivision 2 requires their exclusion from the cost per admission and it avoids double payment. It is also necessary due to Minnesota Statutes, section 256.969, subdivision 8 which requires the outlier costs that are not recognized in outlier payments to be included in the per admission payment. This is reasonable because the formula, prior to the subtraction, already includes those costs. It is necessary

to subtract the highest amount associated with outliers because Minnesota Statutes, section 256.969, subdivision 8 requires payment to be at the higher of the day or cost outlier. This is reasonable in order to avoid a duplication of costs within the per admission and outlier rate and thus, a double payment.

Item D. It is necessary to adjust the per admission operating rates for case mix due to Minnesota Statutes, section 256.969, subdivision 2a. The process is reasonable because it is unchanged from the existing rules. However, in the interest of understanding the rules, an explanation is presented. The purpose of relative values is to reflect the cost relationship between admissions in one diagnostic category versus another. If payments for each hospital were determined simply by multiplying the average cost after inflation by the relative value, the resulting payment would not be equitable. This is because a hospital with high costs admissions would, in effect, be paid twice for treating costlier admissions. First, by its high average cost per admission and second, by its high relative value. The inverse is also true of a low cost hospital. To avoid this duplication of a hospital's case mix, a hospital's average cost per admission must be standardized for the variation by dividing by its case mix index. The result of this computation is the determination of a cost per admission per unit of case mix.

Subitems (1) to (4) The result of the procedure is unchanged under the proposed rules. Deleting the reference to the inclusion of outliers is necessary because outliers are part of an admission. Thus, admissions that result in an outlier continue to be included. The rounding to five digits is necessary in the interest of specificity. This is reasonable as it has no effect on rates because the relative values are balanced against this with five digits. The rounding to whole dollars is necessary in the interest of specificity. It is reasonable because it is unchanged from the existing rules.

Subpart 2. Minnesota and local trade area hospitals. It is necessary to determine day outlier rates due to Minnesota Statutes, section 256.969, subdivision 8.

Item A. It is necessary to recognize the cost of a day outlier as the amount above the trim point that is not added back to the per admission rates due to Minnesota Statutes, section 256.969, subdivision 2 and 8. This is reasonable so that all base year costs are included in either the outlier or the per admission rates, but not both. It is necessary to divide the outlier costs by total days in excess of the trim point so that appropriate payments are made based on the historical cost. It is not necessary to recognize the amount above the trim point for cost outliers because the formula for payment automatically includes it. Thus, the total payments, in constant dollars, would equal

the historical cost for an equal admission.

Item B. The need and reasonableness for a case mix adjustment and the procedures of subitems (1) to (4) are the same as at part 9500.1115, subpart 1, item D. Outlier rates are also required to be adjusted for case mix due to the requirements of Minnesota Statutes, section 256.969, subdivision 8.

Subpart 3. Out of area hospitals. The establishment of separate rates is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 18. The addition of local trade area hospital data and the removal of local trade area hospitals from this payment are the only changes under the proposed rules and are necessary due to Minnesota Statutes, section 256.969, subdivisions 17 and 18.

Items A. to C. The use of a weighted average rate to determine the rates is unchanged from existing part 9500.1130, subpart 10.

Subpart 4. Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year. It is necessary to establish rates for a hospital that did not have MA admissions in the base year because it would be impossible to determine rates. The addition of local trade area hospitals is the only change under the proposed rules and is required by Minnesota Statutes, section 256.969, subdivision 17.

Items A. to C. The use of a weighted average rate and metropolitan statistical area designation to determine the rates is unchanged from the existing part 9500.1130, subpart 11.

Subpart 5. Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions or day outliers in the base year. It is necessary to establish rates for a hospital that did not have MA admissions in the base year because it would be impossible to determine rates. The addition of local trade area hospitals is the only change under the proposed rules and is required by Minnesota Statutes, section 256.969, subdivision 17. The use of a weighted average rate and nonmetropolitan statistical area designation to determine the rates is unchanged from the existing rules at part 9500.1130, subpart 11.

Subpart 6. Limitation on separate payment and outlier percentage. It is necessary to prohibit out of area hospitals from billing separately for certified registered nurse anesthetist services because rates are established through averages and the data will reflect certified registered nurse anesthetist costs in many hospitals. This is reasonable in order to avoid duplicative payments. It is reasonable to allow separate billing for CRNA services if the hospital's per

admission rates are allowed to be established on a hospital specific basis so that the hospital and department do not have to have two sets of billing procedures for one hospital. It is necessary to deny an alternative outlier percentage to hospitals that have rates established through averages because the outlier and per admission payments would not be complementary and thus, would not be appropriate. This is reasonable because the averaging formula automatically creates the complementary relationship.

9500.1116 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY.

Subpart 1. Neonatal transfers.

Item A. It is necessary to establish neonatal intensive care unit per day rates due to the requirements of Minnesota Statutes, section 256.969, subdivision 13. Local trade area hospital data are included due to the requirements of Minnesota Statutes, section 256.969, subdivision 17.

Subitem (1) The need and reasonableness is the same as at part 9500.1110, subpart 1, items A to F.

Subitem (2) The need and reasonableness is the same as at part 9500.1110, subpart 1, items G, H and I. Relative values are also required due to Minnesota Statutes, section 256.969, subdivision 13.

Subitem (3) The need and reasonableness is the same as at part 9500.1115, subpart 1, item D. Adjusting for case mix is also required by Minnesota Statutes, section 256.969, subdivision 13.

Item B. Minnesota and local trade area metropolitan statistical area hospitals. The need and reasonableness is the same as at part 9500.1115, subpart 4.

Item C. Minnesota and local trade area nonmetropolitan statistical area hospitals. The need and reasonableness is the same as at part 9500.1115, subpart 5.

Subpart 2. Long-term hospital. It is necessary to establish per day rates for long term hospitals because a long-term hospital designation requires an average length of stay of more than 25 days as compared to an acute care hospital of 5 days. This is reasonable due to permissive nature of Minnesota Statutes, section 256.969, subdivision 11. Also, since only one long term hospital exists, separate relative values can not be created.

Items A and B. The need and reasonableness is the same as at part 9500.1110, subpart 1, items A to F.

9500.1120 DETERMINATION OF HOSPITAL COST INDEX.

Subpart 1. Adoption of hospital cost index. The source of the HCI is unchanged under the proposed rules.

Subpart 2. Determination of hospital cost index. It is necessary to determine the HCI due to Minnesota Statutes, section 256.969, subdivision 1. It is reasonable to adjust for cost changes between the base year and the rate year so that the value of payments reflect current values.

Item A. It is necessary to develop cost change estimates for a specific market basket of cost items due to Minnesota Statutes, section 256.969, subdivision 1. The amendments to the market basket items are detailed in the statute. This is reasonable because the methodology has the same effect as the existing process.

Item B. It is necessary to develop Minnesota market basket weights due to Minnesota Statutes, section 256.969, subdivision 1. This is reasonable because the methodology has the same effect as the existing process.

Item C. It is necessary to determine the weighted cost changes due to Minnesota Statutes, section 256.969, subdivision 1. This is reasonable because the methodology has the same effect as the existing process.

Item D. The use of statutory limits and the rounding are unchanged under the proposed rules. The change from one to three decimals does not have an effect due to the change in item A from a percentage to a decimal format.

Item E. It is necessary to increase the index under MA due to the requirements of Minnesota Statutes 256.969, subdivision 1. This is reasonable so that rates are accurate.

Item F. It is necessary to add one to the cost change so that the result can be used to increase the base year rates. This is reasonable so that the calculation of the final rate is simplified. It is necessary to compound the annual cost changes due to the requirements of Minnesota Statutes, section 256.969, subdivision 1. The process and rounding is unchanged under the proposed rules.

Subpart 3. Publication of hospital cost index. This subpart is deleted because it was applicable to a fiscal year rate establishment methodology that has been superseded by Minnesota Statutes, section 256.969, subdivision 2b.

9500.1121 DETERMINATION OF DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. Eligibility for disproportionate population adjustment. It is necessary to establish a disproportionate population adjustment under the MA program due to Title XIX, Section 1923(d) of the Social Security Act as amended by the Omnibus Budget Reconciliation Act of 1987, the Medicare Catastrophic Act of 1988 and the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991. It is reasonable to implement the disproportionate population adjustment under MA using the federal method so that the federal share of payments is not jeopardized. It is also necessary to comply with federal law under MA due to the requirements of Minnesota Statutes, section 256.969, subdivision 9. The requirements under GAMC do not result in a change from the present methodology that is used to establish the disproportionate population adjustment. It is necessary to establish a separate disproportionate population adjustment under GAMC because Minnesota Statutes, section 256.969, subdivision 9 specifically differentiates between MA and GAMC. This difference is reasonable so that GAMC is not unnecessarily burdened by federal regulations and because the cost is entirely state funded.

Item A. It is necessary to comply with these requirements under MA in order to be eligible for a disproportionate population adjustment due to federal law. This is reasonable so that federal monies are not lost.

Item B. The methodology under GAMC does not result in a change from present operations.

Item C. The methodology under MA is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 9.

Item D. The methodology under MA is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 9.

Item E. The methodology is necessary due to the requirements of federal law. In practice, no private hospital has ever met the requirement.

Subpart 2. Days utilization rate used in cases where hospital qualifies under two rates. It is necessary to establish a superiority of the days methodology because Minnesota Statutes are silent on the low income approach and administration is enhanced. This is reasonable because Minnesota Statutes, section 256.969, subdivision 9 specifically provide for the days approach and the information necessary to calculate the low income approach has to be based on a survey of information which is

difficult to assess for accuracy.

9500.1122 DETERMINATION OF PROPERTY COST PER ADMISSION.

Subpart 1. Minnesota and local trade area hospitals. It is necessary to establish property rate determinations from data within the each hospital's base year due to the Minnesota Statutes, section 256.969, subdivision 2c. Local trade area hospital data are included due to the requirements of Minnesota Statutes, section 256.969, subdivision 17 and the treatment of out of area hospital data is unchanged.

Item A. The need and reasonableness is the same as at part 9500.1110, subpart 1, item D.

Subitem (1) The claim for an admission indicates the amount of accomodation charges for property services. It is necessary to multiply the appropriate days times the appropriate property cost because this will, after summing, determine the total property part of the accomodation cost for an admission.

Subitem (2) The claim for an admission indicates the amounts of ancillary service charges by type of service. It is necessary to multiply those amounts by the appropriate ancillary service property cost to charge ratio because this will determine the ancillary service cost. It is reasonable to sum the products because this will, after summing, determine the total property part of the ancillary cost for an admission.

Subitem (3) It is necessary to sum the accomodation and ancillary parts of the property cost in order to determine the total base year property cost per admission.

Subitem (4) It is necessary to determine a total base year cost in order to calculate the percentage change in property costs due to the requirements of Minnesota Statutes, section 256.969, subdivision 2c.

Item B. It is necessary to determine the cost of each admission based on recent year data due to the requirements of Minnesota Statutes, section 256.969, subdivision 2c.

Subitem (1) It is necessary to multiply the base year days by the recent year accomodation property cost so that the cost of the accomodation reflects the recent year value. It is necessary to use the same service per diem because a hospital may have a claim in the base year that should be assigned to a neonatal intensive care unit, but the hospital does not have that type of unit. In this case, the nursery unit per diem is used. In the recent year, however, the hospital has a neonatal intensive care unit, but the nursery unit per diem is used because the hospital

will have rates based on the metropolitan statistical area or nonmetropolitan statistical area averages. It is reasonable to use the same per diem because these rates already have the neonatal intensive care unit costs included and double payments are avoided.

Subitem (2) The methodology for establishing the recent year cost of ancillary services is not the best method because it results in an estimation of the recent year cost. The best method would be to cost the recent year claims in the same manner that base year claims are costed. However, this is not realistic because the rate setting system would have to be duplicated to obtain the recent year cost and all recent year claims are not available due to the one year billing lag. Also, since the methodology is only used to find a percentage of change, a precise mathematical approach to find cost is not necessary or intended. Therefore, as an alternative, it is necessary to multiply the base year charges by the recent year cost to base year charge ratio so that the cost of the ancillary service reflects the recent year value for the same service. It is reasonable to use base year charges and recent year cost to base year charge ratios so that costs are not artifically increased due to changes in volume or charges. For example, a base year ratio of .07 or $7/$100 is the same as a recent year ratio of $14/$200 and it appears that the cost increase of $7 is not measured. However, the increase is due to volume and the cost per unit of service is unchanged because both costs and charges are affected by inflation. Conversely, if the $7 increase occurred on the same charge base of $100, the use of the recent year ratio would show a 100% change in cost. As a result, this method adjusts for constant charges and more accurately reflects cost increases that occur due to a higher cost per unit of service. The formula has a tendency to overcompensate for changes in volume because, in the ratio, recent year costs can increase while charges are held constant. It is felt that this is a better alternative to the chance of undercompensating with recent year cost and charge in the ratios. It is necessary to annualize the recent year cost because the base year data always reflects a twelve month period, while a recent may not. This is reasonable so that artifically low ratios do not result.

Subitem (3) It is necessary to sum the accomodation and ancillary parts of the property cost in order to determine the total recent year cost per admission.

Subitem (4) It is necessary to determine a total base year property cost in order to calculate the percentage change in property costs as required by Minnesota Statutes, section 256.969, subdivision 2c.

Item C. It is necessary to determine any positive difference between the base year and the recent year property cost due to

the requirements of Minnesota Statutes, section 256.969, subdivision 2c. This is reasonable in order to reduce the effect of the lag time on cost between the base year and the rate year.

Subitems (1) and (2) It is necessary to calculate the 85% of the positive percentage growth between the base year and the recent year in order to comply with Minnesota Statutes, section 256.969, subdivision 2c. This is reasonable so that property rates are updated from the base year.

Subitem (3) It is necessary to add one to the decimal equivalent of the percentage so that the base year property rate may be increased. This is reasonable so that the math is simplified to one operation.

Item D. It is necessary to determine the property cost by program and specialty group because the rates differ based on this variable. This is reasonable in order to assign the cost more closely to the service that is provided.

Subitems (1) It is necessary to assign each property cost to a group. This is reasonable because it is unchanged from the existing rules.

Subitem (2) It is necessary to multiply the average base year cost per admission by percentage factor so that the base year cost is increased as required by statute.

Subitem (3) It is necessary to divide by the number of admissions in order to determine an average base year cost per admission. The rounding to whole dollars is necessary in the interest of specificity. It is reasonable because it is unchanged from the existing rules.

Subpart 2. Out of area hospitals. The need and reasonableness is the same as at part 9500.1115, subpart 3.

Subpart 3. Minnesota and local trade area metropolitan statistical area hospitals that do not have medical assistance admissions in the base year. The need and reasonableness is the same as at part 9500.1115, subpart 4.

Subpart 4. Minnesota and local trade area nonmetropolitan statistical area hospitals that do not have medical assistance admissions in the base year. The need and reasonableness is the same as at part 9500.1115, subpart 5.

9500.1124 DETERMINATION OF PROPERTY COST PER DAY.

Subpart 1. Neonatal transfers.

Item A. The need and reasonableness is the same as at part 9500.1122, subdivision 1, items A to D.

Item B. The need and reasonableness is the same as at part 9500.1115, subpart 4 except that metropolitan statistical area and nonmetropolitan statistical area hospitals are combined because there are no nonmetropolitan statistical area hospitals with an neonatal intensive care unit. This combining is reasonable in order to avoid a rate of zero in the event that a hospital develops this service in a nonmetropolitan statistical area area

Subpart 2. Long-term hospitals. The need and reasonableness is the same as at part 9500.1122, subdivision 1, items A to D.

9500.1128 DETERMINATION OF PAYMENT RATES.

Subpart 1. Notification. It is necessary to the provide notice of the rates and to adjust rates for admissions that result in long stays due to the requirements of Minnesota Statutes, section 256.969, subdivision 3a.

Subpart 2. Rate per admission.

Item A. The change from existing part 9500.1125, subpart 3 integrates the rate year part of the HCI into the adjusted base year cost. The change is reasonable because, under the proposed rules, the rates of all hospitals are in effect for the same period of time while, under the existing rules, rates are in effect based on various fiscal years.

Subitem (1) It is necessary to change the formula sequence under MA due to the requirements of Minnesota Statutes, section 256.969, subdivision 9. This is reasonable so that property costs are also increased by the disproportionate population adjustment.

Subitem (2) The formula sequence under GAMC is unchanged from the existing part 9500.1125, subpart 3.

Item B. It is necessary to include this cost due to the requirements of Minnesota Statutes, section 256.969, subdivision 19. The cost will be added to each mother claim because this diagnostic grouping is unique to the birth while the grouping of a child is not.

Item C. It is necessary to make payments for outliers due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. This is reasonable because the outlier part of the cost for these admissions has been excluded from the allowable base year cost per admission.

Subitem (1) It is necessary to determine day outlier rates under the formula due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. This is reasonable so that total payments, in constant dollars, would equal the historical cost for an equal admission.

Subitem (2) It is necessary to make payments for the total days in excess of the trim point so that appropriate payments are made based on the historical cost. This is reasonable because total days were used to divide up costs into per admission and outlier rates. Thus, the total payments, in constant dollars, would equal the historical cost for an equal admission.

Subitem (3) It is necessary to determine cost outlier payments due to the requirements of Minnesota Statutes, section 256.969, subdivision 8.

Unit (a) It is necessary to determine a hospital specific cost to charge ratio due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. This is reasonable because the proposed rules use the same methodology to develop a statewide average at existing part 9500.1130, subpart 9, item A.

Unit (b) It is necessary to determine a cost weighted average cost to charge ratio for these hospitals because hospital specific data does not exist. This is reasonable because the proposed rules use the same methodology to develop a statewide average at existing part 9500.1130, subpart 9, item B.

Unit (c) The claim costing is unchanged from the existing part 9500.1130, subpart 9, item B.

Unit (d) The determination of cost above the trim point is unchanged from existing part 9500.1130, subpart 9, item B.

Units (e) and (f) The determination of cost recognized by the outlier payment is unchanged from existing part 9500.1130, subpart 9, item B. It is reasonable to exclude diagnostic categories that are automatically paid at 90 percent so that the average is not artifically increased by admissions that are not applicable to and do not use the average.

Unit (g) It is necessary to include the disproportionate population adjustment on all operating costs due to Minnesota statutes 256.969, subdivision 9. This is reasonable because it has already been included in the per admission rate and day outlier rate.

Subitem (4) It is necessary to pay the greater amount due to the requirements of Minnesota Statutes, section 256.969, subdivision 8. This is reasonable because the greater amount was excluded from the allowable base year cost per admission. It is necessary

to exclude cost outlier status for a partially denied stay because an accurate method of allocating the cost to the denied days is not available. This is reasonable because the rate establishment process for a cost outlier that involves denied days was based on the same methods. Thus, the total payments, in constant dollars, would equal the historical cost for an equal admission.

Item D. It is necessary to determine transfer rates under the formula due to the requirements of Minnesota Statutes, section 256.969, subdivision 14. The method is, in effect, unchanged from existing part 9500.1130, subpart 7, item 7 except that the property rate is also divided by the average length of stay for the diagnostic category. The exclusion of hospitals that are paid on a per day basis is necessary because the transfer rate is a per day allocation of payment of full treatment for the same diagnosis occurrence by more than one hospital. This is reasonable because the per day system already has the desired effect of allocating the payment of full treatment on a per day basis.

Subitem (1) The limitation is unchanged from existing part 9500.1130, subpart 7, item A.

Subitem (2) It is necessary to exempt rehabilitation hospitals and rehabilitation distinct parts from payment at a transfer rate so that rates may be established separately as required by Minnesota statutes 256.969, subdivision 9. This is reasonable because many admissions to rehabilitation hospitals and rehabilitation distinct parts are transfers from an acute setting and transfers are not counted in the base rate if the stay if less than the average length of stay. Since rehabilitation hospitals and rehabilitation distinct parts have their own specific set of relative values and thus, a high average length of stay, many claims would be removed from their base rate. Also, the type of service provided is not a continuation of treatment of the acute care diagnosis so an allocation of payment is not warranted. It is necessary and reasonable to provide the exception to subject readmissions the transfer payment requirements of readmissions involving a referral, patient preference or scheduling conflict because it would involve a continuation of treatment for the same diagnosis.

Subpart 3. Rate per day.

Item A. It is necessary to determine neonatal transfer rates under the formula due to the requirements of Minnesota Statutes, section 256.969, subdivision 13. This is reasonable so that total payments, in constant dollars, would equal the historical cost for an equal admission.

Item B. It is necessary to determine long term hospital rates

under the formula due to the requirements of Minnesota Statutes, section 256.969, subdivision 11. This is reasonable so that total payments, in constant dollars, would equal the historical cost for an equal admission.

Subpart 4. Rebasing adjustment. It is necessary to adjust the rates for differences due to rebasing due to the requirements of Minnesota Statutes 256.9695, subdivision 3 and for the reasons given at part 9500.1131.

Subpart 5. Readmissions. The treatment of readmissions is unchanged from existing part 9500.1130, subpart 8.

9500.1129 PAYMENT LIMITATIONS.

Subpart 1. Charge limitation.

Item A. The limit is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 18 and is unchanged from existing part 9500.1130, subpart 10.

Item B. The limit is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 3a and 42 CFR 447.271. It is reasonable because the government should not pay more than a provider requests and because non-implementation would result in the loss of federal funds.

Subpart 2. Transfers. The treatment of transfers is unchanged from existing part 9500.1130, subpart 7, item B.

9500.1130 PAYMENT PROCEDURES.

Subpart 1. Submittal of claims. The result of the additions/deletions is to clarify the use of interim claims.

Subpart 1a. Payor of last resort. The process is required by 42 CFR 433.138 and unchanged from existing part 9500.1130, subpart 12.

Subpart 1b. Third party liability. It is necessary to provide for a hierarchy of application because the items could be construed as not mutually exclusive. This is reasonable so that an understanding of priority is apparent.

Item A. The formula is unchanged from existing part 9500.1130, subpart 6, except that spend down and other liability is no longer specified. This deletion is reasonable because other rules relating to eligibility contain a more comprehensive explanation of the recipient liability requirements and these rules are related to rate determinations.

Item B. It is necessary to treat exhausted benefit stays as MA because the patient is no longer covered by Medicare. It is reasonable because MA is the primary payor. This does not result in a change from present operations.

Item C. It is necessary for MA to not pay when a patient has payment in full coverage due to Minnesota Statutes, section 256B.37, subdivision 5. This is reasonable because the entire stay is covered and the patient does not have a liability.

Item D. It is necessary to pay the coinsurance and deductables because the entire stay has not been covered. This is reasonable because MA is covering the the patient's liability.

Item E. It is necessary to pay stays that involve third party liability at the MA rate minus third party liability due to Minnesota Statutes, section 256B.37, subdivision 5. It is reasonable to limit the payment to covered charges minus third party liability so that MA as primary payor is not triggered by a small charge that is not covered by the third party, but is covered by MA. The limit is also reasonable because MA is not the primary payor and a double payment would result if MA paid an entire rate for a small charge.

Item F. It is necessary apply recipient resources to all payments because MA is a secondary payor to the patient. This is reasonable because MA provides coverage based on the resources of the patient.

Subpart 2. Required claims. It is necessary to delete this subpart because other rules contain a more comprehensive explanation of the requirements. This is reasonable because this abbreviated portion of those rules is not useful.

Subpart 3. Reimbursement in response to submitted claims. It is necessary to delete this subpart because other rules contain a more comprehensive explanation of the requirements. This is reasonable because this abbreviated portion of those rules is of limited usefulness.

Subpart 4. Adjustment to reimbursement. It is necessary to delete this subpart because other rules contain a more comprehensive explanation of the requirements. This is reasonable because this abbreviated portion of those rules is of limited usefulness.

Subpart 5. Rejection of claims. It is necessary to delete this subpart because other rules contain a more comprehensive explanation of the requirements. This is reasonable because this abbreviated portion of those rules is of limited usefulness. The requirements of subitems (1) to (4) have also been listed under proposed part 9500.1095.

Subpart 6. Medicare crossover claims. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1130, subpart 3, items A and B.

Subpart 7. Reimbursement for transfers. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1128, subpart 2, item D.

Subpart 8. Reimbursement for readmissions. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1128, subpart 4.

Subpart 9. Reimbursement for outliers. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1128, subpart 2, item C.

Subpart 10. Reimbursement to an out-of-area hospital. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1115, subpart 3 and part 9500.1122, subpart 2.

Subpart 11. Reimbursement for MSA and non-MSA hospitals statewide that do not have admissions in the base year. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1115, subparts 4 and 5, part 9500.1116, subpart 1, items C and D, part 9500.1122, subparts 3 and 4 and part 9500.1124, subpart 1, items B and C.

Subpart 12. Payor of last resort. It is necessary to move this subpart in the interest of clarity. See proposed part 9500.1130, subpart 2.

9500.1131 DETERMINATION OF DIFFERENCES DUE TO REBASING.

Subpart 1. Operating costs before and after rebasing. It is necessary to determine the effects of rebasing due to the requirements of Minnesota Statutes, section 256.9695, subdivision 3. The process included in this subpart is necessary in order to implement the requirements of paragraph (e) of that section because the upgrade to the MMIS was not completed by July 1, 1992. It is reasonable to base the rebasing effect on cost rather than rates so that dissimilar methods of rate setting between the two base periods are taken into consideration. The previous method, for example, added a flat 40% of the outlier dollars back to the per admission rate while the proposed methods allocate a variable amount based on the hospital's choice. Also, transfer admissions were included in the previous methods while the proposed methods exclude these admissions. Since both methods are based on cost, this approach will result in a more exacting calculation of the difference between base year data.

Item A. It is necessary to calculate the cost from the preceding base year so that the change resulting from rebasing can be determined. The base year in effect on June 30, 1992 is used because the change in base years in required to have the effect of taking place on July 1, 1992. It is reasonable to calculate the difference in operating costs separately from the property costs because different means of comparing the data are necessary due to different rate setting methods.

Subitem (1) It is necessary to establish the difference on a per admission basis so that a common denominator is used. This is reasonable so that the data is not skewed by differences in volume between the two years. It is necessary to calculate the cost separately for MA, AFDC and GAMC because the programs have different inflation indices and different payment adjustments such as the disproportionate population adjustment and the small rural increase. This is reasonable because it simplifies the math and reduces the averaging effect that a combining of the two programs would have when the adjustment is paid. It is necessary to separate MA and AFDC because developing a weight to combine the rates is not possible when metropolitan statistical area or nonmetropolitan statistical area data is used. This is reasonable because the hospital may have that type of admission in the payment year.

Subitem (2) It is necessary to inflate the cost per admission to June 30, 1993 because implementation is based on the MMIS upgrade. This is reasonable because the MMIS upgrade is expected to occur on July 1, 1993. June 30, 1993 is reasonable as it reflects the midpoint between July 1, 1992 and June 30, 1993 because the trending starts with the end of the hospital's base year.

Item B. The need and reasonableness is the same as at part 9500.1135, subpart 1, item A.

Subitem (1) It is necessary to calculate the costs with transfer and per day admission costs included so that the rate setting methods of the previous and proposed current base year are comparable. This is reasonable so that the effect of rebasing can be determined. It is reasonable to include transfer costs because the previous rate setting methods included these costs while the proposed current proposed methods do not. It is reasonable to include admissions that will be paid on a per day basis so that the effect of rebasing is simplified to one adjustment. In addition, this is more accurate because the payment of the adjustment will not be effected by volume changes and the separating of data in both base years could not be done with equal precision. The need and reasonableness for the methods of costing the data is the same as at part 9500.1110, subpart 1, items A to E. CRNA services even if separately billed, as allowed under the proposed rules, are included because

the prior methods required inclusion in the rates.

Subitem (2) It is necessary to separate the costs by program so that comparability to the previous base year data is maintained and for the reasons at part 9500.1135, subpart 1, item A, subitem (1).

Subitem (3) It is necessary to remove rehabilitation distinct part and newborn admissions from the admission count so that comparability to the previous base year data is maintained. This is reasonable because the previous methods did not count these admissions separately.

Subitem (4) The need and reasonableness is the same as at part 9500.1135, subpart 1, item A, subitem (1).

Subitem (5) The need and reasonableness is the same as at part 9500.1135, subpart 1, item A, subitem (2).

Item C. It is necessary to find the difference before and after rebasing so that the effect of rebasing is determined. It is reasonable to use the methods to derive a comparison because it results in a common denominator of cost which reflects the actual change that is built into both rate setting systems. It is also reasonable to make adjustments to the proposed current base year rather than the previous base year data because that data was not created in anticipation of the proposed rule changes.

Item D. It is necessary to establish cost for a hospital that did not have MA admissions in either base year because it would be impossible to determine a change due to rebasing. This is reasonable because these are the rate setting costs that are used for the hospitals.

Subpart 2. Effect of rebasing property costs. The need and reasonableness is the same as at part 9500.1135, subpart 1.

Item A. The need and reasonableness for the inclusion of transfer and per day admissions is the same as at part 9500.1135, subpart 1, item B, subitem (1). The need and reasonableness for the methods of costing the data is the same as at part 9500.1122, subpart 1, item A, subitems (1) to (3) and item C, subitem (3).

Item B. The need and reasonableness is the same as at part 9500.1135, subpart 1, item A, subitem (1).

Item C. The need and reasonableness is the same as at part 9500.1135, subpart 1, item B, subitem (3).

Item D. The need and reasonableness is the same as at part 9500.1135, subpart 1, item A, subitem (1).

Item E. The need and reasonableness is the same as at part 9500.1135, subpart 1, item D.

Subpart 3. Cost differences before and after rebasing. This subpart is necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 9. It is necessary to accumulate the effects of rebasing so that all changes are accounted for. This is reasonable so that a number of rebasing effects can be limited to one adjustment.

Item A. It is necessary to determine the effect of the disproportionate population adjustment and the small rural increase because they have an effect on the rebased costs. It is reasonable to calculate the disproportionate population adjustment change because the disproportionate population adjustment is also rebased when rates are rebased.

Subitem (1) It is necessary to determine the disproportionate population adjustment effect on July 1, 1992 because that is the date that the effect of rebasing is required. It is necessary to adjust the operating costs by the disproportionate population adjustment because these costs were subject to the disproportionate population adjustment. This is reasonable so that the effect of rebasing can be determined. It is reasonable to add the property rate in effect on July 1, 1992 so that a total difference due to rebasing can be found.

Subitem (2) It is necessary to determine the disproportionate population adjustment effect on October 1, 1992 because changes were made to the disproportionate population adjustment on that date. It is necessary to adjust both the operating and property costs by the disproportionate population adjustment because these costs were subject to the disproportionate population adjustment beginning October 1, 1992. This is reasonable so that the effect of rebasing can be determined.

Subitem (3) It is necessary to weight the result by time because the rates are in effect from July 1, 1992 to June 30, 1993. This is reasonable because the weight reflects the time proportion each rate is in effect during the twelve month delay to the MMIS upgrade. This is also reasonable so that the adjustment is limited to one for the year.

Subitem (4) It is necessary to determine the effect that the disproportionate population adjustment would have if rebasing occurred on July 1, 1992. It is necessary to adjust the operating costs by the disproportionate population adjustment because these costs were subject to the disproportionate population adjustment. This is reasonable so that the effect of rebasing can be determined. It is reasonable to add the rebased property rate so that a total difference due to rebasing can be found.

Subitem (5) It is necessary to determine the disproportionate population adjustment effect on October 1, 1992 because changes were made to the disproportionate population adjustment on that date. It is necessary to adjust both the operating and property costs by the disproportionate population adjustment because these costs were subject to the disproportionate population adjustment beginning October 1, 1992. This is reasonable so that the effect of rebasing can be determined.

Subitem (6) It is necessary to weight the result by time because the rate would have been in effect had rebasing occurred on July 1, 1992. This is reasonable because the weight reflects the time proportion each rate would have been in effect during the twelve delay to the MMIS upgrade. This is also reasonable so that the adjustment is limited to one for the year.

Subitem (7) The adjustment is necessary because the small rural increase is reduced by the disproportionate population adjustment due to the requirements of Minnesota Statutes, section 256.969, subdivision 20. This is reasonable so the effect of rebasing can be determined.

Subitem (8) It is necessary to weight the result by time because the rate would have been in effect had rebasing occurred on July 1, 1992. This is reasonable because the weight reflects nine months of the twelve month delay to the MMIS upgrade.

Subitem (9) It is necessary to adjust the costs because these costs were subject to the small rural increase. This is reasonable so the effect of rebasing can be determined.

Subitem (10) The adjustment is necessary because the small rural increase is reduced by the disproportionate population adjustment due to the requirements of Minnesota Statutes, section 256.969, subdivision 20. This is reasonable so the effect of rebasing can be determined.

Subitem (11) It is necessary to weight the result by time because the rate would have been in effect had rebasing occurred on July 1, 1992. This is reasonable because the weight reflects nine months of the twelve month delay to the MMIS upgrade.

Subitem (12) It is necessary to adjust the costs because these costs are subject to the small rural increase. This is reasonable so the effect of rebasing can be determined.

Subitem (13) It is necessary to find the difference between rates there were in effect and the rates that should have been in effect. This is reasonable so that the effect of rebasing can be determined.

Item B. It is necessary to determine the effect of the

disproportionate population adjustment because it has an effect on the rebased costs. It is reasonable to calculate the disproportionate population adjustment change because the disproportionate population adjustment is also rebased when rates are rebased. It is reasonable to subtract one from the disproportionate population adjustment in the subitems so that only the amount attributable to the disproportionate population adjustment is calculated.

Subitem (1) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (1).

Subitem (2) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (2).

Subitem (3) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (3) except that the disproportionate population adjustment is not applied to the property costs under the GAMC program.

Subitem (4) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (4).

Subitem (5) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (5).

Subitem (6) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (6).

Subitem (7) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (13).

Subpart 4. Rebasing difference. It is necessary to determine the total effect of rebasing so that an adjustment can be made. This is reasonable so that all the adjustments can be simplified to one by program.

Item A. It is necessary to establish the payment adjustment for a one year period due to the requirements of Minnesota Statutes, section 256.9695, subdivision 3, paragraph (e). This is reasonable because the MMIS was delayed for one year.

Subitem (1) It is necessary to deduct the cash flow add-on in order to determine the difference between the amount that was paid and the rebased amount that should have been paid. This is reasonable to avoid a double payment.

Subitems (2) and (3) It is necessary to convert the admission counting to the methods under which the adjustment will be paid. This is reasonable so that the adjustment does not result in payments that are in excess of the difference due to rebasing. For example, a mother and baby is counted as one admission to

determine the difference due to rebasing while the proposed method of paying for a birth and mother will result in two admissions. Thus, two rebasing adjustments will occur and the gross payments would be doubled. The same is true for rehabilitation distinct part admissions. The cash flow subtraction is prior to the admission counting conversion because it was counted under the current counting methods.

Subitem (4) It is necessary to adjust for changes to the cash flow subtraction so that the difference due to rebasing is accurate. This is reasonable so that hospitals are not over or under paid.

Item B. The need and reasonableness is the same as at part 9500.1135, subpart 4, item A.

Subitem (1) The need and reasonableness is the same as at part 9500.1135, subpart 4, item A, subitem (1).

Subitems (2) and (3) The need and reasonableness is the same as at part 9500.1135, subpart 4, item A, subitems (2) and (3).

Subitem (4) The need and reasonableness is the same as at part 9500.1135, subpart 4, item A, subitem (4).

Subpart 5. Adjustments. This subpart is necessary in the event that changes are made to factors that affect the calculations of subparts 1 to 4. This is reasonable so that the rebasing adjustment is accurately determined.

Item A. It is necessary to adjust the data if the MMIS is delayed beyond the expected implementation date of July 1, 1993 because the formulas are based on that date. This is reasonable because rates that have not been rebased will be paid during the period and the rebased rates are required to compensate for the over or under payment.

Subitem (1) The need and reasonableness is the same as at part 9500.1135, subpart 1, item A, subitem (2).

Subitem (2) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (3).

Subitem (3) The need and reasonableness is the same as at part 9500.1135, subpart 4, item A.

Item B. The need and reasonableness to adjust the data if the disproportionate population adjustment changes is the same as at 9500.1135, subpart 3, item A, subitems (1) to (6). Also, federal law has established limitations on they disproportionate population adjustment that may result in changes after October 1, 1992. It is necessary to adjust the data for appeal

settlements that cover the same period of time because the formulas are based on the rates in effect. This is reasonable because appeal settlements affect the rates.

Subitem (1) The need and reasonableness is the same as at part 9500.1135, subpart 3, item A, subitem (1) to (13).

Subitem (2) The need and reasonableness is the same as at item A, subitem (2).

4500.1140 APPEALS.

Subpart 1. Scope of appeals. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1. It is reasonable to limit appeals to those that have a financial effect on the hospital so that the appeals are specific to the rules that establish rates and payments.

The language was deleted because the Minnesota Statutes, section 256.9695 does not include any provisions for an appeals board. The statutory language that had required an appeals board was eliminated by 1989 session laws, chapter 282.

Subpart 2. Filing of appeals. The filing procedures are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1. It is reasonable to require the information to clarity the issues in the appeal. It is necessary to move the procedural language in the interest of clarity. See proposed part 9500.1140, subpart 6.

Item A. The information is necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1, paragraph (a). It is reasonable to know the items that are under appeal so that the conflict can be defined.

Item B. The information is necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1, paragraph (a). It is reasonable to know the basis for the appeal so that the department knows what legal authority the hospital relies on.

Item C. The information is necessary because the statutes differentiate between types of appeals and different requirements apply to each. It is reasonable to specify the type of appeal so that the department can respond appropriately.

Item D. The information is necessary due to Minnesota Statutes, section 256.9695, subdivision 1, paragraph (a). It is reasonable to know the person to contact to notify of the department's actions.

Subpart 3. Case mix appeals. The requirements are necessary due

to the requirements of Minnesota Statutes, section 256.9695, subdivision 1, paragraph (b). It is reasonable to establish a time frame to bring finality to the dispute. It is reasonable to apply a case mix appeal to all MA patients in a rate year because the rate is an average of data from all MA patients within a year and thus, the need for an adjustment is better defined. It is reasonable to establish the circumstances and basis of case mix evaluation so that all parties understand the parameters that will be considered.

Item A. It is necessary to establish a measurement of case mix change so that a common and comparable unit of service is derived. It is reasonable to use a case mix index because this is the method of payment and it keeps the measurement based in terms of acuity. It is reasonable to base the change in case mix on all federal diagnostic categories so that the cost per unit of service measurement system is sensitive to changes as under a commonly accepted parameters.

Item B. It is necessary to reduce the change in case mix by the case mix change as measured by the payment system diagnostic categories because the payments have already been adjusted for this change.

Item C. It is necessary to adjust payments by the change in case mix so that the incremental difference in cost per unit of acuity is recognized. This is reasonable because it automatically compensates for any present or future modifications that affect the payment system. It is reasonable to not apply the adjustment to the property payments because the base year costs have already been increased to a later point and case mix indices are not applied to these costs under the rate setting system.

Subpart 4. Medicare settled appeals. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1, paragraph (a). It is reasonable to establish a time frame in the interest of administration.

Subpart 5. Rate and payment appeals. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1, paragraph (a). It is reasonable to establish an appeal deadline so the department is aware when a rate payment is final.

Subpart 6. Resolution of appeals. The process and procedures are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1. It is reasonable to settle the appeals through the Office of Administrative hearings because it is an independent agency and is not involved in the dispute.

Item A. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1. It is

reasonable to require a showing that the rates or payments are incorrect so that the dispute can be defined.

Item B. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1. It is reasonable to require an appeal decision to be implemented because it is the final decision of the agency.

Item C. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.969, subdivision 3a and Minnesota Statutes, section 256.9695, subdivision 1, paragraph (a). It is reasonable to limit facts to those available when rates are set so that changes are prospective with changes to the base year.

Item D. The requirements are necessary due to the requirements of Minnesota Statutes, section 256.9695, subdivision 1. It is reasonable to limit the effect of an appeal outcome because the rate setting procedures are highly interrelated mathematically and a change to one rate affects the rates of other hospitals and increases the administrative requirements of the rules.

REPEALER.

All repealed language has been explained in rule sequence throughout the text with the exception of the following:

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

Subparts 1. to 6. It is necessary and reasonable to delete this part because it is applicable to a rate establishment methodology that has been superseded by Minnesota Statutes, section 256.969, subdivisions 2b and 2c.

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

Subparts 1. and 2. It is necessary to move this part in the interest of clarity. See proposed part 9500.1121.

EXPERT WITNESSES

The department does not intend to call expert witnesses from outside the agency to testify if a public hearing is required.

SMALL BUSINESS

Minnesota Statutes, section 14.115 requires that the impact on

small businesses must be considered when an agency proposes rules. The proposed rule amendments fall within the exception provided in Minnesota Statutes, section 14.115, subdivision 7, paragraph (3) which states that this requirement does not apply to service businesses regulated by government bodies, for standards and costs, such as nursing homes, long term care facilities, providers of medical care and residential facilities.

OTHER STATUTORY REQUIREMENTS

Minnesota Statutes, section 14.11, subdivision 1 is not applicable because the proposed rule will not require expenditures of more than $100,000 by local public bodies.

Minnesota Statutes, section 14.11, subdivision 2 is not applicable because the proposed rule will not have any impact on agricultural land.

Minnesota Statutes, section 16.128, is not applicable because the proposed rule does not set fees.

CONCLUSION

Based on the foregoing, the proposed amendments to the inpatient hospital payment rules are necessary and reasonable because they establish a refined payment system and encourage hospitals to conserve medical assistance and general assistance medical care dollars through efficient and economical operation.

George J. Steffen

for NATALIE HAAS STEFFEN
Commissioner

Dated: 3-5-93