



Minnesota Department of
Human Services

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Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Report to the Legislature

Medical Assistance Inpatient Hospital Medicare Upper Limits Disproportionate Share Funding

Laws of Minnesota 2005,
First Special Session,
Chapter 4, Article 8, Section 15

Minnesota Statutes 2006,
Chapter 256, section 969, subdivision 27(f)

February 2007

Medical Assistance Inpatient Hospital Medicare Upper Payment Limits Disproportionate Share Funding

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Report preparation \$11,000

Alternative formats or Additional copies

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REPORT TO THE LEGISLATURE REQUIREMENT

Laws of Minnesota, 2005, First Special Session, Chapter 4, Article 8, Section 15 added Minnesota Statutes 2006, Chapter 256, Section 969, subdivision 27 (f) which requires a report to the legislature related to inpatient hospital payments under the Medical Assistance program. The language states:

- (f) By January 15 of each year, beginning January 15, 2006, the commissioner shall report to the chairs of the house and senate finance committees and divisions with jurisdiction over funding for the Department of Human Services the following estimates for the current and upcoming federal and state fiscal years:
 - (1) the difference between the Medicare upper payment limit and actual or anticipated medical assistance payments for hospital services;
 - (2) the amount of federal disproportionate share hospital funding available to Minnesota and the amount expected to be claimed by the state; and
 - (3) the methodology used to calculate the results reported for clauses (1) and (2).
- (g) For purposes of this subdivision, medical assistance does not include general assistance medical care.

MEDICARE UPPER PAYMENT LIMITS

Attachment A : Methodology

This attachment describes the methodology used to calculate the inpatient hospital Medicare upper payment limit (UPL) and the Medical Assistance (MA) rates.

- The description relates to federal fiscal year (FFY) 2006 ending September 30, 2006 which is the most recently completed UPL. Although the dates and data within the text of the description changes for future estimates, the methodology remains the same.
- Actual UPL comparison data could vary considerably from estimates for all time periods beyond FFY06. This is because hospital MA rates and relative weights for each diagnosis were rebased to more current data effective January 1, 2007, Medicare rates and relative weights are unknown for FFY08 and MA admission counts by hospital that are used to weight both the MA and Medicare rates for the UPL comparison will be updated to more recent data for FFY07 and FFY08.
- The UPL comparison between Medicare and MA rates does not include disproportionate share hospital (DSH) payments under the MA program. DSH payments are limited separately.

Attachment B : Current State Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period July 1, 2006 to June 30, 2007. Privately owned and operated hospitals are \$54,325,000 below the limit and non-state owned or operated government hospitals are \$27,389,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2006. The MA data was increased 11.8% to reflect six months (1/2007 – 6/2007) of the increase, excluding DSH, that resulted from rebasing hospital rates to more current cost data. Privately owned hospitals were increased 9.8% and non-state owned government hospitals were increased 19.1%. Medicare rates have been increased 2.6% for nine months (10/2006 – 6/2007) to reflect the FFY07 Medicare payment schedule.

Attachment C : Upcoming State Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period July 1, 2007 to June 30, 2008. Privately owned and operated hospitals are

\$35,273,000 below the limit and non-state owned or operated government hospitals are \$8,324,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2006. The MA data was increased 23.6% to reflect a full year of the increase, excluding DSH, which resulted from rebasing hospital rates to more current cost data. Privately owned hospitals were increased 19.5% and non-state owned government hospitals were increased 38.1%. Medicare rates have been increased an estimated 0.9% over SFY07 estimates for three months (7/2007 – 9/2007) to reflect the FFY07 Medicare payment schedule and 2.6% for nine months (10/2007 – 6/2008) to reflect the currently unknown FFY08 Medicare payment schedule.

Attachment D : Current Federal Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period October 1, 2006 to September 30, 2007. Privately owned and operated hospitals are \$39,058,000 below the limit and non-state owned or operated government hospitals are \$22,250,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2006. The MA data was increased 17.7% to reflect nine months (1/2007 – 9/2007) of the increase, excluding DSH, that resulted from rebasing hospital rates to more current cost data. Privately owned hospitals were increased 14.6% and non-state owned government hospitals were increased 28.6%. Medicare rates have been increased 3.5% for a full year to reflect the FFY07 Medicare payment schedule.

Attachment E : Upcoming Federal Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period October 1, 2007 to September 30, 2008. Privately owned and operated hospitals are \$21,246,000 below the limit and non-state owned or operated government hospitals are \$2,764,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2006. The MA data was increased 23.6% to reflect a full year of the increase, excluding DSH, which resulted from rebasing hospital rates to more current cost data. Privately owned hospitals were increased 19.5% and non-state owned government hospitals were increased 38.1%. Medicare rates have been increased an estimated 3.5% over FFY07 estimates to estimate a full year of the currently unknown FFY08 Medicare payment schedule.

DISPROPORTIONATE SHARE FUNDING

Federal law establishes the maximum aggregate amount a state can claim as a disproportionate share hospital payment (DSH). The following shows the amount of federal DSH funding available and the amount that is estimated will be claimed under current Minnesota law.

- Individual hospital MA DSH rates were rebased to more current data effective January 1, 2007. Therefore, a history of DSH payments do not exist beginning in 2007 and needs to be estimated. DSH payments are made to hospitals by increasing a hospital's non-DSH payments by a DSH percentage that varies by hospital. Estimates are based on the percentage change due to rebasing hospital rates multiplied by the rebased DSH percentage change and historical payments. The result is then adjusted by the November 2006 MA forecast.
- DSH payments are limited to fixed amounts of federal financial participation (FFP) that vary by federal fiscal year. All DSH limit and spending numbers are listed by FFP. Since MA payments are 50% FFP, the numbers would be doubled when paid to a hospital.

Current State Fiscal Year Estimate

The following estimates the FFP share of DSH funding and payments for the period July 1, 2006 to June 30, 2007.

- \$58,556,100 in DSH funding is available.
- \$25,484,500 is expected to be claimed based on hospital DSH rates in effect for six months of CY06 and six months of CY07.
- \$23,045,500 is expected to be claimed under Minnesota Statutes, 256.969, subdivision 9(f). This requires SFY06 and SFY07 inpatient and outpatient hospital payments that are made under the General Assistance Medical Care (GAMC) program to be made as DSH payments. Although not yet approved by the federal government, it is anticipated that this approach will result in retroactive approval.
- \$10,026,100 is expected to remain available under the DSH limit.

Upcoming State Fiscal Year Estimate

The following estimates the FFP share of DSH funding and payments for the period July 1, 2007 to June 30, 2008.

- \$67,925,000 in DSH funding is available.
- \$33,402,600 is expected to be claimed based on hospital DSH rates in effect for six months of CY07 and six months of CY08.
- \$35,653,900 is expected to be claimed under Minnesota Statutes, 256B.199. This requires the reporting of payments that may qualify for FFP by three hospitals/governmental entities and includes inpatient and outpatient hospital expenditures that are made for GAMC recipients. However, the GAMC data is reported with a three quarter lag and FFP cannot be claimed on SFY07 GAMC payments that have already been paid as DSH payments. Of the three hospitals, one is assumed to qualify as a governmental entity capable of certifying expenditures as a medical expense for purposes of the non-federal share of Medicaid. Any difference that exceeds four percent of MinnesotaCare and MA inpatient payments is paid to hospitals as a payment adjustment under Minnesota Statutes 256.969, subdivision 27.
- (\$1,131,500) is expected to remain available under the DSH limit.

Current Federal Fiscal Year Estimate

The following estimates the FFP share of DSH funding and payments for the period October 1, 2006 to September 30, 2007.

- \$60,647,400 in DSH funding is available.
- \$29,126,500 is expected to be claimed based on hospital DSH rates in effect for three months of CY06 and nine months of CY07.
- \$17,035,000 is expected to be claimed under Minnesota Statutes, 256.969, subdivision 9(f) for nine months (10/2006 – 6/2007). This requires SFY06 and SFY07 inpatient and outpatient hospital payments that are made under the GAMC program to be made as DSH payments. Although not yet approved by the federal government, it is anticipated that this approach will result in retroactive approval.
- \$8,421,900 is expected to be claimed under Minnesota Statutes, 256B.199 for three months (7/2007 – 9/2007). This requires the reporting of payments that may qualify for FFP by three hospitals/governmental entities and includes inpatient and outpatient hospital expenditures that are made for GAMC recipients. However, the GAMC data is reported with a three quarter lag and FFP cannot be claimed on SFY06 and SFY07 GAMC payments that have already been paid as DSH payments. Of the three hospitals, one is assumed to qualify as a governmental entity capable of certifying expenditures as a medical expense for purposes of the non-federal share of Medicaid. Any difference that exceeds four

percent of MinnesotaCare and MA inpatient payments is paid to hospitals as a payment adjustment under Minnesota Statutes 256.969, subdivision 27.

- \$6,064,000 is expected to remain available under the DSH limit.

Upcoming Federal Fiscal Year Estimate

The following estimates the FFP share of DSH funding and payments for the period October 1, 2007 to September 30, 2008.

- \$70,350,900 in DSH funding is available.
- \$34,141,100 is expected to be claimed based on hospital DSH rates in effect in for three months of CY07 and nine months of CY08.
- \$39,978,300 is expected to be claimed under Minnesota Statutes, 256B.199. This requires the reporting of payments that may qualify for FFP by three hospitals/governmental entities and includes inpatient and outpatient hospital expenditures that are made for GAMC recipients. However, the GAMC data is reported with a three quarter lag and FFP cannot be claimed on SFY07 GAMC payments that have already been paid as DSH payments. Of the three hospitals, one is assumed to one is assumed to qualify as a governmental entity capable of certifying expenditures as a medical expense for purposes of the non-federal share of Medicaid. Any difference that exceeds four percent of MinnesotaCare and MA inpatient payments is paid to hospitals as a payment adjustment under Minnesota statutes 256.969, subdivision 27.
- (\$3,768,500) is expected to remain available under the DSH limit.

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**STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES
INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW
FFY 2006**

COMPARISON

42 CFR 447.272 states that Medicaid payments may not exceed the amount that can reasonably be estimated would have been paid for the services using Medicare payment principles. In general, the Medicare and Medicaid prospective payment system (PPS) payments are calculated using base rates which are then adjusted for individual hospital case-mix averages. Exceptions to this general rule are explained elsewhere.

The case-mix averages for individual hospitals are calculated by multiplying each DRG admission (or covered day if appropriate for a type of service) by its relative weight to arrive at a total weight for the DRG. The total weights of each DRG are then added together and divided by the total admissions/days to arrive at the average weight. For hospitals that provide services paid by admissions and days, an average weight is calculated separately for each payment method. (An example would be a hospital that provides acute services and neonatal transfer services. Under the Medicaid payment system the acute services are paid per admission while the neonatal transfer services are paid per covered day.)

When calculating payments case-mix weights are to be applied to PPS base rates including rehabilitation services. There is an incompatibility between the different grouper systems used by Medicare and Medicaid. Medicare uses a case mix grouping (CMG) whereas Medicaid uses a diagnostic related grouping (DRG). Because of this it is not possible to convert the admission DRGs to CMGs. However, the Centers for Medicare & Medicaid Services (CMS) have included an individual hospital estimated relative weight per admission for FFY06 in its data file for Medicare rehabilitation distinct part units (IRF) dated September 13, 2005, and posted on its website. This estimated average weight per admission will be used in calculating the estimated Medicare payments.

As discussed below, this review uses Medicaid admissions and covered days data from calendar year 2004. Because of the timing difference between the date of the data and the period of the review, some of the DRGs assigned in calendar year 2004 are no longer in use by CMS for FFY 2006. This necessitates calculating a DRG weight for those DRGs no longer in use by Medicare during FFY 2006. The Medicare weight for the current DRG from Table 5 of the final rule published in the Federal Register on August 12, 2005, will be assigned to the previous DRG if the previous DRG was replaced with a single DRG. If the previous DRG was converted to multiple DRGs, then a weighted average needs to be calculated for the previous DRG. To do this, first the Medicare weight for the current DRGs will be multiplied by the total Medicare cases for these DRGs from Table 10 of the final rule. Then these products are then added together to arrive at the total weight. Finally, the total weight is divided by the total Medicare cases for these current DRGs to arrive at the average weight for the previous DRG.

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ADMISSIONS

The number of Medicaid admissions and days used for the upper limit calculation is from calendar year 2004 which is the most current year that complete information is available. Admissions/days to acute hospitals, long-term care hospitals, critical access hospitals, transfers to Neonate Intensive Care Units (NICU), rehabilitative and psychiatric Medicare distinct part units and hospitals, and contracted 45-day mental health services are included as are Local Trade Area (LTA) hospitals. Total admissions are 42,316 (10,510 for non-state owned or operated government hospitals and 31,806 for privately owned and operated hospitals) for the Medicare and Medicaid calculations.

MEDICARE RATE CALCULATION:

The Medicare average operating and capital payment per admission was calculated with rate components that are based on various Medicare payment systems. Sources include the FFY 2006 prospective payment system (PPS) acute care rate schedule, the FFY 2006 PPS rate schedule for IRFs, the RY 2007 and 2006 PPS rate schedules for the long-term care hospitals (LTCH) which are still in a transition period to full PPS, the final rule for PPS inpatient psychiatric facilities (IPF) that have started to transition to full PPS beginning with the cost reporting year beginning on or after January 1, 2005, and updated per diem rates based on the most recent Medicare cost report data for hospitals subject to TEFRA reasonable cost principles. The TEFRA per diem rates are used for children's hospitals and also as part of the blended rates for IPFs transitioning to full PPS. The interim Medicare per diem rates used for critical access hospitals (CAH) are supplied by the Medicare intermediary (Noridian Administrative Services) on an ongoing basis.

The inpatient PPS final rule for the acute care hospitals was initially published in the Federal Register on August 12, 2005. Corrections to the final rule were published in the Federal Register on September 30, 2005, and October 4, 2005. The PPS capital rate was increased an additional 3% in the Minneapolis – St. Paul Metropolitan Statistical Area. Inpatient acute hospitals not submitting quality information to CMS receive a lower base payment rate than those submitting the information. In a press release issued September 29, 2006, CMS announced that 99% of the acute care hospitals qualified to participate had submitted the information and qualified for the full payment rate. A representative from the Minnesota Hospital Association informed this agency that all of their members were submitting the information to CMS. Therefore, the full payment rate will be used for all hospitals in performing the UPL review.

The PPS final rule for IRFs was published in the Federal Register on August 15, 2005. Correction of the final rule was published in the Federal Register on September 30, 2005. Beginning with FFY 2006, an IME adjustment was included as part of the payment for IRFs that are part of a teaching program.

The PPS final rule for LTCH rate year 2006 was published in the Federal Register on

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May 6, 2005. The PPS final rule for LTCH rate year 2007 was published in the Federal Register on May 12, 2006. Because the LTCH rate year (July – June) does not match the Federal fiscal year (October – September), it is necessary to prorate rate year 2006 payment rates to nine months and the rate year 2007 payment rates to three months in order to match the Federal fiscal year of this review. Four LTCHs participate in Minnesota's Medicaid program. Based on the data file dated June 6, 2006, posted on CMS's website, three were projected to be paid full PPS rates for LTCH rate year 2007 with one projected to be paid a transition rate. Once a LTCH hospital is paid the full PPS rates it will remain on this payment method until the phase-in period expires.

The PPS final rule for IPFs was published in the Federal Register on November 15, 2004. The payment rates set in this final rule are effective through June 30, 2006 (rate year 2006). The final rule for rate year 2007 was published in the Federal Register on May 9, 2006. There will be a three year transition period from TEFRA to PPS starting with the cost reporting period beginning on or after January 1, 2005 with no option to choose to be paid full PPS prior to the end of the transition period as there was with other PPS payment systems. PPS payments will be made based on a per diem with adjustments for the DRG assigned, the age of the patient, comorbid conditions, whether the hospital has a teaching program, if the hospital is rural, and whether the hospital has an emergency department. Because the IPF rate year (July 1 – June 30) does not match the Federal fiscal year (October – September), it is necessary to prorate rate year 2006 payment rates to nine months and the rate year 2007 payment rates to three months in order to match the Federal fiscal year of this review.

Hospitals subject to the TEFRA rates were adjusted to per diem rates in accordance with a finding by CMS in its audit of the upper payment limits (UPL) for FFY 2002. The Medicare allowable inpatient cost, which includes capital-related costs and incentives, was divided by Medicare days to calculate a per diem from the hospital's most recent Medicare cost report. (The cost reports range from report years ending in the years 2002 – 2005 with the majority being in 2004.) The per diem was inflated to FFY 2006 based on CMS's annual prospective payment rate update at full market basket for acute care hospitals. TEFRA rates are calculated based on reasonable costs and are not adjusted by a case-mix weight.

The average Medicare rate is calculated using a multi-step process. First, each hospital's operating, capital, and TEFRA rates are multiplied by its Medicaid admissions/days. The resulting payments are then adjusted by the individual hospital's average case-mix weights (except the TEFRA rates). The resulting total payments of each hospital are added together to arrive at a total that is then divided by the total Medicaid admissions.

OUTLIERS

The estimated average rates per admission for Medicare do not include payments for outliers. Medicare outlier payments equal 5.1% of total PPS operating payments and

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4.8% of total PPS capital payments for the acute hospital services, 3.0% of the total PPS IRF payments, 8.0% of the total PPS LTCH payments, and 2.0% of total PPS IPF payments. Because one of the LTCHs is receiving a blended transition rate, the outlier payment adjustment for the LTCHs will be included as part of the LTCH payment calculation rather than as a separate calculation since the outlier adjustment only applies to the PPS portion of the rates. Because the IPFs are receiving blended transition rates, the outlier payment adjustment for the IPFs will be included as part of the IPF payment calculation rather than as a separate calculation since the outlier adjustment only applies to the PPS portion of the rates.

MEDICAL EDUCATION

The indirect medical education (IME) operating and capital adjustment factors are from CMS's public use file dated August 17, 2005, and posted on its website. One hospital, Children's Health Care – St. Paul, was not in the data file. Children's Health Care – St. Paul does not have a TEFRA rate. IME costs are not reflected in the Medicare rate per admission but would be in the Medicaid rate per admission. To compensate for this discrepancy, an IME adjustment was calculated and included in the Medicare calculation.

Children's Health Care – St. Paul's adjustment factor was calculated using data from its most recent Medicare cost report which is the reporting year ending in 2002. Its operating adjustment factor is calculated using the operating formula specified in CMS's final rule with the Resident to Bed Ratio coming from Worksheet E, Part A, Line 3.20, of the cost report. The formula multiplier is 1.37 for FFY 2006. The capital adjustment factor is from Worksheet L, Part I, Line 4.02, of the cost report.

For those hospitals that meet the criteria for the IME adjustment, both the operating and capital portions of their payments are adjusted. Each hospital's total operating and capital payments are multiplied by the applicable IME factor; however, this factor was not used for the TEFRA rates since IME costs are included in these rates. These totals are added together and divided by total Medicaid admissions to derive a per admission amount.

Direct medical education was calculated applying the Medicare formula for a Minnesota Medicaid only inpatient volume from the most recent Medicare cost report periods. The Minnesota Medicaid inpatient days, inpatient charges, and outpatient charges used in the calculation were generated with a query from this agency's data warehouse. The amount calculated for each hospital was then trended forward to FFY 2006. The indexes as calculated in prior years are 7.5% for FFY 2002; 1.1% for FFY 2003; 3.2% for FFY 2004; and 7.7% for FFY 2005. For FFY 2006, the amount was increased by 22.6% which is the Medicare percentage change in total operating, capital and outlier rates from FFY 2005 to FFY 2006 ($(\$8,062 - \$6,575) / \$6,575 = 22.6\%$).

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DISPROPORTIONATE SHARE / LOW INCOME PATIENTS

CMS has determined that the Medicare Disproportionate Share Hospital (DSH) payments may be included even though the Medicaid DSH is not. The PPS acute operating and capital rates are adjusted, but the TEFRA, LTCH, and IPF rates are not eligible for DSH payments. The operating and capital DSH adjustment factors are from CMS's public use file referenced earlier. If any hospital was not included in that file, the adjustment factors are calculated based on information in the most recent Medicare cost report.

Gillette Children's and Children's Health Care – Minneapolis hospitals have a TEFRA rate so a DSH adjustment is not applicable. Since Children's Health Care – St. Paul does not have a TEFRA rate, DSH costs would not be reflected in the Medicare rate per admission. To compensate, Children's Health Care – St. Paul's 2002 Medicare report was reviewed and it was determined that its DSH percentage (the combined SSI and Medicaid ratios) was 48.857%; therefore, a DSH adjustment was calculated and included in the Medicare calculation.

The PPS rate schedule for the IRFs includes an adjustment for units serving Low Income Patients (LIP). This is similar to DSH payments, and in fact, the LIP adjustment factor uses a DSH percentage in its calculation, but for rehabilitative services provided. The DSH percentage used in the calculation is from CMS's data file dated September 13, 2005, and posted on its website.

ORGAN ACQUISITION COSTS

Organ acquisition costs of Medicaid organ transplant admissions are calculated from the most recent Medicare cost reports. The costs are added together and divided by total Medicaid admissions to derive a per-admission amount because Medicare rates do not include these costs.

MEDICAID RATE CALCULATION:

The Medicaid average payment per admission is based on hospital operating and capital rates and contracted mental health service rates in effect in calendar years 2005 and 2006. The rates were weighted 25% for 2005 rates and 75% for 2006 rates to correspond to the federal fiscal year. The average rate is calculated by multiplying each hospital's operating and property / contracted rates by Medicaid admissions / days. The operating payments were then adjusted by hospital specific weighted average case-mix factors. Long term care hospitals and hospitals with contracted mental health services are paid per diem rates without adjustment for case-mix weights. As explained earlier, no adjustment for case-mix was applied to hospitals for rehabilitation services. The total payments for each hospital are then summed with the overall total being divided by the sum of the statewide total Medicaid admissions.

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Previously the contracted mental health service per diem rates included payments for both hospital and physician services. However, for contracted rates entered into on or after January 1, 2005, the physician service payments are made separate from the hospital payments. Therefore, it is not necessary to adjust the payments covered by this review to remove physician services.

SMALL, RURAL

The applicable 2005 / 2006 15% or 20% Medicaid adjustment to small, rural hospitals as reduced by the disproportionate population adjustment was added to each hospital's payment.

NICU

Admissions to NICUs that are transferred from a hospital are paid on a per diem basis. For each hospital with neonate transfers, the NICU days were multiplied by the operating and property per diem rates. The operating payments were then adjusted by applying the hospital specific weighted average case-mix factors. The total adjusted operating payments and property payments were summed and divided by total admissions to determine the average NICU payment per admission.

OUTLIERS

The estimated average rates per admission for Medicaid does not include payments for outliers. Medicaid outlier payments as a percent of total Medicaid payments are calculated based on payments made in CY 2004. The outlier rates are 2.31% for non-state owned or operated government hospitals and 6.98% for privately owned and operated hospitals (5.7% overall).

MEDICAL EDUCATION AND RESEARCH COSTS (MERC)

CMS's approval for the previous state plan for MERC payments expired on June 30, 2005. CMS approved a temporary plan for MERC payments effective July 1, 2005, and expiring June 30, 2007, at which time the State of Minnesota expects to have approval for a new method of determining the distribution of MERC funds. The funding of the MERC Trust Fund is derived from fee for service (FFS) Medicaid payment rates and Pre-Paid Medical Assistance Plan (PMAP) capitation payment rates. Only the distributions to hospitals funded by FFS are to be included in this review.

OUTSTATE PAYMENT AT 90% METRO AVERAGE

Hospitals located outside of the seven-county metropolitan area are paid the greater of their rates including the small, rural adjustment, or 90% of the average seven-county

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metropolitan rate for sixteen DRGs. The DRGs are primarily composed of birth, neonate, and mental health admissions.

This 16-DRG adjustment was effective July 1, 2001. Total payments are contingent upon how much the payments for non-state owned or operated government hospitals are under the Medicare upper limit. The 2003 legislature froze the total payment at an amount not to exceed the amount recognized in March 2003. This amount is \$848,388 (\$20 per admission) which was 69% of the metro average at that time.

The 2005 legislature increased the 16-DRG adjustment to the full 90 percent of the average seven-county metro rate effective August 1, 2005. Based on payment data for SFY 03, this results in additional payments of \$3,372,246 (\$80 per admission).

Because IGT still funds \$848,388 and the rest is funded by the general fund this is shown as two lines.

RATEABLE REDUCTION

The payments were reduced by 0.5% effective July 1, 2002. The payments were further reduced by the governor through the unallowment process by 5.0% effective March 1, 2003, by 5.0% effective July 1, 2003, and 6.0% effective August 1, 2005. Mental health admissions were excluded from the 5.0% and 6.0% payment reductions. In addition to being excluded from the 5.0% and 6.0% payment reductions, contracted mental health days are also excluded from the 0.5% payment reduction.

RATEABLE INCREASE

The 2003 legislature enacted legislation to increase payments by 2% effective January 1, 2004. The LTA hospitals are excluded from the payment increase. Hospitals with contracted mental health services have the increase included as part of the negotiated rates.

Attachment B

**STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES
INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW
ESTIMATE OF SFY 2007 FOR LEGISLATIVE REPORT**

MEDICARE AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$8,030	\$6,683	\$8,476	Operating and Capital Payment
243	259	238	Outlier Adjustment
600	1,495	305	Indirect Medical Education
316	742	175	Direct Medical Education
514	1,141	307	Disproportionate Share / Low Income Patients
<u>33</u>	<u>7</u>	<u>41</u>	Organ Acquisition Cost Payment
<u>\$9,736</u>	<u>\$10,327</u>	<u>\$9,542</u>	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$6,567	\$6,872	\$6,467	Operating and Property Payment
284	27	369	NICU Adjustment
352	140	434	Outlier Adjustment
481	599	442	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
<u>92</u>	<u>74</u>	<u>98</u>	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
\$7,796	\$7,721	\$7,834	Total Estimated Average Payment

DIFFERENCE:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$1,940	\$2,606	\$1,708	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are \$54,324,648 (\$1,708 X 31,806 admissions) below the limit.
2. Payments to government hospitals not owned or operated by the State of Minnesota are \$27,389,060 (\$2,606 X 10,510 admissions) below the limit.

Attachment C

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INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW
ESTIMATE OF SFY 2008 FOR LEGISLATIVE REPORT**

MEDICARE AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$8,311	\$6,917	\$8,772	Operating and Capital Payment
252	268	247	Outlier Adjustment
622	1,548	315	Indirect Medical Education
327	768	182	Direct Medical Education
533	1,181	317	Disproportionate Share / Low Income Patients
<u>34</u>	<u>7</u>	<u>43</u>	Organ Acquisition Cost Payment
<u>\$10,079</u>	<u>\$10,689</u>	<u>\$9,876</u>	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$7,260	\$ 8,489	\$6,912	Operating and Property Payment
314	33	394	NICU Adjustment
389	173	464	Outlier Adjustment
481	599	442	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
104	93	106	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
<u>444</u>	<u>501</u>	<u>425</u>	Quarterly Payment Adjustment
<u>\$9,012</u>	<u>\$9,897</u>	<u>\$8,767</u>	Total Estimated Average Payment

DIFFERENCE:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$1,067	\$792	\$1,109	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are \$35,272,854 (\$1,109 X 31,806 admissions) below the limit.
2. Payments to government hospitals not owned or operated by the State of Minnesota are \$8,323,920 (\$792 X 10,510 admissions) below the limit.

Attachment D

**STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES
INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW
ESTIMATE OF FFY 2007 FOR LEGISLATIVE REPORT**

MEDICARE AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$8,099	\$6,740	\$8,548	Operating and Capital Payment
245	261	240	Outlier Adjustment
605	1,508	307	Indirect Medical Education
319	748	177	Direct Medical Education
519	1,151	309	Disproportionate Share / Low Income Patients
<u>33</u>	<u>7</u>	<u>41</u>	Organ Acquisition Cost Payment
<u>\$9,820</u>	<u>\$10,415</u>	<u>\$9,622</u>	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$6,914	\$7,235	\$6,808	Operating and Property Payment
299	28	388	NICU Adjustment
371	147	457	Outlier Adjustment
481	599	442	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
98	78	104	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
<u>179</u>	<u>202</u>	<u>171</u>	Quarterly Payment Adjustment
<u>\$8,362</u>	<u>\$8,298</u>	<u>\$8,394</u>	Total Estimated Average Payment

DIFFERENCE:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$1,458	\$2,117	\$1,228	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are \$39,057,768 (\$1,228 X 31,806 admissions) below the limit.
2. Payments to government hospitals not owned or operated by the State of Minnesota are \$22,249,670 (\$2,117 X 10,510 admissions) below the limit.

Attachment E

**STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES
INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW
ESTIMATE OF FFY 2008 FOR LEGISLATIVE REPORT**

MEDICARE AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$8,382	\$6,976	\$8,847	Operating and Capital Payment
254	270	249	Outlier Adjustment
627	1,561	318	Indirect Medical Education
330	774	183	Direct Medical Education
537	1,191	320	Disproportionate Share / Low Income Patients
<u>34</u>	<u>7</u>	<u>43</u>	Organ Acquisition Cost Payment
<u>\$10,164</u>	<u>\$10,779</u>	<u>\$9,960</u>	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$7,260	\$8,489	\$6,912	Operating and Property Payment
314	33	394	NICU Adjustment
389	173	464	Outlier Adjustment
481	599	442	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
104	93	106	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
<u>992</u>	<u>1,120</u>	<u>950</u>	Quarterly Payment Adjustment
<u>\$9,560</u>	<u>\$10,516</u>	<u>\$9,292</u>	Total Estimated Average Payment

DIFFERENCE:

<u>Total</u>	<u>Non-State Gov't</u>	<u>Privately Owned</u>	
\$604	\$263	\$668	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are \$21,246,408 (\$668 X 31,806 admissions) below the limit.
2. Payments to government hospitals not owned or operated by the State of Minnesota are \$2,764,130 (\$263 X 10,510 admissions) below the limit.