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State/Territory Name: MN

State Plan Amendment (SPA) #:13-004

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

DEC 05 2013

Jim Golden
State Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
P.O. Box 64983
St. Paul, MN 55164-0983

RE: Minnesota State Plan Amendment (SPA) 13-04

Dear Mr. Golden:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-04. Effective for services on or after January 1, 2013, this amendment revises rates and methodologies for reimbursement for inpatient hospital services. Specifically, this amendment clarifies the definition of hospital acquired condition and adds provider preventable conditions (PPC) language required by federal guidance, eliminates rebasing the base year cost data used to determine reimbursement rates, and revises disproportionate share hospital (DSH) payment methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 13-04 is approved effective January 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (312) 353-9860.

Sincerely,

[redacted]

Cindy Mann,
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 13-04	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTER FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2013	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §§ 447.26, 447.252, 455.304	7. FEDERAL BUDGET IMPACT: a. FFY 2013: $0 b. FFY 2014: $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, pages 1 – 48 Attachment 4.19-A, Supplement 2, pages 1 – 6 Attachment 4.19-B, page 101	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT:
Hospital acquired conditions, rate rebasing, DSH methodology

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Sean Barrett Minnesota Department of Human Services 540 Cedar Street, PO Box 64983 St. Paul, MN 55164-0983
13. TYPED NAME: Ann Berg	
14. TITLE: Deputy Medicaid Director	
15. DATE SUBMITTED: March 29, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: DEC 05 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, Policy + Financial Mgt. CMCS
23. REMARKS:	

FORM CMS-179 (07-92)

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided by Non-State Owned Facilities

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SECTION 1.0 PURPOSE AND SCOPE

The Minnesota inpatient hospital payment system under the Medical Assistance Program is authorized by state law. Payment rates are prospectively established on a per admission or per day basis under a diagnostic related group (DRG) system that adjusts Medicare categories into Minnesota diagnostic categories. Additional rates are established for hospitals that provide specialty services (Rehabilitation Distinct Part and Neonatal Transfer at receiving hospitals with neonatal intensive care units). The system provides for the payment of operating and property costs with additional payments including a disproportionate population adjustment and an appeals mechanism.

The rate setting methodology is based on the cost finding and allowable cost principles of the Medicare program. The rates are established for each calendar year using hospital specific Medical Assistance claims data and cost data.

To be eligible for payment, inpatient hospital services must be medically necessary.

Minnesota has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SECTION 2.0 DEFINITIONS

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

Adjusted base year operating cost. "Adjusted base year operating cost" means a hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.

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

Allowable base year operating cost. "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day that is adjusted for case mix and excludes property costs.

Ancillary service. "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and

intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical dependency services customarily charged in addition to an accommodation service charge.

Base year. "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish rates.

Case mix. "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.

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

City of the first class. "City of the first class" means a city that has more than 100,000 inhabitants, provided that once a city is defined in such a manner, it can not be reclassified unless its population decreases by 25 percent from the census figures that last qualified the city for inclusion in the class.

Cost outlier. "Cost outlier" means the adjustment included in the relative value that is applied to the admission and outlier rates so that payment is adjusted for exceptionally high cost stays. The adjustment is applied to all admissions with an above average cost, including patients that have not yet attained the age of one in all hospitals and that have not yet attained the age of six in disproportionate population hospitals.

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

Day outlier. "Day outlier" means an admission where the length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories, by two standard deviations.

Diagnostic categories. "Diagnostic categories" means the diagnostic classifications containing one or more diagnostic related groups (DRGs) used by the Medicare program. The DRG classifications must be assigned according to the base year admissions for routine inpatient hospital services, rehabilitation distinct part and neonatal transfers at receiving hospitals with a neonatal intensive care unit, with modifications as specified in items A to D.

A. Diagnostic categories for routine inpatient hospital services. The following diagnostic categories are for all admissions, except as provided in items B or C:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS CODES
A. Nervous System Diseases and Disorders		
(1) Intracranial vascular procedures with PDx of hemorrhage	528	
(2) Craniotomy for multiple significant trauma, Implant of chemotherapeutic agent or complex CNS diagnosis	484, 543	
(3) Ventricular shunt, all ages, with CC and Craniotomy, age >17, with CC	001, 003, 529	003 includes shunt with CC as the principal procedure
(4) Spinal and Extracranial procedures, and Stroke with thrombolytic agent	531-533, 559	
(5) Craniotomy, age 0-17	003	003 excludes shunt as the principal procedure
(6) Craniotomy, age >17 without CC and Other nervous system procedures with CC	002, 007	
(7) Other nervous system, Ventricular shunt and Extracranial procedures without CC	003, 008, 530, 534	003 includes shunt without CC as the principal procedure
(8) Spinal disorders and injury, Nervous system infection, and Hypertensive encephalopathy	009, 020, 022	
(9) Intracranial hemorrhage or Cerebral infarction	014	
(10) Neoplasms and Degenerative disorders of the nervous system, Stupor with coma >1 hour	010, 012, 027	
(11) Nonspecific cerebrovascular disorders and Stupor with coma <1 hour with CC, and Other disorders of the nervous system	016, 028, 034, 035	
(12) Nonspecific CVA, Cranial and		

peripheral nerve disorder, Other stupor and coma	015, 018, 023, 030	
(13) Seizure and headache, age >17, with CC	024	
(14) Nervous system neoplasm without CC, Multiple Sclerosis, and Cerebral Ataxia	011, 013	
(15) Other nervous system diseases and disorders	017, 019, 021, 026, 029, 033, 524	
(16) Seizure and headache without CC and Concussion, age >17	025, 031, 032	
B. Eye Diseases and Disorders		
(1) Surgical procedures of Eyes	036-042	
(2) Eyes disorders and diseases	043-048	
C. Ear, Nose, Throat, and Mouth Diseases and Disorders		
(1) [Reserved for future use]		
(2) [Reserved for future use]		
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) Other ENT and mouth O.R. procedures	063	
(6) Miscellaneous and major ear, nose, throat and mouth procedures	049, 055	Codes in DRG 049 except 20.96-20.97
(7) Cochlear Implants only	049	Codes 20.96-20.97
(8) Sinus, mastoid, salivary gland and nose procedures	050, 053, 054, 056	
(9) T & A, Myringotomy, and Salivary gland procedures	051, 057, 060, 061, 062	
(10) Cleft lip and palate repair and Other T & A procedures	052, 058, 059	
(11) Epiglottis, Nasal trauma, and ENT and mouth malignancy	064, 067, 072, 073	
(12) Other ENT and mouth diagnoses and other mouth procedures	066, 068, 074, 168, 169, 185, 187	
(13) Dyseqilibrium, Otitis media with CC, age 0-17, and Other dental and throat disease	065, 069, 070, 071, 186	
D. Respiratory System Diseases and Disorders		
(1) With ventilator support < 96 hrs	475	Excludes 96.72
(2) With ventilator support 96+ hrs	475	Includes 96.72
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) [Reserved for future use]		

(6) Respiratory neoplasms	082
(7) [Reserved for future use]	
(8)	[Reserved for future use]
(9) COPD, Simple pneumonia with CC, Chest trauma w/o CC, and Other respiratory disorders	084, 088, 089, 093, 094, 099
(10) Tracheostomy for face, mouth and neck diagnoses	482
(11) Bronchitis and asthma with CC or Simple pneumonia and pleurisy except with CC	090, 091, 096
(12) Pleural effusion, Infection and inflammation with CC, Pulmonary edema and respiratory failure	079, 085, 087
(13) Pulmonary embolism and Other respiratory diseases with CC	078, 101
(14)	[Reserved for future use]
(15) Specific respiratory system diseases and disorders	080. 081, 083, 092
(16) Pleural effusion, Pneumothorax, Bronchitis and Other diagnoses without CC	086, 095, 097, 098, 100, 102
(17)	[Reserved for future use]
(18)	[Reserved for future use]
(19)Ventilator 96+ hours With ECMO/Tracheostomy with major surgery or With extensive burns with skin graft	504, 541
(20) Tracheostomy with ventilator 96+ hours or without major surgery	542
(21-74) [Reserved for future use]	
(75) Major chest procedures	075
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E. Circulatory System Diseases and Disorders	
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and vascular procedures, and Pacemaker device replacement	118, 120, 479, 518, 554, 556	
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(7) Drug-eluding stent, Other vascular procedures, Cardiac pacemaker with major CV diagnosis or AICD lead or generator	551, 553, 557, 558	
(8) Heart failure and shock and Unexplained cardiac arrest	127, 129	
(9) AMI without major complications, Cardiac cath without complex diagnoses, and Hypertension	122, 125, 134	
(10) Peripheral vascular disease with CC	130	
(11) Acute MI and Other circulatory diagnoses with CC, Endocarditis	121, 126, 134	
(12) ASHD with CC, Other circulatory conditions without CC, and Vein ligation and stripping	119, 132 139, 140, 143, 145	
(13) Deep vein thrombophlebitis, peripheral vascular disorders without CC, Congenital valve disease, age>17, and Arrhythmia with CC	128, 131, 135, 136, 138	
(14) Major CV procedure without CC, Acute MI, expired, and Cardiac cath with complex diagnosis	111, 123, 124	
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(17)Coronary bypass with and without cath, without major CV diagnosis	548, 550	
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(1) Anal/stomal, Hernia, Appendectomy and other procedures	158, 162, 163, 167	
(2) Hernia procedures age > 17, Appendectomy without complicating diagnosis with CC	160, 161, 166	
(3) Bowel and other digestive system surgery	147, 151, 153, 155, 157, 159, 165, 171	

(4) Stomach and esophagus procedures and Digestive disease, age 0-17	149, 156, 164, 172, 190
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(6) Rectal resection, Lysis of peritoneal adhesions and Other major bowel surgery	146, 148, 150, 154
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(7) Other surgery for liver, gall bladder and pancreas disease	192, 195, 197, 199, 200
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(3) Hip and femur procedures with CC and other musculoskeletal surgery	210, 217, 233, 471, 498, 501
(4) Surgeries of hip and lower extremity and cervical fusion without CC	212, 213, 216, 519, 544, 545
(5) Back and neck except fusion and Lower extremity procedures	211, 218, 220, 228, 234, 491, 499
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(13) [Reserved for future use]	
(14) [Reserved for future use]	
(15) [Reserved for future use]	
(16) [Reserved for future use]	
(17) [Reserved for future use]	

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(3) [Reserved for future use]	
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(1) Treated with surgical procedure	415
(2) Other infection and parasitic diseases	423
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(1) Treated with surgical procedure (ages 0+)	424
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(1) (Ages 0-20) with CC	521	DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66,

		94.67, 94.69
(2) (Ages > 20) with CC	521	DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
(3) Age 0-20, without CC and Rehab	523	
(4) Age > 20, without CC and Rehab	523	

U. [Reserved for future use]

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(2) [Reserved for future use]	
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Z. [Reserved for future use]

AA. [Reserved for future use]

BB. [Reserved for future use]

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(2) [Reserved for future use]		
(3) [Reserved for future use]		
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(5) Neonate respiratory distress syndrome	386	Codes in DRG 386 except 76501-76505
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(2) Weight 1250 to 1749 Grams	387	76506, 76510, 76515, 76516
(3) Weight > 1749 Grams	387	Codes in DRG 387 except 76500, 76506, 76510-76516
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(2) Other problems	390	

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TT. [Reserved for future use]	
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(3) Kidney transplant	302
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WW. Human Immunodeficiency Virus	
(1) Treated with extensive operating room procedure	488
(2) With major related condition	489
(3) With or without other related condition	490

B. Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part. The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS CODES
A. Nervous System Diseases and Disorders	001- 003, 006-035, 524 524, 528-534, 543, 559	except codes in category Y and Z
C. [Reserved for future use]		
D. [Reserved for future use]		
E. [Reserved for future use]		
F. [Reserved for future use]		
G. [Reserved for future use]		
H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues	210-213, 216-220, 223-230, 232-256, 471, 491, 496-503, 519, 520, 537, 538, 544-546	except codes in category Y and Z
I-Q [Reserved for future use]		
R. Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders	424-432, 521, 523	except codes in category Y and Z; DRG 521 excludes procedures 94.61, 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
S. Multiple Significant Trauma/ Unrelated Operating Room Procedures	468, 476, 477,	except codes in category Y and Z
T. Other Conditions Requiring Rehabilitation Services	036-106, 108, 110, 111, 113, 114, 117-208, 257-399, 401-423, 439-455, 461-467, 473, 475, 479-482, 488-490, 492-495, 504-513, 515, 518, 525, 535, 536, 539, 540-542, 547-558	except codes in category

		Y & Z
U. [Reserved for future use]		
V. [Reserved for future use]		
W. [Reserved for future use]		
X. [Reserved for future use]		
Y. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in paraplegia	All DRGs	Diagnosis codes 344.1, 806.21, 806.26 806.31, 806.36, 952.11, 952.16 in combination with 905.0, 907.0, or 907.2, excluding cases with 781.0, 781.2, 781.3, & 781.4
Z. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in quadriplegia or hemiplegia	All DRGs	Diagnosis codes 344.01-344.04, 344.09, 806.0x, 806.1x, or 952.0x in combination with 907.2, excluding cases with 781.0, 781.2, & 780.03; or Diagnosis codes 344.00-344.04, 344.09, 342.01, 342.81, or 342.91 in combination with 907.0 or 905.0, excluding cases 781.0, 781.3, & 780.03

C. Diagnostic categories for neonatal transfers. The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS CODES
AA. [Reserved for future use]		
BB. [Reserved for future use]		
CC. [Reserved for future use]		
DD. [Reserved for future use]		
EE. [Reserved for future use]		
FF. [Reserved for future use]		
GG. [Reserved for future use]		
HH. [Reserved for future use]		
II. [Reserved for future use]		
JJ. [Reserved for future use]		
KK. Extreme Immaturity and Tracheostomy		
(1) [Reserved for future use]		

Supersedes: 12-25 (11-30a, 11-22, 11-12, 11-05, 10-23,10-11,(09-21,09-13,09-08,09-02,08-10/07-12/07-11/07-03/07-02/05-13/04-15(a)/04-02/03-39/03-02/02-28/02-11/02-05/01-25/01-19/01-17/01-01/00-29/00-04/99-23/99-05/98-37/97-42/97-19/97-15/97-03/95-20/95-04/94-18/94-08/93-39/93-33/92-44/92-31/91-17/90-25)

(2) Weight < 750 Grams and Tracheostomy	386, 482, 541, 542	76501, 76502
(3) [Reserved for future use]		
(4) Weight 750 to 1499 Grams	386	765.03 to 765.05
	387	765.00
(5) Neonate Respiratory Distress Syndrome	386	Codes for DRG 386 except 76501-76505
LL. Prematurity with Major Problems	387	Codes for DRG 387 except 76500
MM. Prematurity without Major Problems (Weight > 1749 Grams)	388	
NN. Full Term Neonates		
(1) With major problems (age 0)	389	
(2) With other problems	390	

D. Additional DRG requirements.

1. Version 23 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

2. The discharge status will be changed to "discharge to home" for DRG 433.

3. A diagnosis with the prefix "v57" will be excluded when grouping under item B.

4. The discharge status will be changed to "discharge to home" when grouping under item A for a transfer to a Medicare rehabilitation distinct part.

5. A transfer from a hospital paid under a diagnostic category in item A, which includes ICD-9-CM procedure code 86.06 (implantation of a totally implantable infusion pump) for the treatment of spasticity, to a Medicare rehabilitation distinct part must include ICD-9-CM diagnosis code 781.0 when grouping under item B.

6. Neonates transferred into a neonatal intensive care unit with a DRG assignment of DRG 482, 541 or 542, age less than one year, will be grouped under item C.

7. The discharge status will be changed to "discharge to home" for all neonates in DRG 385, except for neonates that expire at the birth hospital and the discharge date is the same as the date of birth.

8. For payment of admissions that result from the unavailability of a home health nurse, and there is one or more acute episodes of illness during the admission resulting in changes in physician orders and the treatment plan, the principal diagnoses V58.89,

Other Specified Aftercare and V63.1, Medical Services in Home not Available will be excluded.

9. For neonates transferred into a neonatal intensive care unit within 28 days of birth, with a principal diagnosis of congenital anomaly (ICD-9-CM code 740-759) and a secondary diagnosis of conditions originating in the perinatal period (ICD-9-CM code 760-779), the principal diagnosis and the first sequenced secondary diagnosis in the range 760-779 will be interchanged when grouping under item C.

10. The admission source will be changed to "admitted as a transfer from another hospital" for neonates born before admission to the hospital and admitted directly to a Level IV neonatal intensive care unit.

11. For patients in DRG 386-390 and the age is greater than zero, the principal diagnosis fromICD-9-CM Chapter 15, Certain conditions originating in the perinatal period (diagnoses codes 760-779), will be excluded when grouping under item A.

12. For payment under DRG 521, alcohol/drug abuse or dependence with complications or comorbidities, payment is not made for patients engaged in alcohol and/or drug rehabilitation.

13. For DRG 003, the patient age will be changed to 18 years. If the admission subsequently groups to DRG 529 or 530, that DRG will be assigned. Otherwise the admission will remain in DRG 003.

14. The admission source will be changed to "admitted as a transfer from a different acute care hospital" for all newborns admitted to the hospital within the first 28 days after birth with a principal diagnosis of V29.0-V29.9.

15. The prematurity subcategory diagnosis codes 765.20 and 765.26 through 765.29 will be ignored when assigning a DRG if a diagnosis code from 764, 765 or 765.1 is not included on the claim.

Hospital-acquired condition. "Hospital-acquired condition" means a condition listed below that is not identified by the hospital as present on admission and is designated as a complicating condition or major complicating condition as specified in items A to B:

A. **Hospital-acquired conditions.** The following hospital-acquired conditions are for all admissions, except as provided in items B:

	ICD-9-CM
1. Foreign object accidentally retained after surgery	998.4, 998.7
2. Air embolism	999.1
3. Blood incompatibility reaction	999.6
4. Pressure ulcers stage III or IV	707.23, 707.24
5. Falls and trauma including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock	800-829, 830-839, 850-854 925-929, 940-949, 991-994
6. Catheter-associated urinary tract infection	996.64
7. Vascular catheter-associated infection	999.31
8. Manifestations of poor glycemic control	249.10, 249.11, 249.20,249.21 250.10-250.13, 250.20-250.23 251.0
9. Surgical site infection following orthopedic procedures	Dx 996.67, 998.59 Proc 81.01-81.08, 81.23-81.24, 81.31-81.38 81.83, 81.85
10. Surgical site infection following bariatric surgery	Dx 998.59 44.38-44.39, 44.95 for Principal Dx 278.01
11. Surgical site infection, mediastinitis following coronary artery bypass graft surgery	Dx 519.2 Proc 36.10-36.19
12. Deep vein thrombosis or pulmonary embolism following total knee or hip replacement	Dx 453.40-453.42, 415.11, 415.19 Proc 81.54, 00.85-00.87, 81.51-52

B. Additional hospital-acquired conditions requirements.

1. Deep vein thrombosis or pulmonary embolism following total knee or hip replacement is not a hospital-acquired condition for pediatric and obstetric patients.

Hospital cost index or HCI. "Hospital cost index" or "HCI" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare, which include direct and indirect medical education costs, but not to include the Medical Assistance hospital surcharge and without regard to adjustments in payments imposed by Medicare.

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

Local trade area hospital. "Local trade area hospital" means a MSA hospital with 20 or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year that is located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota.

Long-term care hospital. "Long-term care hospital" means a Minnesota hospital or a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

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

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means inpatient hospital costs excluding property costs.

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota excluding MSA hospitals located in a county of the other state in which the county is contiguous to Minnesota.

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

Rate year. "Rate year" means a calendar year from January 1 through December 31.

Rehabilitation distinct part. "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Relative value. "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within item A, B or C. The relative value is calculated from the total allowable operating costs of all admissions. This includes the full, untruncated costs of all exceptionally high cost or long stay admissions. Due to this inclusion of all costs, the relative value is composed of two parts. The basic unit of the relative value adjusts for the cost of an average admission within the given diagnostic category. The additional component of the relative value consists of an adjustment to compensate for the costs of exceptionally high cost admissions occurring within the diagnostic category. This factor, when applied to the base rate and the day outlier rate, cause additional payment

adjustments to be made to compensate for cost outliers typically found within the diagnostic category. Since all cost is included, the cost outlier threshold is the average cost and is set to pay a cost outlier adjustment for all admissions with a cost that is above the average. The amount of payment adjustment to the operating rate increases as the cost of an admission increases above the average cost.

Seven-county metropolitan area hospital. "Seven-county metropolitan area hospital" means a Minnesota hospital located in one of the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey , Scott, or Washington.

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

Trim point. "Trim point" means that number of inpatient days beyond which an admission is a day outlier.

SECTION 3.0 ESTABLISHMENT OF BASE YEARS

A. The base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year data will be moved forward three years beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995, except for 1997, 2005, 2009, and 2011 or every one year if notice is provided at least six months prior to the rate year by the Department. For the January 1, 2011 rebased rate year, rates for Minnesota long term care hospitals (section 9.02) only shall be rebased to the most recent hospital fiscal year ending on or before September 1, 2008 not including payments described in section 13.01 or section 15.04. Effective January 1, 2013, and after, rates for all hospitals shall not be rebased ~~at full value~~. For long-term care hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report. That base year will remain until it falls within the same period as other hospitals.

SECTION 4.0 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES

4.01 Determination of relative values. The Department determines the relative values of the diagnostic categories as follows:

A. Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

B. Exclude the claims and charges in subitems (1) to (7):

(1) Medicare crossover claims;

(2) claims paid on a transfer rate per day according to Section 10.03;

(3) inpatient hospital services for which Medical Assistance payment was not made;

(4) inpatient hospital claims paid to a long-term care hospital;

(5) inpatient hospital services not covered by the Medical Assistance program on October 1 prior to a rebased rate year;

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges; and

(7) inpatient hospital services paid under Section 15.11.

C. Combine claims into the admission that generated the claim according to readmissions at Section 12.2.

D. Determine operating costs for each hospital admission using each hospital's base year data according to subitems (1) to (5).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist costs and charges if the hospital determines that certified registered nurse anesthetist services will be paid separately.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products

of all teaching program accommodation services.

(4) Add subitems (1) to (3).

(5) Multiply the result of subitem (4) by the hospital cost index at Section 7.0 that corresponds to the hospital's fiscal year end.

E. Assign each admission and operating cost identified in item D, subitem (5), to the appropriate diagnostic category in routine inpatient hospital services, rehabilitation distinct part or neonatal transfers at receiving hospitals with a neonatal intensive care unit.

F. Determine the mean cost per admission within routine inpatient hospital services and the rehabilitation distinct part for routine inpatient hospital services and the rehabilitation distinct part admissions identified in item E by dividing the sum of the operating costs by the total number of admissions.

G. Determine the mean cost per admission for each diagnostic category identified in item E for routine inpatient hospital services and for the rehabilitation distinct part specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

H. Determine the relative value for each diagnostic category by dividing item G by the corresponding result of item F for routine inpatient hospital services and the rehabilitation distinct part specialty group and round the quotient to five decimal places.

I. Determine the mean length of stay for each diagnostic category identified in item E for routine inpatient hospital services and rehabilitation distinct part by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

J. Determine the day outlier trim point for each diagnostic category for routine inpatient hospital services and the rehabilitation distinct part specialty group and round to whole days.

SECTION 5.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER

5.01 Adjusted base year operating cost per admission for Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per admission routine inpatient hospital services and the rehabilitation distinct part specialty group for each hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to Section 4.01, items A to E.

B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments. For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within routine inpatient hospital services and rehabilitation distinct part specialty group, and divide this amount by the number of admissions within routine inpatient hospital services and the rehabilitation distinct part specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions for routine inpatient hospital services and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.02 Adjusted base year operating cost per day outlier for Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per day outlier for routine inpatient hospital services and the rehabilitation distinct part specialty group for each hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in Section 5.01, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days for routine inpatient hospital services and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.03 Out-of-area hospitals. The Department determines the adjusted base year operating cost per admission and per day outlier for routine inpatient hospital services according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier for each Minnesota and local trade area hospital determined in Sections 5.01 and 5.02 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

5.04 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions or five or more day outlier Medical Assistance admissions in the base year and low volume local trade area hospitals. The Department determines the adjusted base year operating cost per admission or per day outlier for routine inpatient hospital services according to items A to C.

A. Multiply each adjusted base year cost per admission and per day outlier for each Minnesota MSA and local trade area hospital determined in Sections 5.01 and 5.02 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

5.05 Non-MSA hospitals that do not have five or more Medical Assistance admissions or

five or more day outlier Medical Assistance admissions in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier for routine inpatient hospital services for non-MSA hospitals by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 5.04.

5.06 Minnesota and local trade area hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) rehabilitation distinct part specialty group admissions or five or more day outlier Medical Assistance rehabilitation distinct part specialty group admissions in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals by substituting Minnesota and local trade area hospital terms and data for the metropolitan statistical area hospital terms and data under Section 5.04.

5.07 Non-seven-county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital adjusted base year operating cost per admission or per day outlier, for routine inpatient hospital services and the rehabilitation distinct part specialty group under Section 15.10, by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 5.04.

5.08 Limitation on separate payment. Out-of-area hospitals that have a rate established under Section 5.03 may not have certified registered nurse anesthetists services paid separately from this Attachment.

SECTION 6.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY

6.01 Neonatal transfers For Minnesota and local trade area hospitals, the Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit (NICU) specialty group according to items A to F.

A. Determine the operating cost per day within each diagnostic category as defined at Section 2.0, item D, according to Section 4.01, items A to E, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

B. Determine relative values for each diagnostic category at Section 2.0, item D, according to Section 4.01, items F, G, and H, after substituting the term "day" for "admission."

C. For each Minnesota and local trade area hospital that has admissions that result from a

transfer to a neonatal intensive care unit specialty group, determine the operating cost for each admission according to Section 4.01, items A to E.

D. Add the results for each admission in subitem C.

E. Divide the total from item D by the total corresponding inpatient hospital days for each admission in item C.

F. Adjust item E for case mix according to Section 5.01, subitem D, after substituting the term "day" for "admission."

6.02 Minnesota and local trade area hospitals that do not have five or more Medical Assistance neonatal transfer admissions in the base year. The Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a NICU specialty group according to items A to C.

A. Multiply each adjusted base year operating cost per for each Minnesota and local trade area hospital determined in Section 6.01, item F, by the number of corresponding days in the hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total days for all Minnesota and local trade area hospitals and round that amount to whole dollars.

6.03 Non-seven-county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a NICU under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.02.

6.04 Long-term care hospital.

The Department determines the base year operating cost per day for long-term care hospitals for the rate year according to items A and B.

A. Determine the operating cost per day according to Section 4.01, items A to D, except that claims excluded in Section 4.01, item B, subitems (2) and (4), will be included.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

6.05 Long-term care hospitals that do not have five or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year. The Department determines the operating cost per day according to items A to C.

A. Multiply each operating cost per day for each long-term care hospital as determined in Section 6.04, item B, by the number of corresponding days in that hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total days for all long-term care hospitals and round that amount to whole dollars.

SECTION 7.0 DETERMINATION OF HOSPITAL COST INDEX (HCI)

7.01 Adoption of HCI. The most recent *Health Care Costs* published by Data Resources Incorporated (DRI) is used.

7.02 Determination of HCI. For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the Department determines the HCI according to items A to C.

A. For each rate year, the Department obtains from DRI the average annual historical and projected cost change estimates in a decimal format for the operating costs by applying the change in the Consumer Price Index - All Items (United States city average) (CPI-U) in the third quarter of the prior rate year.

B. Add one to the amounts in item A and multiply these amounts together. Round the result to three decimal places.

C. For the 2002 rate year and after, the HCI is zero.

SECTION 8.0 DETERMINATION OF PROPERTY COST PER ADMISSION

8.01 Minnesota and local trade area hospitals. The Department determines the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each admission in Section 4.01, item C, using each

hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost-to-charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in Section 4.01, item C, using each hospital's base year data and recent year Medicare cost report data that was submitted by the October 1 prior to a rebased rate year according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission for routine hospital services and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3) to routine inpatient hospital services, the rehabilitation distinct part or neonatal transfers at receiving hospitals with a neonatal intensive care unit.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within routine inpatient hospital services, the rehabilitation distinct part or neonatal transfers at receiving hospitals with a neonatal intensive care unit in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

8.02 Out-of-area hospitals. The Department determines the property cost per admission for routine inpatient hospital services according to items A to C.

A. Multiply each property cost per admission for each Minnesota and local trade area hospital determined in Section 8.01, item D, subitem (3), by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

8.03 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year and low volume local trade area hospitals. The Department determines the property cost per admission for routine inpatient hospital services according to items A to C.

A. Multiply each property cost per admission for each Minnesota MSA and local trade area hospital determined in Section 8.01, item D, subitem (3), by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total admissions for all Minnesota MSA hospitals and local trade area hospitals and round the resulting amount to whole dollars.

8.04 Non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year. The Department determines the property cost per admission for routine inpatient hospital services for non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year by substituting non-MSA area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 8.03.

8.05 Minnesota and local trade area hospitals that do not have five or more Medical

Assistance (including General Assistance Medical Care, a State-funded program) rehabilitation distinct part specialty group admissions in the base year. The Department determines the property cost per admission for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year substituting Minnesota and local trade area hospital terms and data for the Minnesota MSA and local trade area hospital terms and data under Section 8.03.

8.06 Non-seven county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital property cost per admission for routine inpatient hospital services and the rehabilitation distinct part specialty group under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 8.03.

SECTION 9.0 DETERMINATION OF PROPERTY COST PER DAY

9.01 Neonatal transfers.

A. For Minnesota and local trade area hospitals, the Department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a NICU specialty group according to Section 8.01, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area hospitals that do not have five or more Medical Assistance neonatal transfer admissions in the base year, the Department determines the neonatal transfer property cost per day for admissions in the base year according to Section 8.03 after substituting the term "day" for "admission."

C. For non-seven-county metropolitan area hospitals, the Department will determine the non-seven-county metropolitan area hospital neonatal transfer property cost per day for neonatal transfer admissions in the base year under Section 15.10 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data according to Section 8.03, after substituting the term "day" for "admission."

9.02 Long-term care hospitals.

A. For long-term care hospitals, the Department determines the property cost per day according to Section 9.01, item A, except that claims excluded in Section 4.01, item B, subitems (2) and (4), will be included.

B. For long-term care hospitals that do not have five or more Medical Assistance

(including General Assistance Medical Care, a State-funded program) long-term care hospital admissions in the base year, the Department determines a long-term care hospital property cost per day according to Section 8.03, after substituting the term "day" for "admission."

SECTION 10.0 DETERMINATION OF RATE PER ADMISSION AND PER DAY

10.01 Rate per admission. The Department determines the routine inpatient hospital services or rehabilitation distinct part specialty group rate per admission for Minnesota and local trade area hospitals as follows:

The payment rates are based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year HCI.

Rate Per Admission = [{(Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission} and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment]

10.02 Rate per day outlier. The day outlier rate is in addition to the rate per admission and will be determined for routine inpatient hospital services or the rehabilitation distinct part specialty group as follows:

A. The rate per day for day outliers is determined as follows:

Outlier Rate Per Day = {Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment}

B. The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services, excluding days paid under Section 15.11.

10.03 Transfer rate. Except for admissions subject to Section 10.04, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is

transferred will be determined as follows:

Transfer Rate = {(The rate per admission in item A, below, divided by the arithmetic mean
Rate Per Day length of stay of the diagnostic category)}

A. A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission unless that admission is a day outlier.

B. Except as applicable under Section 12.2, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.

C. An admission that directly precedes an admission to a non-state operated hospital that provides inpatient hospital psychiatric services pursuant to Section 15.07 that is paid according to a contracted rate per day with the Department is exempt from a transfer payment.

10.04 Rate per day.
A. Admissions resulting from a transfer to a NICU specialty group and classified to a diagnostic category of Section 2.0, item D will have rates determined according to Section 10.01 after substituting the word "day" for "admission."

B. Admissions for patients that are not transfers under Section 10.04, item A and are equal to or greater than the age of one at the time of admission and are classified to diagnostic categories KK1 through NN2 of Section 2.0, items A and B with a length of stay less than 50 percent of the mean length of stay for its diagnostic category under Section 4.01, item J, will be paid according to Section 10.03.

C. Admissions or transfers to a long-term care hospital for the rate year will have rates determined according to Section 10.01 after substituting the word "day" for "admission," without regard to relative values.

10.05 Neonatal respiratory distress syndrome. For admissions to be paid under diagnostic category KK5 of Section 2.0, items A and B, inpatient hospital services must be provided in a level II or above nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

SECTION 11.0 RESERVED

SECTION 12.0 PAYMENT PROCEDURES

12.1 Submittal of claims. Hospital billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the diagnostic category.

12.2 Payment for readmissions. An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)

A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:

(1) A recipient leaving the hospital of the first admission against medical advice;

(2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or

(3) A recipient having a new episode of an illness or condition.

B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:

(1) Hospital or physician scheduling conflict;

(2) Hospital or physician preference other than medical necessity;

(3) Patient preference; or

(4) Referral.

C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.

12.3 Non-payment for hospital-acquired conditions. Effective for admissions on or after July 1, 2009, no payment will be made for the care, additional treatment or procedures,

readmission to the hospital after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital when the charges are attributable to a hospital-acquired condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired condition was acquired is responsible for any cost incurred at the hospital to which the patient with the hospital-acquired condition is transferred.

12.4 Limit on payment rate for certain deliveries. Effective for admissions on or after October 1, 2009, a hospital's payment rate for the DRGs listed below shall be no greater than $3,528, exclusive of the adjustments under sections 13.01 to 13.05 and 15.04.

(1) cesarean section without complicating diagnosis	371
(2) vaginal delivery with complicating diagnosis	372
(3) vaginal delivery without complicating diagnosis or operating room procedures	373

SECTION 13.0 DISPROPORTIONATE POPULATION ADJUSTMENT

13.01 Disproportionate population adjustment or DPA eligibility. A Minnesota or local trade area hospital that is not state-owned, that is not a facility of the federal Indian Health Service, and that meets the criteria of items A to D is eligible for an adjustment to the payment rate.

A. A hospital must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medical Assistance recipients. For non-MSA hospitals the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. A hospital that did not offer non-emergency obstetric services as of December 21, 1987 or a hospital whose inpatients are predominately under 18 years of age is not subject to item A.

C. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds 1 percent.

D. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds the arithmetic mean for Minnesota and local trade area hospitals or a low-income inpatient utilization rate that exceeds .25, determined as follows:

Medical Assistance Inpatient Utilization Rate = Medical Assistance inpatient days divided by total inpatient days

If the hospital's Medical Assistance inpatient utilization rate is at the mean, the calculation is carried out to as many decimal places as required to show a difference.

Low Income Utilization Rate = [(Medical Assistance revenues and any cash subsidies received by the hospital directly from state and local government) divided by (total revenues, including the cash subsidies amount for patient hospital services)] plus [(inpatient charity care charges less the cash subsidies amount) divided by (total inpatient charges)]

For purposes of this section, "charity care" is care provided to individuals who have no source of payment from third party or personal resources.

13.02 Medical Assistance inpatient utilization DPA. If a hospital meets the criteria of Section 13.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean in Section 13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient utilization rate.

B. Add 1.0 to the amount in item A.

C. If a hospital meets the criteria of Section 13.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 13.01, item C, the payment adjustment determined under item A is multiplied by 1.1, and added to 1.0.

13.03 Low income inpatient utilization DPA. If a hospital meets the criteria of Section 13.01, items A or B and the low-income inpatient utilization rate under item C, the payment adjustment is determined as follows:

A. Subtract .25 from the hospital's low-income inpatient utilization rate.

B. Add 1.0 to item A if item A is positive.

13.04 Other DPA. If a hospital meets the criteria of Section 13.01, items A or B and both the Medical Assistance inpatient utilization rate criteria and the low-income inpatient utilization rate criteria, the DPA is determined as described in Section 13.02.

13.05 Rateable reduction to DPA. If federal financial participation is not available for all payments made under Sections 13.01 to 13.04, the payments made shall be rateably reduced a

percentage sufficient to ensure that federal financial participation is available for those payments as follows:

A. Divide the federal DPA limit by the total DPA payments to determine an allowable DPA payment ratio.

B. Multiply the result of item A by each hospital's DPA under Sections 13.02 or 13.03.

C. Add 1.0 to the amount in item B.

13.06 Additional DPA. Effective for admissions on or after September 1, 2011, a DPA will be paid to eligible hospitals in addition to any other DPA payment calculated under Sections 13.01 to 13.04. Payments by the State from the MinnesotaCare Program to qualifying hospitals for services provided to individuals not eligible for Medicaid will be considered DPA payments under this section, within the following limitations:

A. Only to the extent that federal funding remains in Minnesota's allotment for disproportionate share hospitals under §1923(f) of the Act after DPA payments in Section 13.02 to 13.04 have been made for the federal fiscal year.

B. Only to the extent that the DPA payments under this section, combined with all other DPA payments, would not exceed the hospital's individual disproportionate share hospital limit under §1923 of the Social Security Act.

MinnesotaCare payments will be counted against Minnesota's disproportionate share hospital allotment in the following order:

(1) fee-for-service inpatient claims;

(2) fee-for-service payments for outpatient hospital services;

A qualifying hospital under this section is one that meets the requirements of Section 13.01, items A or B, and item C. A hospital may elect on an annual basis to not be a disproportionate share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 13.01 to 13.04.

C. The payment rate for MinnesotaCare admissions for persons not eligible for Medicaid for purposes of calculating the DPA under this section is the same rate as the rate under this Attachment for medical assistance, except that the adjustments in sections 15.08 and 15.09 are not included.

Supersedes: 12-25 (11-30a, 11-22, 11-12, 11-05, 10-23,10-11,(09-21,09-13,09-08,09-02,08-10/07-12/07-11/07-03/07-02/05-13/04-15(a)/04-02/03-39/03-02/02-28/02-11/02-05/01-25/01-19/01-17/01-01/00-29/00-04/99-23/99-05/98-37/97-42/97-19/97-15/97-03/95-20/95-04/94-18/94-08/93-39/93-33/92-44/92-31/91-17/90-25)

13.07 Additional DPA. Effective for services delivered on or after June 1, 2010 and before March 1, 2011, a DPA will be paid to eligible hospitals in addition to any other DPA payment calculated under Sections 13.01 to 13.04. Payments by the State to qualifying hospitals will be considered DPA payments under this section, within the following limitations:

A. Only to the extent that federal funding remains in Minnesota's allotment for disproportionate share hospitals under §1923(f) of the Act after DPA payments in Section 13.02 to 13.04 have been made for the federal fiscal year.

B. Only to the extent that the DPA payments under this section, combined with all other DPA payments, would not exceed the hospital's individual disproportionate share hospital limit under §1923 of the Social Security Act.

C. Total payments under this section do not exceed the available funding for each calendar quarter.

A qualifying hospital under this section is a hospital that has contracted with the State to serve as a Coordinated Care Delivery System for the applicable quarter and meets the requirements in section 13.01.

The total available funding per quarter is distributed to qualifying hospitals in the following manner.

A. The total amount of fee-for-service GAMC inpatient and outpatient hospital payments made to all of the qualifying hospitals in calendar year 2008 is calculated and each qualifying hospital is assigned a distribution percentage based on its share of the GAMC payments to all of the qualifying hospitals. The GAMC payment amounts for Hennepin County Medical Center, Regions Hospital, Saint Mary's Medical Center, and the University of Minnesota Medical Center – Fairview Hospital, will be weighted at 110 percent.

B. The total available funding for each quarter will be distributed to each qualifying hospital based on the distribution percentage calculated in paragraph A.

C. The base year GAMC fee-for-service payment amounts in paragraph A will be updated by one calendar year each June 1, beginning June 1, 2011.

13.08 Additional DPA. Effective for services delivered on or after June 1, 2010 through February 28, 2011 a DPA will be paid to eligible hospitals from temporary uncompensated care pool in addition to any other DPA payment calculated under Sections 13.01 to 13.04. Payments by the State from the temporary uncompensated care pool to qualifying hospitals will be considered DPA payments under this section, within the following limitations:

A. Only to the extent that federal funding remains in Minnesota's allotment for disproportionate share hospitals under §1923(f) of the Act after DPA payments in Section 13.02 to 13.04 have been made for the federal fiscal year.

B. Only to the extent that the DPA payments under this section, combined with all other DPA payments, would not exceed the hospital's individual disproportionate share hospital limit under §1923 of the Social Security Act.

C. Total payments under this section do not exceed the $30 million in available funding for the temporary uncompensated care pool.

A qualifying hospital under this section is a hospital that has not contracted with the State to serve as a Coordinated Care Delivery System, has submitted claims against the temporary uncompensated care pool for the applicable time period, and meets the requirements in section 13.01.

The total available funding is distributed to qualifying hospitals in the following manner:

A. Each hospital will submit claims for inpatient and outpatient hospital care delivered to uninsured individuals that are not enrolled in a Coordinated Care Delivery System and meet the eligibility requirements under Minnesota Stat. §256D031. The claims will be priced, but not paid, using the rate methodology described in Supplement 1 of this Attachment except that the payment reduction at section 15.23 of Supplement 1 will not apply.

B. Qualifying hospitals will be assigned a distribution percentage based on each hospital's share of the total price of all claims submitted by all qualifying hospitals for the temporary uncompensated care pool.

C. Payments will be made to each qualifying hospital equal to the distribution percentage multiplied by the total uncompensated care pool funding.

Two quarterly interim payments will be made using the same methodology as the final payment and will be reconciled to one annual payment based on the final distribution percentage of each qualifying hospital by June 30, 2011.

13.09 Additional DPA. Effective for costs incurred on or after July 1, 2006, a DPA payment in addition to those payments described in 13.01 through 13.06 will be paid to eligible hospitals.

The amount of the payment will be equal to the remaining uncompensated care costs of the hospital after taking into account the payments described in 13.01 through 13.06 as determined

by the certified audit described in 42 CFR §§ 455.300 – 455.304. Payment will be distributed in the quarter following the quarter in which the certified DSH audit is completed.

Payments under this section will be limited by each hospital's facility specific DSH limit, as defined in section §1923(g)(1) of the Social Security Act, and the overall DSH allotment for the state.

For the purposes of this section, an eligible hospital is defined as a seven county metropolitan area hospital that:

A) Meets the criteria for payment under section 13.02 (C), and

B) is owned or operated by a county.

SECTION 14.0 APPEALS

A hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that are discovered as a result of the submission of appeals will be implemented. Regardless of any appeal outcome, relative values shall not be recalculated.

The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Department and the Office of Administrative Hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Department's determination is incorrect or not according to law.

A. To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the Department within 60 days of the date the payment rate determination was mailed to the hospital. The appeal request shall specify:

(1) The disputed items.

(2) The authority in federal or state statute or rule upon which the hospital relies for each disputed item.

(3) The name and address of the person to contact regarding the appeal.

B. To appeal a payment rate or payment change that results from a difference in case mix

between the base year and the rate year, the procedures and requirements listed above apply. However, the appeal must be filed with the Department or postmarked within 120 days after the end of the rate year. A case mix appeal must apply to the cost of services to all Medical Assistance patients who received inpatient services from the hospital for which the hospital received Medical Assistance payment, excluding Medicare crossovers. The appeal is effective for the entire rate year. A case mix appeal excludes Medical Assistance admissions that have a relative value of zero for its DRG.

For a case mix appeal filed after July 1, 1997, the combined difference in case mix for Medical Assistance and General Assistance Medical Care, a State-funded program, must exceed five percent. For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.

C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins on the mailing date of the notice by the Medicare program or the date the Medical Assistance payment rate determination notice is mailed, whichever is later.

D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.

SECTION 15.0 OTHER PAYMENT FACTORS

15.01 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

15.02 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42,

sections 248A and 248B.

15.03 Small rural payment adjustment.

A. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20 percent.

B. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds and greater than 100 but fewer than 250 Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15 percent.

The payment adjustment does not include Medicare crossover admissions in the admissions count nor are Medicare crossover admissions eligible for the percentage increase. Minnesota hospitals located in a city of the first class are not eligible for the payment adjustment in this section. Minnesota hospitals that receive the non-seven-county metropolitan area hospital payment adjustment under Section 15.10 are also not eligible for the payment adjustment in Section 15.03.

The small rural payment adjustment is reduced by the amount of the hospital's DPA under Sections 13.01 to 13.05 and the hospital payment adjustment under Section 15.04.

15.04 Hospital payment adjustment. If federal financial participation is not available for all payments made under Sections 13.01 to 13.04 and payments are made under Section 13.05 or if a hospital does not meet the criteria of Section 13.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 13.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 13.01 to 13.04.

Payments made under this section are not disproportionate share hospital payment adjustments under §1923 of the Social Security Act.

15.05 [Reserved]

15.06 Out of state negotiation. Out-of-area payments will be established based on a negotiated rate if a hospital shows that the automatic payment of the out-of-area hospital rate per admission is below the hospital's allowable cost of the services. A rate is not negotiated until the claim is received and allowable costs are determined. Payments, including third party liability, may not exceed the charges on a claim specific basis for inpatient hospital services that are covered by Medical Assistance.

15.07 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payor of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts: If the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

15.08 Medical education.

In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

15.09 Additional adjustment for Certain Hospitals

A. Hennepin County Medical Center and Regions Hospital. Effective July 15, 2001, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment, in total for Hennepin County Medical Center and for Regions Hospital, will be made each year, after the close of the federal fiscal year, that is the difference between the non-State government-owned or operated hospital Medicare upper payment limit, as specified in Code of Federal Regulations, title 42, section 447.272, using current Medicare payment methods for hospitals, and the non-State government-owned or operated hospital payments of this Attachment.

B. Effective for the payment attributable to FFY 2010, and thereafter, out of the total available funding described in paragraph (A) payments to each of the two hospitals will be determined by:

(1) Calculating an upper payment limit for each of the hospitals receiving payment under this section using the same methodology applied to the entire group of non-State government-owned hospitals.

(2) Calculating a ratio for each of the hospitals receiving a payment under this section that is equal to:

the difference between the upper payment limit for each hospital computed in step (1) and total Medicaid payments to that hospital and, if positive,

divided by the sum of the positive amounts of the differences between the upper

payment limit and the Medicaid payments to each of the hospitals.

(3) Applying the ratio computed in step (2) to the difference between the upper payment limit for the non-State government-owned group of hospitals and total Medicaid payments to that group of hospitals.

15.10 Non-seven-county metropolitan area hospital payment adjustment. For a Minnesota hospital located outside of the seven-county metropolitan area, effective for admissions occurring on or after July 1, 2001 for the DRGs listed below, if 90 percent of the seven-county metropolitan area hospital payment is greater than the hospital's payment, exclusive of Sections 13.01 to 13.05 and 15.04, then payment is made at 90 percent of the seven-county metropolitan area hospital payment, inclusive of the hospital's adjustment under Sections 13.01 to 13.05 and 15.04. This payment adjustment will not exceed the Medicare upper limit as specified in Code of Federal Regulations, title 42, section 447.272.

(1)	cesarean section with complicating diagnosis	370
(2)	cesarean section without complicating diagnosis	371
(3)	vaginal delivery with complicating diagnosis	372
(4)	vaginal delivery without complicating diagnosis or operating room procedures	373
(5)	extreme immaturity	386
(6)	prematurity without major problems	388
(7)	full term neonates with other problems	390
(8)	normal newborns	391
(9)	neonates, died on birth date	385
(10)	acute adjustment reaction and psychosocial dysfunction	425
(11)	psychosis	430
(12)	childhood mental disorders	431
(13)	appendectomy	164-167

15.11 Admissions with length of stay exceeding 365 days. Effective January 29, 2002, the following payment is in addition to the rate per admission under Section 10.01 and the rate per day outlier under Section 10.02 for inpatient hospital services provided beyond 365 days:

[(Hospital operating cost-to-charge ratio determined in Section 4.01, item D, subitem (4) for all admissions, including General Assistance Medicare Care, a State-funded program) multiplied by (charges for those inpatient hospital services beyond 365

Payment = days) multiplied by (disproportionate population adjustment) and multiplied by (the small, rural hospital adjustment) multiplied by (the hospital payment adjustment)]

The payment is not applicable to rate per day payments under Section 10.04.

15.12 Reduction. For admissions on or after July 1, 2002, except those paid under Section 15.07, the total payment, before third-party liability and spenddown, is reduced by .5 percent.

15.13 Reduction. In addition to the reduction in Section 15.12, for admissions on or after March 1, 2003, except those paid under Section 15.02 and the psychiatric diagnostic categories, the total payment, before third-party liability and spenddown, is reduced by five percent.

15.14 Increase. Effective with admissions on or after January 1, 2004, the total payment, after third-party liability and spenddown, and Sections 15.12, 15.13, 15.16, 15.17, 15.18, 15.19, 15.21, and 15.22 is increased by two percent for Minnesota hospitals.

15.16 Reduction. In addition to the reductions in Sections 15.12 and 15.13, effective with admissions on or after August 1, 2005, except those paid under Section 15.02 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by six percent.

15.17 Reduction. In addition to the reductions in Sections 15.12, 15.13, and 15.16 effective with admissions on or after July 1, 2008 through June 30, 2009, except those paid under Section 15.02 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 3.46 percent.

15.18 Reduction. In addition to the reductions in Sections 15.12, 15.13, 15.16, and 15.21 effective with admissions on or after July 1, 2009 through June 30, 2011, except those paid under Section 15.02 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.9 percent.

15.19 Reduction. In addition to the reductions in Sections 15.12, 15.13, 15.16, and 15.21 effective with admissions on or after July 1, 2011, except those paid under Section 15.02 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.79 percent.

15.20 [Reserved]

15.21 Reduction In addition to the reduction in Section 15.12, 15.13, 15.16, and 15.18 and

15.19 when applicable, for admissions on or after July 1, 2009, except those paid under Section 15.02 the total payment, after third-party liability and spenddown, is reduced by one percent.

15.22 Hearing detection fee increase. Effective for admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under Minnesota Statutes §141.125, subdivision 1, that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

15.23 Reduction In addition to the reduction in Section 15.12, 15.13, 15.16, 15.19, and 15.21, for admissions on or after July 1, 2011, except those paid under Section 15.02, the total payment, after third-party liability and spenddown, is reduced by 1.96 percent.

15.24 **Reduction** In addition to the reduction in Section 15.12, 15.13, 15.16, 15.19, 15.21, and 15.23, for admissions occurring on or after September 1, 2011, through June 30, 2015, except those paid under Section 15.02, long-term hospitals as determined under Medicare, children's hospitals whose patients are predominantly under 18 years of age, the total payment, after third-party liability and spenddown, is reduced by 10 percent.

15.25 **Payment Adjustment for Provider Preventable Conditions.** The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

The State identifies the following Health Care-Acquired Conditions for non-payment under section 12.3 of Attachment 4.19-A:

X Hospital-Acquired Conditions as identified by Medicare and described in section 2.0.

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 5.a. of Attachment 4.19-B:

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

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

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

~~**Identification of Eligible Costs for Reimbursement through Disproportionate Population Adjustments (DPA also known as DSH) Payments**~~

~~The Minnesota Department of Human Services will determine fee for service and managed care Medical Assistance and uncompensated care costs for hospitals based on the protocol outlined below.~~

~~**Interim Hospital Payment Related to Medical Assistance Costs (Medicaid Shortfall)**~~

~~The purpose of the interim Medical Assistance inpatient and outpatient hospital DPA payment is to establish the Medical Assistance inpatient and outpatient hospital eligible costs for the purpose of using a portion of those costs to make a DSH payment in a state fiscal year. The source documents for hospital Medical Assistance fee for service days and charge data is the Department's MMIS claim system. The source document for hospital Medical Assistance managed care days and charge data is the hospital's managed care day and charge file as verified by the Department. The hospital will submit to the Department, a file containing patient demographic information, day and charge data by cost center, and total payment data (including co-insurance) for each managed care inpatient and outpatient hospital service during the cost reporting period. The Department will match the patient demographic (name, DOB, SSN, recipient ID) and date of service data in the file received from the hospital to the information in the Department's Medical Assistance eligibility system. The Department will modify the hospital file by deleting any data that is not associated with Medical Assistance and return the modified file to the hospital for inclusion in the cost report.~~

~~The source document for identifying eligible fee for service and managed care costs is a hospital's most recent CMS 2552-96 cost report as filed with the Medicare fiscal intermediary. The costs from the CMS 2552-96 are those that are allowable under Medicare cost principles and determined using the Title XIX format. On the CMS 2552-96, total allowable costs for each cost center are from Worksheet B, Part I, column 25 (instead of 27), which includes interns and residents costs since such costs are not separately reimbursed for direct graduate medical education via a per resident amount methodology. These costs are included in the Worksheet C and D series in the Title XIX format. The Medical Assistance days and charge data are for inpatient and outpatient hospital services and exclude non-hospital services including, but not limited to professional services, and non-hospital component services including but not limited to hospital based nursing and rural health clinic facilities, ambulance services, and physician professional services. An interim annual payment amount will be determined for each state fiscal year.~~

~~The Department will use the protocol outlined below to determine the interim payment for the hospital's uncompensated care costs for treating Medical Assistance fee for service and managed care patients:~~

~~1. Medical Assistance costs for inpatient ancillary services are calculated by multiplying the total Medical Assistance inpatient ancillary charges applicable to each ancillary service cost center by that ancillary service cost center's ratio of costs to charges (RCCs) from Worksheet D-4, column 1, lines 37 to 62. Total inpatient ancillary service cost is reported on Worksheet D-4, column 3, line 101.~~

~~2. Medical Assistance costs for outpatient ancillary services are calculated by multiplying the total Medical Assistance outpatient charges applicable to each ancillary service cost center by that ancillary service cost center's RCCs from Worksheet D, Part V, column 1, lines 37 to 62. Total outpatient ancillary service cost is reported on Worksheet D, Part V, column 9, line 101 and Worksheet E-3, Part III, column 1, line 2.~~

~~3. Medical Assistance costs for inpatient routine services are calculated by multiplying the total Medical Assistance inpatient days applicable to each routine service cost center by that routine service cost center's average per diem cost from Worksheet D-1, Part II, column 1, line 38 and column 3, lines 42 to 47.03.~~

~~4. Medical Assistance costs for inpatient routine and ancillary services are reported on Worksheet D-1, Part II, column 1, line 49 and Worksheet E-3, Part III, column 1, line 1.~~

~~5. The total cost for Medical Assistance services is the sum of items 4 and 2 and reported on Worksheet E-3, Part III, column 1, line 6.~~

~~6. Hospital payments for Medical Assistance services for coinsurance, recipient resources, and third party liability are reported on Worksheet E-3, Part III, column 1, line 36.~~

~~7. Hospital payments for Medical Assistance services, excluding DPA and supplemental payments, are reported on Worksheet E-3, Part III, column 1, line 57.~~

~~8. The interim payment before application of the supplemental payments on Worksheet E-3, Part III, column 1, line 58 is item 5 less items 6 and 7.~~

~~9. The Department will ensure that the amounts in item 8 are reduced by the total amount hospital's supplemental Medical Assistance payments.~~

~~10. The Department will verify that the hospital has used the Medical Assistance data generated from the MMIS claims system, the managed care day encounter file as verified by the Department using the patient demographic data match, and the most recent as filed CMS-2552-96 report.~~

~~11. The hospital will certify the CMS-2552-96, Title XIX format. This certification will be completed prior to each claim.~~

~~Reconciliation of Interim Hospital Payment Related to Medical Assistance Costs~~

~~Each non-state, government-owned hospital's interim payment will be subsequently reconciled by the Department based on the hospital's two CMS 2552-96 cost reports that correspond to the state fiscal year in which the interim payment was made as cost reports are filed with the Medicare fiscal intermediary and again as the cost reports are finalized by the Medicare fiscal intermediary. If at the end of the interim or final reconciliation process it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.~~

~~1. The interim and final reconciliation processes will use the same computation methodology as described for the interim DPA payment except that the hospital Medical Assistance days, charge and payment data from the MMIS claim systems and the managed care encounter file as verified by the Department will be updated, and the CMS 2552-96 cost reports will correspond to the state fiscal year in which the interim payment was made. Revenue offset data will also be updated and verified.~~

~~2. Any differences between the interim payment amount and the interim and final reconciled payment amounts will be made as a prior period adjustment on the CMS 64.~~

~~Interim Hospital Payment Related to Costs Incurred Providing Services to Uninsured Patients (Uncompensated Care)~~

~~The purpose of the interim uninsured inpatient and outpatient hospital DPA payment is to establish the uninsured inpatient and outpatient hospital DSH eligible costs for the purpose of using a portion of those costs to make a DSH payment in a state fiscal year. The Department will collect from a non-state, government-owned hospital its cost center specific hospital days and charge data for services it has provided to uninsured patients including payments the hospital has received from or on behalf of those uninsured patients. The uninsured are individuals who have no health insurance or other source of third party coverage. Uninsured days, charge and payment data will be entered into the CMS 2252-96 to determine the DSH eligible costs related to services provided to uninsured patients. The source documents for identifying eligible costs are a hospital's most recent CMS 2552-96 cost report as filed with the Medicare fiscal intermediary. The costs from the CMS 2552-96 are those that are allowable under Medicare cost principles. As discussed in the Interim Medical Assistance Payment section, total allowable costs for each cost center are from Worksheet B, Part I, column 25 (instead of 27). These costs will be included in the Worksheet C and D series. The uninsured days and charge data are for inpatient and outpatient hospital services and exclude non-hospital services including, but not limited to professional services, and non-hospital component services including but not limited to hospital-based nursing and rural health clinic facilities, ambulance services, and physician professional services. The CEO and CFO of each hospital, or a designee, will sign and certify to the accuracy of the information on the cost report.~~

~~The Department will use the protocol outlined below to determine interim payment for a hospital:~~

1. Uninsured costs for inpatient ancillary services are calculated by multiplying the total uninsured inpatient ancillary charges applicable to each ancillary service cost center by that ancillary service cost center's ratio of costs to charges (RCCs) from Worksheet D-4, column 1, lines 37 to 62. Total inpatient ancillary service cost is reported on Worksheet D-4, column 3, line 101.

2. Uninsured costs for outpatient ancillary services are calculated by multiplying the total uninsured outpatient charges applicable to each ancillary service cost center by that ancillary service cost center's RCCs from Worksheet D, Part V, column 1, lines 37 to 62. Total outpatient ancillary service cost is reported on Worksheet D, Part V, column 9, line 101 and Worksheet E-3, Part III, column 1, line 2.

3. Uninsured costs for inpatient routine services are calculated by multiplying the total uninsured inpatient days applicable to each routine service cost center by that routine service cost center's average per diem cost from Worksheet D-1, Part II, line 38 and column 3, lines 42 to 47.03.

4. Uninsured costs for inpatient routine and ancillary services are reported on Worksheet D-1, Part II, column 1, line 49 and Worksheet E-3, Part III, column 1, line 1.

5. The total cost for uninsured services is the sum of items 4 and 2 and reported on Worksheet E-3, Part III, column 1, line 6.

6. Hospital payments made by or on behalf of uninsured patients are reported on Worksheet E-3, Part III, column 1, line 57.

7. The interim payment is Worksheet E-3, Part III, column 1, line 58 in item 5 less item 6.

8. The Department will require that the hospital certify the eligible uninsured day, charge and payment used in the CMS-2552-96, Title XIX format. . This certification will be completed prior to each claim.

Reconciliation of Interim Hospital Payment for Uninsured Patients

1. The interim and final reconciliation processes will use the same computation methodology as described in the interim payment process except that the hospital uninsured days, charge and payment data will be updated and drawn from the two audited CMS-2552-96, Title XIX cost reports that correspond to the state fiscal year in which the interim DSH payment was made, as those cost reports are filed with and then finalized by the Medicare fiscal intermediary. Revenue offset data will also be updated and verified.

2. Any difference between the interim payment amount and the interim and final reconciled payment amounts will be made as a prior period adjustment on the CMS-64.

~~months. The Department will ensure that the total costs claimed under this DSH payment provision in a state plan DSH payment year will not exceed the costs justified in the underlying hospital cost reports for the applicable years.~~

~~The Department will also use the interim and final reconciliation process to ensure that the DPA payment claims for FFP do not result in total DSH claims exceeding the Minnesota's overall DSH allotment for the applicable FFY.~~

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere. (continued)

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this attachment (cont'd):

cc. Supplemental payment for medical education

Other provider-preventable conditions are not eligible for payment as described in Attachment 4.19-A.