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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: MN 25-0020

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

June 2, 2026

Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

RE: TN 25-0020

Dear Deputy Medicaid Director Hultman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Minnesota state plan amendment (SPA) to Attachment 4.19-A, MN-25-0020, which was submitted to CMS on September 29, 2025. This plan amendment purpose is to rebase inpatient hospital payment rates.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at Tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

June 2, 2026

Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

RE: TN 25-0020

Dear Deputy Medicaid Director Hultman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Minnesota state plan amendment (SPA) to Attachment 4.19-D MN 25-0020, which was submitted to CMS on September 29, 2025. This plan amendment purpose is to re-base inpatient hospital payment rates.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages. Additionally, a companion letter is included with this approval package. CMS identified issues with the state's base payment methodology for nursing facility providers. The letter clarifies that the SPA contains a previously approved methodology for base payment to out-of-state providers that may differ from base payments made to in-state providers and that CMS is not approving any payment that may violate Circuit opinion in Asante v. Kennedy, No. 23-5055 (D.C. Cir. 2025), petition for cert. filed (U.S. Sept. 17, 2025) (No. 25-361). More details can be found in the attached companion letter.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598or via email at tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

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: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0020

2. STATE: MN

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. 441.700-441.750

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Page 4, 5, 9, 10, 11, 14, 15, 16, 17, 19, 21, 24, 25, 28, 30,
Attachment **4-19-A pages 1,4,5,8,9,10,13,14,15,16,20,21,23,24,25**

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
same
Attachment 4-19-A pages 1,4,5,8,9,10,13,14,15,16,20,21,23,24,25

9. SUBJECT OF AMENDMENT
Updates the inpatient hospital rebase.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Patrick Hultman

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
September 29, 2025

15. RETURN TO
Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

FOR CMS USE ONLY

16. DATE RECEIVED
September 29, 2025

17. DATE APPROVED
June 2, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

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

diagnosis-related groups (APR-DRGs). The DRG classifications must be assigned according to the base year discharges for inpatient hospital services under the APR-DRG, rehabilitation, and long term hospital methodologies.

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

Disproportionate Population Adjustment Factor. "Disproportionate Population Adjustment (DPA) factor" is the numerical multiplier applied to each eligible claim to add the Disproportionate Share Hospital payment to the payment amount computing using the applicable rate methodology.

Fixed-loss amount. "Fixed-loss amount" means the amount added to the base DRG payment to establish the outlier threshold amount. For rates set using 2012, 2014, 2016, or 2018 or as the base year, the fixed loss amount is $70,000 dollars. For rates set using 2019 as the base year, the fixed loss amount is $75,500. For rates set using 2022 as the base year, the fixed loss amount is $81,500.

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

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

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

Hospital-acquired condition. "Hospital-acquired condition" means a condition represented by an ICD-9-CM or ICD-10-CM diagnosis code, that is listed on the Centers for Medicare and Medicaid Services annual hospital-acquired conditions list that is not identified by the hospital as present on admission and is designated as a complicating condition or major complicating condition.

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

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare including direct and indirect medical education costs.

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

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

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

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

Marginal cost factor. "Marginal cost factor" means a percentage of the estimated costs recognized above the outlier threshold amount. For rates set using 2019 as the base year, the marginal cost factor is 50 percent for DRGs with a severity of illness factor of 1, 2, 3 or 4. For rates set using 2022 as the base year, the marginal cost factor is 50 percent for DRGs with a severity of illness factor of 1, 2, 3, or 4.

Medical Education Payment Adjustment. "Medical Education Payment Adjustment" means the percentage multiplier needed to increase payments by the amount of the Medical Education Research Costs distribution for the hospital or system of hospitals and clinics as determined under MN Statutes 62J.692, subdivision 4.

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.

MinnesotaCare Tax ~~Add on~~ Assessment Amount. "MinnesotaCare Tax ~~Add on~~ Assessment Amount" is equal to 1.8%.~~, the percentage value is set in Minnesota Statutes section 25995.52 for the time period that covers the discharge date of the claim.~~

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

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

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

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota, and is not a local trade area hospital.

SECTION 4.0 ALL PATIENT-REFINED DIAGNOSIS-RELATED GROUP (APR-DRG) HOSPITALS

4.01 Establishment of base years.
Effective for discharges occurring on or after November 1, 2014, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012. Effective for discharges occurring on or after July 1, 2017 payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2014. Effective for discharges occurring on or after July 1, 2019 payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2016. Effective for discharges occurring on or after January 1, 2022 payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of 2018. Effective for discharges on or after July 1, 2023, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of 2019. Effective for discharges on or after July 1, 2025, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of 2022.

The rebasing in 2014 will be budget neutral, to ensure that the total aggregate payments under the rebased system are equal to the total aggregate payments made for the same number and types of services in the base year. Existing applicable rate increases or decreases applied to the hospitals being rebased during the entire base period will be incorporated into the budget neutrality calculation.

Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. Changes in costs between base years shall be measured using the lower of the hospital cost index, or the percentage change in the case mix adjusted cost per claim. The base year for each rebasing period is established by considering the most recent year for which filed Medicare cost reports are available.

4.02 Determination of relative values. The APR-DRG relative values of the diagnostic categories will be based on the "HSRV" national weights developed by 3M utilizing the HCUP NIS discharge data applicable to the base year.

4.03 Statewide Standardized APR-DRG amount. The statewide, standardized amount is set such that aggregate, simulated new APR-DRG system-payments are equal to aggregate DRG model-claim, allowed amounts under the DRG system in effect in each base year plus the applicable inflation factor. For rates effective July 1, 2017, the model claims data will be CY 2014. For rates effective July 1, 2019, the model claims data will be CY 2016. For rates effective January 1, 2022, the model claims data will be CY 2017 and CY 2018. For rates effective July 1, 2023, the model claims data will be CY 2018 and CY 2019. For rates effective July 1, 2025, the model claims data will be CY 2021 and CY 2022. The wage index and labor portions are based on factors in the FFY 202219 Medicare Inpatient Prospective Payment

System (IPPS). The wage indices include provider-specific reclassifications in the FFY 2016 Medicare IPPS, but do not include the frontier state adjustment in their FFY 202219 Medicare IPPS wage index.

4.04 Wage-adjusted Base Rate. APR-DRG wage-adjusted base rates are calculated using a statewide standardized amount with the labor percentage adjusted by the applicable Medicare IPPS wage index for the rate year. MSA hospitals use the standard wage index. Non-MSA hospitals use the rural wage index, but the Frontier State adjustment is not applied.

Wage-adjusted Base Rate =	(Statewide standardized APR-DRG amount multiplied by the labor percentage, multiplied by the applicable wage index) plus the (Statewide standardized APR-DRG amount multiplied by (1.0 minus the labor percentage))

A. Labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the product of the labor percentage and the applicable wage index

B. Non-labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the difference between one and the labor percentage

C. Sum the results of A and B.

SECTION 4.1 POLICY ADJUSTMENT FACTOR

Policy Adjustment factors are category-specific adjustments made to the payment. They are defined in terms of APR-DRG Base Groupings and include all SOI Categories. Policy Adjustment factors have a base value of 1.0 unless an adjustment factor has been adopted and indicated below by the Department.

Effective for the discharges on or after November 1, 2014, policy adjustments are applied to the following APR-DRG categories:

A. Mental Health: 740, 750, 751,752, 753, 754, 755, 756, 757, 758, 759,760, 761, 762

- A policy adjustment factor of 2.541.97 will be applied when the SOI is equal to one.
- A policy adjustment factor of 2.622.06 will be applied with the SOI is equal to two.
- A policy adjustment factor of 2.006 will be applied when the SOI is equal to three.

- A policy adjustment factor of 1.708 will be applied when the SOI is equal to four.

B. Neonate: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 630, 631, 633, 634, 636, 639, 863

- A policy adjustment factor of 1.00 will be applied to neonatal stays.

C. Normal New Born: 626, 640

- A policy adjustment factor of 1.320 will be applied to deliveries without medical complications.

D. Obstetrics – Vaginal Deliveries: 560

- A policy adjustment factor of 1.20 will be applied to vaginal deliveries in a hospital located outside the seven-county metro area.
- A policy adjustment factor of 1.00 will be applied to vaginal deliveries in a hospital located within the seven-county metro area.

E. Obstetrics Cesarean: 540

- A policy adjustment factor of 1.00 will be applied to cesarean deliveries.

F. Obstetrics Other: 541, 542, 543, 547, 548, 561, 564, 566

- A policy adjustment factor of 1.00 will be applied for obstetrics services, other than child birth.

G. Transplant: 001, 002, 006, 007, 008, 011, 440

- A policy adjustment factor of 1.202 will be applied to transplant services.

H. Rehabilitation: 860

- A policy adjustment factor of 1.00 will be applied to rehabilitation services.

I. Other Pediatric: all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and provided in a Children's hospital

- A policy adjustment factor of 1.00 will be applied regardless of SOI.

J. Other Pediatric all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and not provided in a Children's hospital

- A policy adjustment factor of 1.00 will be applied regardless of SOI.

K. Other Adult all other Base Groups with Age >18 years old

- A policy adjustment factor of 1.00 will be applied regardless of SOI

SECTION 4.2 TRANSITION ADJUSTMENT FACTOR

The transition adjustment factor is a provider-specific prospective value applied during the transitional period to ensure that a provider's aggregate simulated payments under rebased rates using base period claims data do not increase or decrease by more than five percent from aggregate base period payments.

(5) Multiply the result in item (1) by the policy adjustment factor
(6) Add the fixed loss amount to the result in item (2)

C. Subtract B from A.

D. If the result in C is positive, multiply the difference by the marginal cost factor to determine the outlier payment. If the result in C is negative, the outlier payment is zero.

4.36 Out-of-area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value
C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may shall be established based on a negotiated rate if the Department contracts directly with the hospital.

4.37 Interim Payment Methodology
The Department shall pay an interim payment based on the methodologies existing prior to the rebasing effective July 1, 202523.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under an interim payment methodology.

4.38 Alternative Payment Methodology for Children's Hospitals
Effective for audit years following July 1, 2017, for each audit year in which the audit of the Disproportionate Share Hospital (DSH) payment requires the inclusion of days, costs, and revenues associated with patients who have private health care coverage and who are eligible for Medicaid, an alternative payment rate shall be calculated for Minnesota hospitals that are designated as Children's hospitals and enumerated as such by Medicare.

Alternative Payment =	Allowable Charges multiplied by the product of: The applicable base year cost-to-charge ratio and The cost coverage percentage for the applicable base year minus two percentage points.

A. Calculate Base Year Cost Coverage Percentage for each eligible hospital

(1) Multiply Base Year allowable charges by the hospital's Base Year costtocharge ratio to determine base year costs.
(2) Divide total Base Year Payments by total Base Year Costs as determined in (1).

B. Reduce Base Year Payment to Cost Ratio
(1) Subtract two percentage points from the result of (A).

C. Determine Payment Year Costs
(1) Multiply Payment Year Allowable Charges by the Base Year costtocharge ratio for each eligible hospital.

D. Determine Final Payment Amount
(1) Multiply the result of (C) by the result of (B).

Allowable base year costs are limited to Medicare allowable costs for providing inpatient hospital services to patients enrolled in Minnesota Medicaid on a fee-for-service basis. Base year costs shall be determined using the most recent Medicare Cost Report available on the date that is two years after the beginning of the calendar year that is the base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods.

In any year in which a Children's hospital is paid using this alternative payment methodology, no payments under Section 8 shall be made to the hospital.

SECTION 4.39 Alternative Payment Methodology for Hospitals Receiving Directed Payments from Managed Care Plans

Effective for discharges on or after January 1, 2022, hospitals that are in the pool of providers receiving directed payments as required by contracts between the state and managed care plans will be paid using an alternative payment methodology. The alternative payment methodology will follow the provisions of sections 4.31 Standard payment, 4.33 Transfer payment, 4.34 Outlier payment, 4.37 Interim payment, 4.41 Rate adjustment and all of the provisions in section 4.5. The alternative payment methodology also includes the provisions in section 4.6 when the provider meets the requirements for payments under that section.

In addition to the payments under these provisions, a rate factor will be applied following the computation of the standard, transfer and outlier payments and prior to the application of the rate adjustment in section 4.41. For discharges on or after January 1, 2022, the alternative payment rate factor will be a factor equal to 99 percent of the sum of the factors as computed under sections 8.02, 8.03, and 8.04.

For providers paid under this alternative payment methodology, no payments under Section 8 shall be made.

SECTION 4.4 Alternate Payment Methodology for Hospitals with Extremely Long Lengths of Stay

Effective for the Disproportionate Share Hospital audit for calendar year 2021, a hospital that discharged a patient following a length of stay of more than twenty years shall receive total payments equal to 99 percent of the combined amount of the feeforservice payments and the disproportionate share hospital payments for the year in which the patient was discharged.

For providers paid under this alternative payment methodology, no payments under Section 8 shall be made.

SECTION 4.41 RATE ADJUSTMENT
For hospitals located in Minnesota, the total payment, after third-party liability and spend down is increased by the MinnesotaCare tax add-on amount.

SECTION 4.5 OTHER PAYMENT FACTORS

4.51 Charge limitation. Individual hospital payments, including 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 the billed charges on each claim.

4.52 Reserved

4.53 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

4.54 Non-payment for hospital-acquired and provider-preventable conditions. 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 or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

4.55 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.

4.56 Newborn Screening Fee. Effective for admissions occurring on or after July 1, 20235, payment rates shall be adjusted to include the increases to the fee that are is effective on or after July 1, 20225, for newborn screening tests required by the Minnesota Department of Health that is paid by the hospital for Medical Assistance recipients. This payment increase

SECTION 6.0 CRITICAL ACCESS HOSPITALS (CAH)

6.01 Establishment of base years.

Effective for discharges occurring on or after July 1, 2015, payment rates for services provided by critical access hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012. The base year will be updated (re-based) every two years to the most recent year for which filed, Medicare cost reports are available. The re-basing shall reflect changes in hospital costs between the existing base year and the next base year.

For every year that is not a re-basing year, payment rates shall be inflated using the Centers for Medicare & Medicaid Services' Inpatient Hospital Market Basket Index.

SECTION 6.2 CALCULATION OF PAYMENT RATES

6.21 Standard Payment for Minnesota and Local Trade Area Hospitals

Effective for discharges on or after July 1, 2015, payment rates shall be facility-specific, per diem payment rates. The per diem rates shall be based on a facility-specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March, 2014 for the cost report period ending in 2012. Effective for discharges on or after July 1, 2017, the per diem rates shall be based on a facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March 2016 for the cost report period ended in 2014. Effective for discharges on or after July 1, 2019, the per diem rates shall be based on a facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of March 2018 for the cost report period ended in 2016. Effective for discharges on or after January 1, 2022, the per diem rates shall be based on facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of January of 2020 for the cost report period ended in 2018. Effective for discharges on or after July 1, 2025, the per diem rates shall be based on facility specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of July of 2024 for the cost report period ended in 2022. The calculated cost based rate shall be the final rate and will not be settled to actual, incurred costs.

Standard Payment =	Covered Days multiplied by facility-specific per diem rate.

A. Calculate a payment-to-cost ratio using allowable cost and revenue data from Medicare Cost Report

B. Determine payment-to-cost ratio tier

(1) Hospitals with base year payment-to-cost ratios at or below 80 percent shall have a per diem payment rate set to reimburse 85 percent of base year costs.
(2) Hospitals with base year payment to cost ratios above 80 percent up to and including 90

percent shall have a per diem rate set to reimburse 95 percent of base year costs.

(3) Hospitals with base year payment to cost ratios above 90 percent shall have a per diem rate set to reimburse 100 percent of base year costs.

C. Set facility specific per diem rates to reimburse the target payment to cost ratio as determined in B.

6.22 Transfer Payment for Minnesota and Local Trade Area Hospitals

Transfer Payment =	Standard payment (per diem), multiplied by the actual length of stay.

6.24 Out-of-Area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value
C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may shall be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

6.25 Interim Payment Methodology

If the methodology described in this attachment cannot be implemented prior to July 1, 20251, the Department will employ an interim payment methodology.

The interim payment rate is equal to the rate in effect on July 1, 20250.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under the interim payment methodology.

SECTION 6.3 OTHER PAYMENT FACTORS

6.31 Charge limitation. Individual hospital payments, including 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 the billed charges on each claim.

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

(1) payer 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.

6.36 Medical Education and Research Costs. 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. Effective for discharges on or after January 1, 2024, payments to each hospital and the affiliated clinics will be included in the payment rates for inpatient hospital services. Hospital systems may shall elect to have all MERC payments for each hospital and clinic within the system paid to a single hospital within the system. Payments made within the inpatient hospital rates shall be reconciled annually to ensure that total payments do not exceed the amounts determined in the formula in Supplement 3 of this attachment.

6.37 Newborn Screening Fee. Effective for admissions occurring on or after January 1, 20225, payment rates shall be adjusted to include the increases to the fee that are is effective on or after January 1, 20225, for newborn screening tests required by the Minnesota Department of Health 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.

SECTION 7.0 LONG-TERM HOSPITALS

7.01 Establishment of base years.
For the January 1, 2011, rebased rate year, rates for Minnesota long term hospitals (section 7.0) only will be rebased to the most recent hospital fiscal year ending on or before September 1, 2008, not including payments described in section 8.01 or section 7.45. Effective January 1, 2013, and after, rates for all long-term hospitals will not be rebased. For long-term hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report.

Effective for discharges on or after July 1, 2019, rates for all Minnesota and Local Trade Area long term hospitals will be rebased. The base year will be updated (re-based) every two years to the most recent year for which filed, Medicare cost reports are available. The re-basing shall reflect changes in hospital costs between the existing base year and the next base year.

For every year that is not a re-basing year, payment rates shall be inflated using the Centers for Medicare & Medicaid Services' Inpatient Hospital Market Basket Index.

SECTION 7.2 CALCULATION OF PAYMENT RATES

7.21 Standard Payment for Minnesota and Local Trade Area Hospitals
Effective for discharges on or after July 1, 2023, payment rates shall be facility-specific, per diem payment rates. The per diem rates shall be based on a facility-specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of December 2021 for the cost reporting period ending in 2019. Effective for discharges on or after July 1, 2025, payment rates shall be facility-specific, per diem payment rates. The per diem rates shall be based on a facility-specific percentage of costs as recorded on the most recently filed Medicare Cost Report as of July of 2024 for the cost reporting period ending in 2022. The calculated cost based rate shall be the final rate and will not be settled to actual, incurred costs.

Standard Payment =	Covered Days multiplied by facility-specific per diem rate.

A. Calculate a payment-to-cost ratio using allowable cost and revenue data from Medicare Cost Report

B. Determine payment-to-cost ratio tier

(1) Hospitals with base year payment-to-cost ratios at or below 80 percent shall have a per diem payment rate set to reimburse 85 percent of base year costs.
(2) Hospitals with base year payment to cost ratios above 80 percent up to and including 90 percent shall have a per diem rate set to reimburse 95 percent of base year costs.

(3) Hospitals with base year payment to cost ratios above 90 percent shall have a per diem rate set to reimburse 100 percent of base year costs.

C. Set facility specific per diem rates to reimburse the target payment to cost ratio as determined in B. Compare the facility specific rate in C with the facility specific rate effective June 30, 2023. The final rate will be the higher of the computed rate or the rate in effect on June 30, 2023.

7.22 Transfer Payment for Minnesota and Local Trade Area Hospitals

Transfer Payment =	Standard payment (per diem), multiplied by the actual length of stay.

7.24 Out-of-Area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value
C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

7.25 Interim Payment Methodology
If the methodology described in this attachment cannot be implemented prior to July 1, 20253, the Department will employ an interim payment methodology.

The interim payment rate is equal to the rate in effect on July 1, 20250.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under the interim payment methodology.