

**SENATE  
STATE OF MINNESOTA  
NINETIETH SESSION**

**S.F. No. 1335**

(SENATE AUTHORS: BENSON and Lourey)

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OFFICIAL STATUS  
Introduction and first reading  
Referred to Health and Human Services Finance and Policy

1.1 A bill for an act  
1.2 relating to human services; modifying certain hospital rate and reimbursement  
1.3 provisions; amending Minnesota Statutes 2016, sections 256.9686, subdivision 8;  
1.4 256.969, subdivisions 1, 2b, 3a, 3c, 4b, 8, 8c, 9, 12; 256B.75.

1.5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.6 Section 1. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

1.7 Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.  
1.8 Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June  
1.9 30.

1.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

1.11 Sec. 2. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

1.12 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in  
1.13 the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The  
1.14 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to  
1.15 the midpoint of the current rate year.

1.16 (b) Except as authorized under this section, for fiscal years beginning on or after July  
1.17 1, 1993, the commissioner of human services shall not provide automatic annual inflation  
1.18 adjustments for hospital payment rates under medical assistance.

1.19 **EFFECTIVE DATE.** This section is effective July 1, 2017.

2.1 Sec. 3. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

2.2 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November  
2.3 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according  
2.4 to the following:

2.5 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based  
2.6 methodology;

2.7 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology  
2.8 under subdivision 25;

2.9 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation  
2.10 distinct parts as defined by Medicare shall be paid according to the methodology under  
2.11 subdivision 12; and

2.12 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

2.13 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not  
2.14 be rebased, except that a Minnesota long-term hospital shall be rebased effective January  
2.15 1, 2011, based on its most recent Medicare cost report ending on or before September 1,  
2.16 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on  
2.17 December 31, 2010. For rate setting periods after November 1, 2014, in which the base  
2.18 years are updated, a Minnesota long-term hospital's base year shall remain within the same  
2.19 period as other hospitals.

2.20 (c) Effective for discharges occurring on and after November 1, 2014, payment rates  
2.21 for hospital inpatient services provided by hospitals located in Minnesota or the local trade  
2.22 area, except for the hospitals paid under the methodologies described in paragraph (a),  
2.23 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a  
2.24 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall  
2.25 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring  
2.26 that the total aggregate payments under the rebased system are equal to the total aggregate  
2.27 payments that were made for the same number and types of services in the base year. Separate  
2.28 budget neutrality calculations shall be determined for payments made to critical access  
2.29 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases  
2.30 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during  
2.31 the entire base period shall be incorporated into the budget neutrality calculation.

2.32 (d) For discharges occurring on or after November 1, 2014, through the next rebasing  
2.33 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph

3.1 (a), clause (4), shall include adjustments to the projected rates that result in no greater than  
3.2 a five percent increase or decrease from the base year payments for any hospital. Any  
3.3 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)  
3.4 shall maintain budget neutrality as described in paragraph (c).

3.5 (e) For discharges occurring on or after November 1, 2014, through the next two rebasing  
3.6 ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates,  
3.7 and when evaluating whether additional adjustments should be made, the commissioner  
3.8 shall consider the impact of the rates on the following:

3.9 (1) pediatric services;

3.10 (2) behavioral health services;

3.11 (3) trauma services as defined by the National Uniform Billing Committee;

3.12 (4) transplant services;

3.13 (5) obstetric services, newborn services, and behavioral health services provided by  
3.14 hospitals outside the seven-county metropolitan area;

3.15 (6) outlier admissions;

3.16 (7) low-volume providers; and

3.17 (8) services provided by small rural hospitals that are not critical access hospitals.

3.18 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

3.19 (1) for hospitals paid under the DRG methodology, the base year payment rate per  
3.20 admission is standardized by the applicable Medicare wage index and adjusted by the  
3.21 hospital's disproportionate population adjustment;

3.22 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,  
3.23 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on  
3.24 October 31, 2014;

3.25 (3) the cost and charge data used to establish hospital payment rates must only reflect  
3.26 inpatient services covered by medical assistance; and

3.27 (4) in determining hospital payment rates for discharges occurring on or after the rate  
3.28 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per  
3.29 discharge shall be based on the cost-finding methods and allowable costs of the Medicare  
3.30 program in effect during the base year or years. In determining hospital payment rates for  
3.31 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding

4.1 methods and allowable costs of the Medicare program in effect during the base year or  
4.2 years.

4.3 (g) The commissioner shall validate the rates effective November 1, 2014, by applying  
4.4 the rates established under paragraph (c), and any adjustments made to the rates under  
4.5 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the  
4.6 total aggregate payments for the same number and types of services under the rebased rates  
4.7 are equal to the total aggregate payments made during calendar year 2013.

4.8 (h) Effective for discharges occurring on or after July 1, 2017, and every two years  
4.9 thereafter, payment rates under this section shall be rebased to reflect only those changes  
4.10 in hospital costs between the existing base year and the next base year. Changes in costs  
4.11 between base years shall be measured using the lower of the hospital cost index defined in  
4.12 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per  
4.13 claim. The commissioner shall establish the base year for each rebasing period considering  
4.14 the most recent year for which filed Medicare cost reports are available. The estimated  
4.15 change in the average payment per hospital discharge resulting from a scheduled rebasing  
4.16 must be calculated and made available to the legislature by January 15 of each year in which  
4.17 rebasing is scheduled to occur, and must include by hospital the differential in payment  
4.18 rates compared to the individual hospital's costs.

4.19 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates  
4.20 for critical access hospitals located in Minnesota or the local trade area shall be determined  
4.21 using a new cost-based methodology. The commissioner shall establish within the  
4.22 methodology tiers of payment designed to promote efficiency and cost-effectiveness.  
4.23 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed  
4.24 the total cost for critical access hospitals as reflected in base year cost reports. Until the  
4.25 next rebasing that occurs, the new methodology shall result in no greater than a five percent  
4.26 decrease from the base year payments for any hospital, except a hospital that had payments  
4.27 that were greater than 100 percent of the hospital's costs in the base year shall have their  
4.28 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and  
4.29 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor  
4.30 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not  
4.31 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the  
4.32 following criteria:

4.33 (1) hospitals that had payments at or below 80 percent of their costs in the base year  
4.34 shall have a rate set that equals 85 percent of their base year costs;

5.1 (2) hospitals that had payments that were above 80 percent, up to and including 90  
5.2 percent of their costs in the base year shall have a rate set that equals 95 percent of their  
5.3 base year costs; and

5.4 (3) hospitals that had payments that were above 90 percent of their costs in the base year  
5.5 shall have a rate set that equals 100 percent of their base year costs.

5.6 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals  
5.7 to coincide with the next rebasing under paragraph (h). The factors used to develop the new  
5.8 methodology may include, but are not limited to:

5.9 (1) the ratio between the hospital's costs for treating medical assistance patients and the  
5.10 hospital's charges to the medical assistance program;

5.11 (2) the ratio between the hospital's costs for treating medical assistance patients and the  
5.12 hospital's payments received from the medical assistance program for the care of medical  
5.13 assistance patients;

5.14 (3) the ratio between the hospital's charges to the medical assistance program and the  
5.15 hospital's payments received from the medical assistance program for the care of medical  
5.16 assistance patients;

5.17 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

5.18 (5) the proportion of that hospital's costs that are administrative and trends in  
5.19 administrative costs; and

5.20 (6) geographic location.

5.21 **EFFECTIVE DATE.** This section is effective July 1, 2017.

5.22 Sec. 4. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

5.23 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program  
5.24 must not be submitted until the recipient is discharged. However, the commissioner shall  
5.25 establish monthly interim payments for inpatient hospitals that have individual patient  
5.26 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section  
5.27 256.9693, medical assistance reimbursement for treatment of mental illness shall be  
5.28 reimbursed based on diagnostic classifications. Individual hospital payments established  
5.29 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party  
5.30 and recipient liability, for discharges occurring during the rate year shall not exceed, in  
5.31 aggregate, the charges for the medical assistance covered inpatient services paid for the  
5.32 same period of time to the hospital. Services that have rates established under subdivision

6.1 ~~11 or~~ 12, must be limited separately from other services. After consulting with the affected  
6.2 hospitals, the commissioner may consider related hospitals one entity and may merge the  
6.3 payment rates while maintaining separate provider numbers. The operating and property  
6.4 base rates per admission or per day shall be derived from the best Medicare and claims data  
6.5 available when rates are established. The commissioner shall determine the best Medicare  
6.6 and claims data, taking into consideration variables of recency of the data, audit disposition,  
6.7 settlement status, and the ability to set rates in a timely manner. The commissioner shall  
6.8 notify hospitals of payment rates 30 days prior to implementation. The rate setting data  
6.9 must reflect the admissions data used to establish relative values. The commissioner may  
6.10 adjust base year cost, relative value, and case mix index data to exclude the costs of services  
6.11 that have been discontinued by the October 1 of the year preceding the rate year or that are  
6.12 paid separately from inpatient services. Inpatient stays that encompass portions of two or  
6.13 more rate years shall have payments established based on payment rates in effect at the time  
6.14 of admission unless the date of admission preceded the rate year in effect by six months or  
6.15 more. In this case, operating payment rates for services rendered during the rate year in  
6.16 effect and established based on the date of admission shall be adjusted to the rate year in  
6.17 effect by the hospital cost index.

6.18 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,  
6.19 before third-party liability and spenddown, made to hospitals for inpatient services is reduced  
6.20 by .5 percent from the current statutory rates.

6.21 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service  
6.22 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before  
6.23 third-party liability and spenddown, is reduced five percent from the current statutory rates.  
6.24 Mental health services within diagnosis related groups 424 to 432 or corresponding  
6.25 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

6.26 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for  
6.27 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for  
6.28 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from  
6.29 the current statutory rates. Mental health services within diagnosis related groups 424 to  
6.30 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded  
6.31 from this paragraph. Payments made to managed care plans shall be reduced for services  
6.32 provided on or after January 1, 2006, to reflect this reduction.

6.33 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
6.34 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made  
6.35 to hospitals for inpatient services before third-party liability and spenddown, is reduced

7.1 3.46 percent from the current statutory rates. Mental health services with diagnosis related  
7.2 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision  
7.3 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced  
7.4 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this  
7.5 reduction.

7.6 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
7.7 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made  
7.8 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9  
7.9 percent from the current statutory rates. Mental health services with diagnosis related groups  
7.10 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are  
7.11 excluded from this paragraph. Payments made to managed care plans shall be reduced for  
7.12 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

7.13 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for  
7.14 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient  
7.15 services before third-party liability and spenddown, is reduced 1.79 percent from the current  
7.16 statutory rates. Mental health services with diagnosis related groups 424 to 432 or  
7.17 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from  
7.18 this paragraph. Payments made to managed care plans shall be reduced for services provided  
7.19 on or after July 1, 2011, to reflect this reduction.

7.20 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment  
7.21 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for  
7.22 inpatient services before third-party liability and spenddown, is reduced one percent from  
7.23 the current statutory rates. Facilities defined under subdivision 16 are excluded from this  
7.24 paragraph. Payments made to managed care plans shall be reduced for services provided  
7.25 on or after October 1, 2009, to reflect this reduction.

7.26 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment  
7.27 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for  
7.28 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from  
7.29 the current statutory rates. Facilities defined under subdivision 16 are excluded from this  
7.30 paragraph. Payments made to managed care plans shall be reduced for services provided  
7.31 on or after January 1, 2011, to reflect this reduction.

7.32 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under  
7.33 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision

8.1 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),  
8.2 and must not be applied to each claim.

8.3 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under  
8.4 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision  
8.5 must be incorporated into the rates and must not be applied to each claim.

8.6 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under  
8.7 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be  
8.8 incorporated into the rates and must not be applied to each claim.

8.9 **EFFECTIVE DATE.** This section is effective July 1, 2017.

8.10 Sec. 5. Minnesota Statutes 2016, section 256.969, subdivision 3c, is amended to read:

8.11 Subd. 3c. ~~Rateable~~ **Rateable reduction and readmissions reduction.** (a) The total  
8.12 payment for fee for service admissions occurring on or after September 1, 2011, to October  
8.13 31, 2014, made to hospitals for inpatient services before third-party liability and spenddown,  
8.14 is reduced ten percent from the current statutory rates. Facilities defined under subdivision  
8.15 16, long-term hospitals as determined under the Medicare program, children's hospitals  
8.16 whose inpatients are predominantly under 18 years of age, and payments under managed  
8.17 care are excluded from this paragraph.

8.18 (b) Effective for admissions occurring during calendar year 2010 and each year after,  
8.19 the commissioner shall calculate a readmission rate for admissions to all hospitals occurring  
8.20 within 30 days of a previous discharge using data from the Reducing Avoidable Readmissions  
8.21 Effectively (RARE) campaign. The commissioner may adjust the readmission rate taking  
8.22 into account factors such as the medical relationship, complicating conditions, and sequencing  
8.23 of treatment between the initial admission and subsequent readmissions.

8.24 (c) Effective for payments to all hospitals on or after July 1, 2013, through October 31,  
8.25 2014, the reduction in paragraph (a) is reduced one percentage point for every percentage  
8.26 point reduction in the overall readmissions rate between the two previous calendar years to  
8.27 a maximum of five percent.

8.28 (d) The exclusion from the rate reduction in paragraph (a) shall apply to a hospital located  
8.29 in Hennepin County with a licensed capacity of 1,700 beds as of September 1, 2011, for  
8.30 admissions of children under 18 years of age occurring on or after September 1, 2011,  
8.31 through August 31, 2013, but shall not apply to payments for admissions occurring on or  
8.32 after September 1, 2013, through October 31, 2014.



9.1 (e) Effective for discharges on or after November 1, 2014, from hospitals paid under  
 9.2 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision  
 9.3 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),  
 9.4 and must not be applied to each claim.

9.5 (f) Effective for discharges on and after July 1, 2015, from hospitals paid under  
 9.6 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision  
 9.7 must be incorporated into the rates and must not be applied to each claim.

9.8 (g) Effective for discharges on and after July 1, 2017, from hospitals paid under  
 9.9 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be  
 9.10 incorporated into the rates and must not be applied to each claim.

9.11 **EFFECTIVE DATE.** This section is effective July 1, 2017.

9.12 Sec. 6. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

9.13 Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one  
 9.14 of the following criteria must annually submit to the commissioner medical assistance cost  
 9.15 reports within six months of the end of the hospital's fiscal year:

9.16 (1) a hospital designated as a critical access hospital that receives medical assistance  
 9.17 payments; ~~or~~

9.18 (2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade  
 9.19 area that receives a disproportionate population adjustment under subdivision 9; or

9.20 (3) a Minnesota hospital that is a licensed children's hospital.

9.21 For purposes of this subdivision, local trade area has the meaning given in subdivision  
 9.22 17.

9.23 (b) The commissioner shall suspend payments to any hospital that fails to submit a report  
 9.24 required under this subdivision. Payments must remain suspended until the report has been  
 9.25 filed with and accepted by the commissioner.

9.26 **EFFECTIVE DATE.** This section is effective July 1, 2017.

9.27 Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

9.28 Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day  
 9.29 outlier thresholds for each diagnostic category established under subdivision 2 at two standard  
 9.30 deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold  
 9.31 shall be in addition to the operating and property payment rates per admission established

10.1 under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable  
10.2 operating cost, after adjustment by the case mix index, hospital cost index, relative values  
10.3 and the disproportionate population adjustment. The outlier threshold for neonatal and burn  
10.4 diagnostic categories shall be established at one standard deviation beyond the mean length  
10.5 of stay, and payment shall be at 90 percent of allowable operating cost calculated in the  
10.6 same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier  
10.7 payment that is at a minimum of 60 percent and a maximum of 80 percent if the  
10.8 commissioner is notified in writing of the request by October 1 of the year preceding the  
10.9 rate year. The chosen percentage applies to all diagnostic categories except burns and  
10.10 neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall  
10.11 be added back to the base year operating payment rate per admission.

10.12 (b) Effective for admissions and transfers occurring on and after November 1, 2014, the  
10.13 commissioner shall establish payment rates for outlier payments that are based on Medicare  
10.14 methodologies.

10.15 **EFFECTIVE DATE.** This section is effective July 1, 2017.

10.16 Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

10.17 Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1,  
10.18 2014, payments for hospital residents shall be made as follows:

10.19 (1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus  
10.20 any outliers; and

10.21 (2) payment for all medically necessary patient care subsequent to the first 180 days  
10.22 shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge  
10.23 ratio by the usual and customary charges.

10.24 (b) For discharges occurring on or after July 1, 2017, payment for hospital residents  
10.25 shall be equal to the payments under subdivision 8, paragraph (b).

10.26 **EFFECTIVE DATE.** This section is effective July 1, 2017.

10.27 Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

10.28 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions  
10.29 occurring on or after July 1, 1993, the medical assistance disproportionate population  
10.30 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional  
10.31 treatment centers and facilities of the federal Indian Health Service, with a medical assistance

11.1 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined  
11.2 as follows:

11.3 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic  
11.4 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian  
11.5 Health Service but less than or equal to one standard deviation above the mean, the  
11.6 adjustment must be determined by multiplying the total of the operating and property  
11.7 payment rates by the difference between the hospital's actual medical assistance inpatient  
11.8 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers  
11.9 and facilities of the federal Indian Health Service; and

11.10 (2) for a hospital with a medical assistance inpatient utilization rate above one standard  
11.11 deviation above the mean, the adjustment must be determined by multiplying the adjustment  
11.12 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall  
11.13 report annually on the number of hospitals likely to receive the adjustment authorized by  
11.14 this paragraph. The commissioner shall specifically report on the adjustments received by  
11.15 public hospitals and public hospital corporations located in cities of the first class.

11.16 (b) Certified public expenditures made by Hennepin County Medical Center shall be  
11.17 considered Medicaid disproportionate share hospital payments. Hennepin County and  
11.18 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning  
11.19 July 1, 2005, or another date specified by the commissioner, that may qualify for  
11.20 reimbursement under federal law. Based on these reports, the commissioner shall apply for  
11.21 federal matching funds.

11.22 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective  
11.23 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for  
11.24 Medicare and Medicaid Services.

11.25 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid  
11.26 in accordance with a new methodology using 2012 as the base year. Annual payments made  
11.27 under this paragraph shall equal the total amount of payments made for 2012. A licensed  
11.28 children's hospital shall receive only a single DSH factor for children's hospitals. Other  
11.29 DSH factors may be combined to arrive at a single factor for each hospital that is eligible  
11.30 for DSH payments. The new methodology shall make payments only to hospitals located  
11.31 in Minnesota and include the following factors:

11.32 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the  
11.33 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000  
11.34 fee-for-service discharges in the base year shall receive a factor of 0.7880;

12.1 (2) a hospital that has in effect for the initial rate year a contract with the commissioner  
 12.2 to provide extended psychiatric inpatient services under section 256.9693 shall receive a  
 12.3 factor of 0.0160;

12.4 (3) a hospital that has received payment from the fee-for-service program for at least 20  
 12.5 transplant services in the base year shall receive a factor of 0.0435;

12.6 (4) a hospital that has a medical assistance utilization rate in the base year between 20  
 12.7 percent up to one standard deviation above the statewide mean utilization rate shall receive  
 12.8 a factor of 0.0468;

12.9 (5) a hospital that has a medical assistance utilization rate in the base year that is at least  
 12.10 one standard deviation above the statewide mean utilization rate but is less than three standard  
 12.11 deviations above the mean shall receive a factor of 0.2300; and

12.12 (6) a hospital that has a medical assistance utilization rate in the base year that is at least  
 12.13 three standard deviations above the statewide mean utilization rate shall receive a factor of  
 12.14 0.3711.

12.15 (e) Any payments or portion of payments made to a hospital under this subdivision that  
 12.16 are subsequently returned to the commissioner because the payments are found to exceed  
 12.17 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the  
 12.18 number of fee-for-service discharges, to other DSH-eligible ~~non-children's~~ non-children's  
 12.19 hospitals that have a medical assistance utilization rate that is at least one standard deviation  
 12.20 above the mean.

12.21 **EFFECTIVE DATE.** This section is effective July 1, 2017.

12.22 Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

12.23 Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are  
 12.24 recognized as rehabilitation distinct parts by the Medicare program shall have separate  
 12.25 provider numbers under the medical assistance program for rate establishment and billing  
 12.26 purposes only. These units shall also have operating payment rates and the disproportionate  
 12.27 population adjustment, if allowed by federal law, established separately from other inpatient  
 12.28 hospital services.

12.29 (b) The commissioner shall establish separate relative values under subdivision 2 for  
 12.30 rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for  
 12.31 discharges occurring on and after November 1, 2014, the commissioner, to the extent  
 12.32 possible, shall replicate the existing payment rate methodology under the new diagnostic  
 12.33 classification system. The result must be budget neutral, ensuring that the total aggregate

13.1 payments under the new system are equal to the total aggregate payments made for the same  
13.2 number and types of services in the base year, calendar year 2012.

13.3 (c) For individual hospitals that did not have separate medical assistance rehabilitation  
13.4 provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the  
13.5 information needed to separate rehabilitation distinct part cost and claims data from other  
13.6 inpatient service data.

13.7 (d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals  
13.8 shall be established under subdivision 2d, paragraph (a), clause (4).

13.9 **EFFECTIVE DATE.** This section is effective July 1, 2017.

13.10 Sec. 11. Minnesota Statutes 2016, section 256B.75, is amended to read:

13.11 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

13.12 (a) For outpatient hospital facility fee payments for services rendered on or after October  
13.13 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,  
13.14 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for  
13.15 which there is a federal maximum allowable payment. Effective for services rendered on  
13.16 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and  
13.17 emergency room facility fees shall be increased by eight percent over the rates in effect on  
13.18 December 31, 1999, except for those services for which there is a federal maximum allowable  
13.19 payment. Services for which there is a federal maximum allowable payment shall be paid  
13.20 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total  
13.21 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare  
13.22 upper limit. If it is determined that a provision of this section conflicts with existing or  
13.23 future requirements of the United States government with respect to federal financial  
13.24 participation in medical assistance, the federal requirements prevail. The commissioner  
13.25 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial  
13.26 participation resulting from rates that are in excess of the Medicare upper limitations.

13.27 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory  
13.28 surgery hospital facility fee services for critical access hospitals designated under section  
13.29 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the  
13.30 cost-finding methods and allowable costs of the Medicare program. Effective for services  
13.31 provided on or after July 1, 2015, rates established for critical access hospitals under this  
13.32 paragraph for the applicable payment year shall be the final payment and shall not be settled  
13.33 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal

14.1 year ending in 2016, the rate for outpatient hospital services shall be computed using  
14.2 information from each hospital's Medicare cost report as filed with Medicare for the year  
14.3 that is two years before the year that the rate is being computed. Rates shall be computed  
14.4 using information from Worksheet C series until the department finalizes the medical  
14.5 assistance cost reporting process for critical access hospitals. After the cost reporting process  
14.6 is finalized, rates shall be computed using information from Title XIX Worksheet D series.  
14.7 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs  
14.8 related to rural health clinics and federally qualified health clinics, divided by ancillary  
14.9 charges plus outpatient charges, excluding charges related to rural health clinics and federally  
14.10 qualified health clinics.

14.11 (c) Effective for services provided on or after July 1, 2003, rates that are based on the  
14.12 Medicare outpatient prospective payment system shall be replaced by a budget neutral  
14.13 prospective payment system that is derived using medical assistance data. The commissioner  
14.14 shall provide a proposal to the 2003 legislature to define and implement this provision.

14.15 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,  
14.16 before third-party liability and spenddown, made to hospitals for outpatient hospital facility  
14.17 services is reduced by .5 percent from the current statutory rate.

14.18 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service  
14.19 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility  
14.20 services before third-party liability and spenddown, is reduced five percent from the current  
14.21 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from  
14.22 this paragraph.

14.23 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for  
14.24 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient  
14.25 hospital facility services before third-party liability and spenddown, is reduced three percent  
14.26 from the current statutory rates. Mental health services and facilities defined under section  
14.27 256.969, subdivision 16, are excluded from this paragraph.

14.28 **EFFECTIVE DATE.** This section is effective July 1, 2017.