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S.F. No. 1616

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03/06/2017	1081	Authors added Abeler; Hayden
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A bill for an act

relating to human services; establishing a contingent, alternate medical assistance payment method for children's hospitals; amending Minnesota Statutes 2016, section 256.969, subdivisions 4b, 9.

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

Section 1. Minnesota Statutes 2016, section 256.969, subdivision 4b, is amended to read:

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

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

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

(3) a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare.

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

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

EFFECTIVE DATE. This section is effective retroactively from January 1, 2015.

Sec. 2. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

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

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

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

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

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

for DSH payments. The new methodology shall make payments only to hospitals located in Minnesota and include the following factors:

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

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

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

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

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

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

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

(f) If the days, costs, and revenues associated with patients who are eligible for medical assistance and also have private health insurance are required to be included in the calculation of the hospital-specific disproportionate share hospital payment limit for a rate year, then the commissioner, effective retroactively to rate years beginning on or after January 1, 2015, shall compute an alternate inpatient payment rate for a Minnesota hospital that is designated as a children's hospital and enumerated as such by Medicare, and shall reimburse the hospital based on this alternate payment rate. The alternate payment rate must meet the criteria in clauses (1) to (4):

(1) the alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to two percent less than each children's hospital's cost coverage percentage in the applicable base year for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance;

(2) costs shall be determined using the most recently available medical assistance cost report provided under subdivision 4b, paragraph (a), clause (3), for the applicable base year. Costs shall be determined using standard Medicare cost finding and cost allocation methods and applied in the same manner as the costs were in the rebasing for the applicable base year. If the medical assistance cost report is not available, costs shall be determined in the interim using the Medicare Cost Report;

(3) in any rate year in which payment to a hospital is made using the alternate payment rate, no payments shall be made to the hospital under this subdivision; and

(4) if the alternate payment amount increases payments at a rate that is higher than the inflation factor applied over the rebasing period, the commissioner shall take this into consideration when setting payment rates at the next rebasing.