

1 Department of Human Services

2

3 Adopted Rules Relating to Hospital Medical Assistance

4 Reimbursement

5

6 Rules as Adopted

7 9500.1090 PURPOSE AND SCOPE.

8 Parts 9500.1090 to 9500.1155 establish a prospective  
9 reimbursement system for all hospitals that participate in and  
10 are reimbursed ~~directly~~ by medical assistance.

11 All provisions of parts 9500.1090 to 9500.1155, except part  
12 9500.1155, subpart 5, shall apply to general assistance medical  
13 care substituting the terms and data for general assistance  
14 medical care for the terms and data referenced for medical  
15 assistance.

16 9500.1095 STATUTORY AUTHORITY.

17 Parts 9500.1090 to 9500.1155 are authorized by Minnesota  
18 Statutes, section 256.969, subdivisions 2 and 6, and Laws of  
19 Minnesota 1983, chapter 312, article V, section 39. Parts  
20 9500.1090 to 9500.1155 must be read in conjunction with Titles  
21 XVIII and XIX of the Social Security Act, Code of Federal  
22 Regulations, title 42, and Minnesota Statutes, chapters 256,  
23 256B, and 256D.

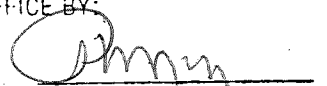
24 9500.1100 DEFINITIONS.

25 Subpart 1. **Scope.** As used in parts 9500.1090 to  
26 9500.1155, the terms in subparts 2 to ~~48~~ 50 have the meanings  
27 given them.

28 Subp. 2. **Adjusted base year cost per admission.** "Adjusted  
29 base year cost per admission" means an allowable base year cost  
30 per admission cumulatively multiplied by the hospital cost index  
31 ~~for-years-prior-to-the-budget~~ through a hospital's current year.

32 Subp. 3. **Admission.** "Admission" means the act that allows  
33 the a recipient to officially enter a hospital to receive  
34 inpatient hospital services under the supervision of a physician  
35 who is a member of the medical staff.

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1 Subp. 4. Admission certification. "Admission  
2 certification" means the determination pursuant to parts  
3 9500.0750 to 9500.1080, 9505.5000 to 9505.5020 [Emergency] and  
4 9505.1000 to 9505.1040 that inpatient hospitalization is  
5 medically necessary.

6 Subp. 5. Allowable base year cost per  
7 admission. "Allowable base year cost per admission" means a  
8 hospital's base year reimbursable inpatient hospital cost per  
9 admission which is adjusted for case mix and which excludes  
10 pass-through costs and outliers.

11 Subp. 6. Ancillary service. "Ancillary service" means  
12 inpatient hospital services that include laboratory, radiology,  
13 drugs, delivery room, operating room, therapy services, and  
14 other special items and services customarily charged for in  
15 addition to a routine service charge.

16 Subp. 7. Appeals board. "Appeals board" means the board  
17 which advises the commissioner on adjustments to a categorical  
18 rate per admission, rate per admission, or a rate per day.

19 Subp. 8. Arithmetic mean cost per admission. "Arithmetic  
20 mean cost per admission" means the number obtained by dividing  
21 the sum of a set of reimbursable inpatient hospital costs per  
22 admission by the number of admissions in the set.

23 Subp. 9. Base year. "Base year" means the a hospital's  
24 fiscal year ending during calendar year 1981.

25 Subp. 10. Budget year. "Budget year" means the a  
26 hospital's fiscal year for which a prospective reimbursement  
27 system is being determined.

28 Subp. 11. Case mix. "Case mix" means the a distribution  
29 of admissions in the diagnostic categories.

30 Subp. 12. Categorical rate per admission. "Categorical  
31 rate per admission" means the adjusted base year cost per  
32 admission multiplied by the budget year hospital cost index and  
33 the relative value of the appropriate diagnostic category plus  
34 the budget year pass-through cost per admission.

35 Subp. 13. Claims. "Claims" means the information  
36 contained on the inpatient hospital invoices submitted to the

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1 department on forms or computer tape by a hospital to request  
2 reimbursement for inpatient hospital services provided to a  
3 recipient.

4 Subp. 14. Commissioner. "Commissioner" means the  
5 commissioner of the Department of Human Services or an  
6 authorized representative of the commissioner.

7 Subp. 15. Cost outlier. "Cost outlier" means an admission  
8 whose reimbursable inpatient hospital cost exceeds the geometric  
9 mean cost per admission for diagnostic categories ~~theta~~ and W  
10 category O, under subpart 20 by one standard deviation and  
11 diagnostic category W, under subpart 20, by three standard  
12 deviations.

13 Subp. 16. Cost-to-charge ratio. "Cost-to-charge ratio"  
14 means a ratio of a hospital's reimbursable inpatient hospital  
15 costs to its charges for inpatient hospital services.

16 Subp. 17. Current year. "Current year" means the a  
17 hospital's fiscal year which occurs immediately before the that  
18 hospital's budget year.

19 Subp. 18. Day outlier. "Day outlier" means an admission  
20 whose length of stay exceeds the geometric mean length of stay  
21 for a diagnostic category ~~by three standard deviations~~  
22 categories A to N, and P to II, under subpart 20 by two standard  
23 deviations or for diagnostic category O, under subpart 20 by one  
24 standard deviation.

25 Subp. 19. Department. "Department" means the Minnesota  
26 Department of Human Services.

27 Subp. 20. Diagnostic categories. "Diagnostic categories"  
28 means the classification of inpatient hospital services  
29 according to the diagnostic related groups (DRG's) under  
30 medicare with adjustments as follows:

| Diagnostic Categories                              | DRG Numbers Within the<br>Diagnostic Category |
|--|---|
| A. Diseases and Disorders of<br>the Nervous System | (1-35)  |
| B. Diseases and Disorders of                       |   |

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|    |                                |                    |
|----|--------------------------------|--------------------|
| 1  | the Eye                        | (36-48)            |
| 2  | C. Diseases and Disorders of   |                    |
| 3  | the Ear, Nose, and Throat      | (49-74)            |
| 4  | D. Diseases and Disorders of   |                    |
| 5  | the Respiratory System         | (75-97, 99-102)    |
| 6  | E. Diseases and Disorders of   |                    |
| 7  | the Circulatory System         | (103-145)          |
| 8  | F. Diseases and Disorders of   |                    |
| 9  | the Digestive System           | (146-183, 185-190) |
| 10 | G. Diseases and Disorders of   |                    |
| 11 | the Hepatobiliary System       |                    |
| 12 | and Pancreas                   | (191-208)          |
| 13 | H. Diseases and Disorders of   |                    |
| 14 | the Musculoskeletal System     |                    |
| 15 | and Connective Tissues         | (209-256)          |
| 16 | I. Diseases and Disorders of   |                    |
| 17 | the Skin, Subcutaneous         |                    |
| 18 | Tissue and Breast              | (257-284)          |
| 19 | J. Endocrine, Nutritional, and |                    |
| 20 | Metabolic Diseases and         |                    |
| 21 | Disorders                      | (285-301)          |
| 22 | K. Diseases and Disorders of   |                    |
| 23 | the Kidney and Urinary Tract   | (302-333)          |
| 24 | L. Diseases and Disorders of   |                    |
| 25 | the Male Reproductive System   | (334-352)          |
| 26 | M. Diseases and Disorders of   |                    |
| 27 | the Female Reproductive        |                    |
| 28 | System                         | (353-369)          |
| 29 | N. Pregnancy, Childbirth, and  |                    |
| 30 | the Puerperium                 | (370, 374-384)     |
| 31 | O. Newborns and Other Neonates |                    |
| 32 | with Conditions Originating    |                    |
| 33 | in the Perinatal Period        | (385-390)          |
| 34 | P. Diseases and Disorders of   |                    |
| 35 | the Blood and Blood-Forming    |                    |
| 36 | Organs and Immunity Disorders  | (392-399)          |

|    |                                   |                    |
|----|-----------------------------------|--------------------|
| 1  | Q. Myeloproliferative Diseases    |                    |
| 2  | and Disorders, Poorly             |                    |
| 3  | Differentiated Malignancy and     |                    |
| 4  | Other Neoplasms NEC               | (400-414)          |
| 5  | R. Infectious and Parasitic       |                    |
| 6  | Diseases (Systemic or             |                    |
| 7  | Unspecified Sites)                | (415-423)          |
| 8  | S. Mental Diseases and Disorders  | (424-425, 427-429, |
| 9  |                                   | 432)               |
| 10 | T. Substance Use and Substance    |                    |
| 11 | Induced Organic Mental            |                    |
| 12 | Disorders (Ages 0-20)             | (433-438)          |
| 13 | U. Substance Use and Substance    |                    |
| 14 | Induced Organic Mental            |                    |
| 15 | Disorders (Ages over 21)          | (433-438)          |
| 16 | V. Injury, Poisoning, and Toxic   |                    |
| 17 | Effects of Drugs                  | (439-455)          |
| 18 | W. Burns                          | (456-460)          |
| 19 | X. Factors Influencing Health     |                    |
| 20 | Status and Other Contacts         |                    |
| 21 | with Health Services              | (461-467)          |
| 22 | Y. Bronchitis and Asthma          |                    |
| 23 | (Ages 0-1)                        | (98)               |
| 24 | Z. Bronchitis and Asthma          |                    |
| 25 | (Ages 2-17)                       | (98)               |
| 26 | AA. Esophagitis, Gastroenteritis, |                    |
| 27 | Miscellaneous Digestive           |                    |
| 28 | Disorders (Ages 0-1)              | (184)              |
| 29 | BB. Esophagitis, Gastroenteritis, |                    |
| 30 | Miscellaneous Digestive           |                    |
| 31 | Disorders (Ages 2-17)             | (184)              |
| 32 | CC. Cesarean section without      |                    |
| 33 | comorbidities and                 |                    |
| 34 | complications                     | (371)              |
| 35 | DD. Vaginal delivery with         |                    |
| 36 | complicating diagnosis            | (372)              |

- 1 EE. Vaginal delivery without  
 2 complicating diagnosis and  
 3 Normal newborns (373), (391)  
 4 FF. Depressive neurosis (426)  
 5 GG. Psychosis (430)  
 6 HH. Childhood mental disorders (431)  
 7 II. Unrelated Operating room  
 8 procedure (468)  
 9 JJ. Cases which could not be  
 10 assigned to other diagnostic  
 11 categories (469-470)
- 12 Subp. 21. Discharge. "Discharge" means a release of a  
 13 recipient from a hospital.
- 14 Subp. 22. General assistance medical care or  
 15 GAMC. "General assistance medical care" or "GAMC" means the  
 16 program established by Minnesota Statutes, section 256D.03.
- 17 Subp. 23. Geometric mean cost per admission. "Geometric  
 18 mean cost per admission" means the nth root of the product of  
 19 the reimbursable inpatient hospital costs per admission for n  
 20 admissions.
- 21 Subp. 24. Geometric mean length of stay. "Geometric mean  
 22 length of stay" means the nth root of the product of the number  
 23 of days spent in a hospital for each admission for n admissions.
- 24 Subp. 25. Hospital. "Hospital" means an institution that,  
 25 except for state-operated facilities, is approved to participate  
 26 as a hospital under medicare.
- 27 Subp. 26. Hospital cost index or HCI. "Hospital cost  
 28 index" or "HCI" means a single percentage annually multiplied by  
 29 the adjusted base year cost per admission or the adjusted base  
 30 year costs to adjust for inflation.
- 31 Subp. 27. Inpatient hospital service. "Inpatient hospital  
 32 service" means a service provided under the supervision of a  
 33 physician and furnished in a hospital for the care and treatment  
 34 of a recipient. The inpatient hospital service may be furnished  
 35 by a physician, or a vendor of an ancillary service which is  
 36 prescribed by a physician and which is eligible for medical

1 assistance reimbursement.

2 Subp. 28. Local agency. "Local agency" means a county or  
3 multicounty agency authorized under Minnesota Statutes as the  
4 agency responsible for determining eligibility for medical  
5 assistance.

6 Subp. 29. Medical assistance or MA. "Medical assistance"  
7 or "MA" means the program established under Title XIX of the  
8 Social Security Act and Minnesota Statutes, chapter 256B.

9 Subp. 30. Medically necessary. "Medically necessary"  
10 means an inpatient hospital service that is consistent with the  
11 recipient's diagnosis or condition, and under the criteria in  
12 parts 9505.0530 [Emergency] and 9505.0540 [Emergency] cannot be  
13 provided on an outpatient basis.

14 Subp. 31. Medicare. "Medicare" means the federal health  
15 insurance program established under Title XVIII of the Social  
16 Security Act.

17 Subp. 32. Medicare crossover claims. "Medicare crossover  
18 claims" means the information contained on the inpatient  
19 hospital invoices submitted to the department on forms or  
20 computer tape by a hospital to request reimbursement for  
21 inpatient hospital services provided to a recipient who is also  
22 eligible for medicare.

23 Subp. 33. Metropolitan statistical area hospital or MSA  
24 hospital. "Metropolitan statistical area hospital" or "MSA  
25 hospital" means a hospital located in a metropolitan statistical  
26 area as determined by Medicare.

27 Subp. 34. Non-metropolitan statistical area hospital or  
28 non-MSA hospital. "Non-metropolitan statistical area hospital"  
29 or "non-MSA hospital" means a hospital not located in a  
30 metropolitan statistical area as determined by Medicare.

31 Subp. 33 35. Operating costs. "Operating costs" means the  
32 reimbursable inpatient hospital costs of-a-hospital excluding  
33 pass-through costs.

34 Subp. 34 36. Outlier. "Outlier" means a day outlier or a  
35 cost outlier.

36 Subp. 35 37. Out-of-area hospital. "Out-of-area hospital"

1 means any hospital outside of Minnesota.

2 Subp. 36 38. Pass-through costs. "Pass-through costs"  
3 means reimbursable inpatient hospital costs not subject to the  
4 HCI.

5 Subp. 37 39. Prior authorization. "Prior authorization"  
6 means prior approval for inpatient hospital services by the  
7 department established under parts 9505.5000 to 9505.5020  
8 [Emergency].

9 Subp. 38 40. Prior year. "Prior year" means the  
10 hospital's fiscal year immediately before the current year.

11 Subp. 39 41. Prospective reimbursement  
12 system. "Prospective reimbursement system" means a method of  
13 reimbursing hospitals for inpatient hospital services on a  
14 categorical rate per admission, rate per admission, or rate per  
15 day, or some combination thereof, determined by the department  
16 in advance of the delivery of inpatient hospital services.

17 Subp. 40 42. Readmission. "Readmission" means an  
18 admission which occurs within seven days of a discharge, whose  
19 diagnostic category or a related diagnostic category is the same  
20 as that identified for that discharge.

21 Subp. 41 43. Recipient. "Recipient" means a person who  
22 has applied to a local agency and has been determined eligible  
23 for medical assistance.

24 Subp. 42 44. Reimbursable inpatient hospital  
25 costs. "Reimbursable inpatient hospital costs" means those  
26 costs allowable under Title XVIII of the Social Security Act for  
27 inpatient hospital services.

28 Subp. 43 45. Relative value. "Relative value" means the  
29 arithmetic mean of the reimbursable inpatient hospital cost per  
30 admission for all admissions in each diagnostic category in  
31 relation to the arithmetic mean of the reimbursable inpatient  
32 hospital cost per admission of all admissions in all other  
33 diagnostic categories on a statewide basis.

34 Subp. 44 46. Routine service. "Routine service" means  
35 those inpatient hospital services included by a hospital in a  
36 daily room charge. Routine services are composed of two broad



1 components: (1) general routine services, and (2) special care  
2 units including nursery care units, coronary care units, and  
3 intensive care units.

4 Subp. ~~45~~ 47. **Second surgical opinion.** "Second surgical  
5 opinion" means the ~~confirming~~ confirmation or ~~denying~~ denial of  
6 the need for the a proposed surgery by a recommended second  
7 physician as specified in part 9505.5030 [Emergency] and  
8 Minnesota Statutes, section 256B.503.

9 Subp. ~~46~~ 48. **Total hospital admissions.** "Total hospital  
10 admissions" means the total number of acts that allow persons to  
11 officially enter a hospital during the base year to receive a  
12 service provided under the supervision of a physician and  
13 furnished in a hospital by a physician, or a vendor of an  
14 ancillary service prescribed by a physician.

15 Subp. ~~47~~ 49. **Total reimbursable costs.** "Total  
16 reimbursable costs" means the costs identified in a hospital's  
17 base year medicare/medical assistance cost report, Health Care  
18 Financing Administration (HCFA) Form 2552, 1981 revision,  
19 Worksheet A, column 7, line 84. Health Care Financing  
20 Administration Form 2552, 1981 revision is incorporated by  
21 reference. The form is published by Medicare, Part A Office,  
22 3535 Blue Cross Road, P.O. Box 43560, Saint Paul, Minnesota  
23 55164. The form is available through the minitex interlibrary  
24 loan system.

25 Subp. ~~48~~ 50. **Transfer.** "Transfer" means the movement of a  
26 recipient after admission from one hospital to another.

27 9500.1105 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES.

28 The department shall use a prospective reimbursement system  
29 to reimburse hospitals for inpatient hospital services provided  
30 to recipients.

31 9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF  
32 DIAGNOSTIC CATEGORIES.

33 Subpart 1. **Determination of relative values.** To determine  
34 the relative values of the diagnostic categories the department  
35 shall:

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1 A. select all claims for all hospitals statewide for  
2 state fiscal years 1983 and 1984;

3 B. assign each claim from item A to the specific  
4 admission which generated the claim except as provided in item C;

5 C. exclude from item B the following claims:

6 (1) medicare crossover claims,

7 (2) claims submitted by out-of-area hospitals,

8 and

9 (3) claims not reimbursed as of February 28, 1985;

10 D. determine reimbursable inpatient hospital costs  
11 for each hospital's admissions for state fiscal years 1983 and  
12 1984 using each hospital's base year data from the HCFA Form  
13 2552 Worksheet, 1981 revision according to subitems (1) to (4):

14 (1) ~~establish~~ determine the cost of routine  
15 services determined by multiplying the routine services charge  
16 for each admission identified in item B by the appropriate  
17 routine service cost-to-charge ratio determined in the base  
18 year,

19 (2) ~~establish~~ determine the cost of ancillary  
20 services by multiplying the ancillary charges for each admission  
21 identified in item B by the appropriate cost-to-charge ratio as  
22 identified in Worksheet C determined in the base year,

23 (3) ~~establish~~ determine the cost of services  
24 rendered by interns and residents not in an approved teaching  
25 program for each admission in item B by multiplying the number  
26 of days for the appropriate routine services by the per diem  
27 cost identified in Worksheet D-2, Part I of the base year, and

28 (4) sum subitems (1) to (3) to determine the  
29 reimbursable inpatient hospital cost for each admission in item  
30 B;

31 E. assign each admission identified in item B to the  
32 appropriate diagnostic related group under medicare using the  
33 Transfer Tape for ICD-9-CM Diagnosis Related Groups Assignment  
34 Software distributed and developed by DRG Support Group Limited,  
35 a subsidiary of Health Systems International, Incorporated;

36 F. assign each admission to a diagnostic category;

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1 G. identify outliers for each diagnostic category;

2 H. determine the statewide arithmetic mean cost per  
3 admission for all admissions by dividing the total reimbursable  
4 inpatient hospital cost for all admissions excluding outliers by  
5 the total number of admissions excluding outliers;

6 I. determine the statewide arithmetic mean cost per  
7 admission for each diagnostic category by dividing the total  
8 reimbursable inpatient hospital costs in each diagnostic  
9 category excluding outliers by the total number of admissions in  
10 each diagnostic category excluding outliers; and

11 J. determine the relative value for each diagnostic  
12 category by dividing item I by item H.

13 Subp. 2. Redetermination of relative values. The  
14 department shall redetermine the relative values of the  
15 diagnostic categories prior to the beginning of each state  
16 fiscal biennium. The redetermination of the relative values  
17 shall be based on claims from the two most recently completed  
18 state fiscal years reimbursed on or before March 1 of the second  
19 year of the biennium and the cost-to-charge ratio ratios  
20 determined during the base year.

21 These redetermined relative values shall be the basis of  
22 reimbursement for the next biennium.

23 Subp. 3. Publication of relative values. The department  
24 shall publish in the State Register the relative values of each  
25 diagnostic category at least 30 days prior to the start of a  
26 biennium.

27 9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER  
28 ADMISSION.

29 To determine the allowable base year cost per admission the  
30 department shall:

31 A. determine reimbursable inpatient hospital costs  
32 for each hospital's base year admissions according to part  
33 9500.1110, subpart 1, item D, substituting the terms and data  
34 for base year admissions for the terms and data referenced for  
35 state fiscal years 1983 and 1984;

36 B. subtract from the amount determined in item A the

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1 amounts in subitems (1) and (2):

2 (1) reimbursable inpatient hospital costs for  
3 outliers as determined in part 9500.1110, subpart 1, item G, and

4 (2) pass-through costs except malpractice  
5 insurance costs apportioned to medical assistance based on the  
6 ratio of reimbursable inpatient hospital costs as adjusted in  
7 subitem (1) to total reimbursable costs;

8 C. divide the reimbursable inpatient hospital costs  
9 as adjusted in item B by the number of base year admissions in  
10 each hospital excluding outliers;

11 D. adjust item C for case mix as follows:

12 (1) assign each base year admission a diagnostic  
13 category as specified in part 9500.1110, subpart 1, items E and  
14 F,

15 (2) multiply each base year admission excluding  
16 outliers by the relative value of the diagnostic category  
17 assigned to that admission,

18 (3) sum the products determined in subitem (2),

19 (4) divide the sum from subitem (3) by the number  
20 of base year admissions excluding outliers, and

21 (5) divide the cost per admission as determined  
22 in item C by subitem (4).

23 9500.1120 DETERMINATION AND PUBLICATION OF HOSPITAL COST INDEX  
24 (HCI).

25 Subpart 1. **Adoption of Health Care Costs.** The most recent  
26 Health Care Costs published by Data Resources Incorporated (DRI)  
27 is incorporated by reference. The health care costs report is  
28 available through the minitex interlibrary loan system. The  
29 report is published monthly.

30 Subp. 2. **Determination of HCI.** For each calendar quarter  
31 the department shall determine the HCI as follows:

32 A. For each calendar quarter obtain from Health Care  
33 Costs published by Data Resources, Inc., inflation estimates for  
34 the following operating costs:

35 (1) salaries  
36 (2) employee benefits

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- 1 (3) medical fees
- 2 (4) raw food
- 3 (5) medical supplies
- 4 (6) pharmaceuticals
- 5 (7) utilities
- 6 (8) repairs and maintenance
- 7 (9) insurance (other than malpractice)
- 8 (10) other operating costs

9 B. During the fourth quarter of each calendar year,  
 10 obtain data for operating costs as found in the aggregate of  
 11 hospitals in Minnesota which indicate the proportion of  
 12 operating costs attributable to each of item A, subitems (1) to  
 13 (10). These proportions will be used in the determination of  
 14 the HCI for the next calendar year.

15 C. Multiply each proportion for item A, subitems (1)  
 16 to (10) by each subitem's inflation estimate.

17 D. Sum the products determined in item C and round  
 18 the sum to one decimal place.

19 Subp. 3. Publication of HCI. The department shall publish  
 20 the HCI in the State Register 30 days prior to the start of each  
 21 calendar quarter. A hospital whose budget year starts during a  
 22 given calendar quarter is subject to the HCI published 30 days  
 23 prior to the start of that quarter.

24 9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION.

25 Subpart 1. Pass-through cost reports. For each hospital's  
 26 budget year, each hospital shall submit to the department a  
 27 written report of pass-through costs. Pass-through cost reports  
 28 must include actual data for the prior year and budgeted data  
 29 for the current and budget years. Pass-through cost reports are  
 30 due 60 days prior to the start of each hospital's budget year  
 31 and must include the following information:

|    | Prior    | Current  | Budget   |
|----|----------|----------|----------|
|    | Year     | Year     | Year     |
|    | (Actual) | (Budget) | (Budget) |
| 32 |          |          |          |
| 33 |          |          |          |
| 34 | Items    |          |          |

35  
 36 A. Depreciation

|   |                          |       |       |       |
|---|--------------------------|-------|-------|-------|
| 1 | B. Rents and leases      | _____ | _____ | _____ |
| 2 | C. Property taxes        | _____ | _____ | _____ |
| 3 | D. Property Insurance    | _____ | _____ | _____ |
| 4 | E. Interest              | _____ | _____ | _____ |
| 5 | F. Malpractice insurance | _____ | _____ | _____ |
| 6 | G. TOTAL PASS-THROUGH    |       |       |       |
| 7 | COSTS (ITEMS A TO F)     | _____ | _____ | _____ |

8 Pass-through costs are limited to items A to F as  
 9 determined by medicare. Pass-through costs do not include costs  
 10 derived from capital projects requiring a certificate of need  
 11 for which the required certificate of need has not been granted.

12 Subp. 2. Determination of budget year pass-through cost  
 13 per admission. The department shall determine the budget year  
 14 pass-through cost per admission from the submitted pass-through  
 15 cost report as specified in subpart 1 as follows:

| 16 |                               | Prior    | Current  | Budget   |
|----|-------------------------------|----------|----------|----------|
| 17 |                               | Year     | Year     | Year     |
| 18 | Items                         | (Actual) | (Budget) | (Budget) |
| 19 |                               |          |          |          |
| 20 | A. Ratio of reimbursable      |          |          |          |
| 21 | inpatient hospital            |          |          |          |
| 22 | costs <u>as determined in</u> |          |          |          |
| 23 | <u>part 9500.1115, item A</u> |          |          |          |
| 24 | to total reim-                |          |          |          |
| 25 | bursable costs-pursu-         |          |          |          |
| 26 | ant-to-part-9500.1115,        |          |          |          |
| 27 | item-B7-subitem-(2)           | _____    | _____    | _____    |
| 28 | B. Pass-through costs         |          |          |          |
| 29 | as specified in               |          |          |          |
| 30 | subpart 1, item G             |          |          |          |
| 31 | multiplied by item A          | _____    | _____    | _____    |
| 32 | C. Number of base year        |          |          |          |
| 33 | admissions excluding          |          |          |          |
| 34 | <u>including outliers</u>     |          |          |          |
| 35 | pursuant-to-part              |          |          |          |
| 36 | 9500.1115,-item-D7            |          |          |          |

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1           subitem-(4) \_\_\_\_\_

2           D. Pass-through cost

3           per admission (item

4           B divided by item C) \_\_\_\_\_

5           Subp. 3. Categorical rate per admission. The department

6 shall determine the categorical rate per admission as follows:

7    [(Adjusted base year cost per admission)

8           Categorical                   multiplied by (budget year HCI) and

9           Rate Per                    = multiplied by (the relative value of the

10          Admission                   appropriate diagnostic category), plus

11   (budget year pass-through cost per

12   admission)]

13          Subp. 4. Pass-through cost per admission adjustment.

14 After the end of each budget year, the commissioner shall

15 redetermine the categorical rate per admission. The

16 commissioner shall substitute actual pass-through costs as

17 determined by medicare for budgeted pass-through costs in

18 subpart 2, item B for that year. If the adjustment indicates an

19 overpayment to the a hospital, the that hospital shall pay to

20 the commissioner the entire overpayment within 60 days of

21 receiving the written notification from the commissioner. If

22 the adjustment indicates an underpayment to a hospital, the

23 commissioner shall pay that hospital the underpayment within 60

24 days of written notification from the commissioner.

25          Subp. 5. Interest. Interest charges must be assessed on

26 underpayment or overpayment balances for pass-through cost

27 adjustments outstanding after the deadlines. The annual

28 interest rate charged must be the rate charged by the

29 commissioner of revenue for late payment of taxes in effect on

30 the 61st day after the written notification.

31          Subp. 6. Effective date. The categorical rate per

32 admission shall be effected effective for all admissions that

33 occur on or after the effective date of parts 9500.1090 to

34 9500.1155.

35 9500.1126 RECAPTURE OF DEPRECIATION.

36          Subpart 1. Recapture of depreciation. The commissioner

1 shall use Medicare to determine the recapture of depreciation  
 2 due to a change in the ownership of a hospital and that is  
 3 apportioned to medical assistance.

4 Subp. 2. Payment of recapture of depreciation to  
 5 commissioner. A hospital shall pay the commissioner the  
 6 recapture of depreciation within 60 days of written notification  
 7 from the commissioner. Interest charges must be assessed  
 8 according to part 9500.1125, subpart 5.

9 Interest charges must be assessed on the recapture of  
 10 depreciation due the commissioner outstanding after the  
 11 deadline. The annual interest rate charged must be the rate  
 12 charged by the commissioner of revenue for late payment of taxes  
 13 in effect on the 61st day after the written notification.

14 9500.1130 REIMBURSEMENT PROCEDURES.

15 Subpart 1. Submittal of claims. Claims must ~~must~~ may be  
 16 submitted to the department after the a recipient is discharged  
 17 or after 30 days, whichever occurs first. A hospital that  
 18 submits a claim to the department after 30 days from admission  
 19 but before discharge shall submit a final claim after discharge,  
 20 but must not submit any other interim claims except as part of  
 21 an appeal.

22 Subp. 2. Required claims. Hospitals must submit complete  
 23 medical assistance claims to the department on forms or computer  
 24 tapes approved by the department.

25 Subp. 3. Reimbursement in response to submitted claims.  
 26 The department will reimburse a hospital for inpatient hospital  
 27 services only after processing that hospital's properly  
 28 submitted claim. The department shall reimburse a hospital a  
 29 categorical rate per admission, out-of-area categorical rate per  
 30 admission, or the categorical rate per admission for MSA or  
 31 non-MSA hospitals.

32 Subp. 4. Adjustment to reimbursement. Reimbursements made  
 33 by-the-department shall be adjusted by the department for the  
 34 reasons specified in subpart 5 and for inappropriate utilization  
 35 as determined by the commissioner under parts 9505.1910 to  
 36 9505.2020 {Emergency}. Adjustment to a hospital's account shall



1 be by debit.

2 Subp. 5. Rejection of claims. Claims will not be  
3 reimbursed for a hospital's failure to:

- 4 A. obtain prior authorization;
- 5 B. provide documentation of a confirming second  
6 surgical opinion;
- 7 C. receive admission certification; and
- 8 D. assign a claim to one of diagnostic categories A  
9 to II in part 9500.1100, subpart 20.

10 Subp. 6. Medicare crossover claims. Medicare crossover  
11 claims shall be reimbursed as follows:

12 Medicare [(medicare deductibles), plus  
13 Crossover = (medicare coinsurance), plus (amounts  
14 Reimbursement for services covered by medical  
15 assistance but not by medicare)]

16 Subp. 7. Reimbursement for transfers. The department  
17 shall reimburse hospitals who discharge transfers and who admit  
18 transfers. Each hospital shall be reimbursed as follows:

19 [(adjusted base year cost per  
20 admission) multiplied by (the relative  
21 Transfer value of the appropriate diagnostic  
22 Reimbursement = category), divided by (the geometric  
23 mean length of stay of the diagnostic  
24 category) and multiplied by (the number  
25 of days of inpatient hospital  
26 services), plus (budget year  
27 pass-through cost per admission)]

28 In no case may a hospital receive a transfer reimbursement  
29 ~~for-a-transfer~~ that exceeds the adjusted base year cost per  
30 admission multiplied by the relative value of the appropriate  
31 diagnostic category unless the transfer is an outlier.

32 Subp. 8. Reimbursement for admissions readmissions. An  
33 admission and readmission to the same hospital shall be  
34 reimbursed with one categorical rate per admission  
35 and ~~reimbursed-for~~ as an outlier if appropriate. A readmission  
36 to a different hospital shall be reimbursed as a transfer as

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1 specified in subpart 7.

2 Subp. 9. Reimbursement for outliers. The department shall  
3 reimburse a hospital for outliers with a categorical rate per  
4 admission, out-of-area categorical rate per admission, or the  
5 categorical rate per admission for MSA or non-MSA hospitals,  
6 plus an amount for outliers as follows:

7 A. To determine reimbursements for day outliers the  
8 department shall:

9 (1) multiply a hospital's adjusted base year cost  
10 per admission by the relative value of the appropriate  
11 diagnostic category;

12 (2) divide the product in subitem (1) by the  
13 geometric mean length of stay for the diagnostic category;

14 (3) multiply the per day amount as determined in  
15 subitem (2) by 60 percent to establish for diagnostic categories  
16 A to N, and P to II, under part 9500.1100, subpart 20 or 80  
17 percent for diagnostic category O, under part 9500.1100, subpart  
18 20 to determine the per day rate for the diagnostic category;

19 (4) ~~subtract the number of inpatient days at~~  
20 ~~three standard deviations for the diagnostic category as~~  
21 ~~identified in part 9500.1110, subpart 1, item G from the actual~~  
22 ~~number of inpatient days to establish the number of outlier days~~  
23 subtract the number of days of inpatient hospital services at  
24 two standard deviations for diagnostic categories A to N and P  
25 to II under part 9500.1100, subpart 20 or the number of days of  
26 inpatient hospital services at one standard deviation for  
27 diagnostic category O, under part 9500.1100, subpart 20, as  
28 determined under part 9500.1110, subpart 1, item G from the  
29 actual number of days a recipient has received inpatient  
30 hospital services to determine the number of outlier days; and

31 (5) multiply the product determined in subitem  
32 (3) by the number of days determined in subitem (4).

33 B. To determine reimbursements for cost outliers the  
34 department shall:

35 (1) determine a statewide base year  
36 cost-to-charge ratio according to hospitals' statewide base year

1 medicare/medical assistance cost reports;

2 (2) multiply the hospital's billed charges by the  
3 statewide cost-to-charge ratio;

4 (3) subtract the cost at three standard  
5 deviations for the diagnostic category categories A to N, and P  
6 to II, under part 9500.1100, subpart 20 and one standard  
7 deviation for diagnostic category O, under part 9500.1100,  
8 subpart 20 as identified in part 9500.1110, subpart 1, item G  
9 from the adjusted cost from subitem (2); and

10 (4) multiply the amount determined in subitem (3)  
11 by 60 percent for diagnostic categories A to N, and P to II,  
12 under part 9500.1100, subpart 20 or by 80 percent for diagnostic  
13 category O, under part 9500.1100, subpart 20.

14 C. If an admission is a day and a cost outlier, the  
15 hospital shall receive reimbursement as a day outlier.

16 Subp. 10. Reimbursement to out-of-area hospital. The  
17 department shall reimburse out-of-area hospitals based on the  
18 lesser of billed charges or the out-of-area hospital categorical  
19 rate per admission. The department shall determine the  
20 out-of-area categorical rate per admission as follows in items A  
21 to E G:

22 A. multiply the adjusted allowable base year cost per  
23 admission in effect on the first day of a calendar year for each  
24 hospital statewide by the number of admissions in each  
25 hospital's base year, excluding outliers;

26 B. sum the products in item A;

27 C. divide the sum from item B by the sum of all  
28 admissions for all hospitals statewide, excluding outliers, to  
29 determine the statewide adjusted allowable base year cost per  
30 admission;

31 D. multiply the pass-through cost per admission in  
32 effect on the first day of a calendar year for each hospital  
33 statewide by the number of admissions in each hospital's base  
34 year, excluding outliers;

35 E. sum the products in item D;

36 F. divide the sum from item E by the sum of all

1 admissions for all hospitals statewide, excluding outliers, to  
2 determine a statewide pass-through cost per admission;

3 G. the department shall determine the categorical  
4 rate per admission for an out-of-area hospital as follows:

5 Out-of-area [(statewide adjusted base year cost per  
6 Hospital admission) multiplied by (the relative  
7 Categorical = value of the appropriate diagnostic  
8 Rate Per category), plus (statewide budget year  
9 Admission pass-through cost per admission)]

10 Subp. 11. Reimbursement for MSA and non-MSA hospitals

11 statewide which that do not have admissions in the base year.

12 ~~The department shall reimburse statewide hospitals which do not~~  
13 ~~have admissions in the base year by using the statewide adjusted~~  
14 ~~base year cost per admission as specified in subpart 10, item C,~~  
15 ~~multiplied by the relative value of the appropriate diagnostic~~  
16 ~~category plus the budget year pass-through cost per admission~~  
17 ~~according to part 9500.1125, subpart 2. The pass-through cost~~  
18 ~~per admission will be adjusted under part 9500.1125, subpart 4,~~  
19 ~~and will be subject to part 9500.1125, subpart 5. The~~  
20 department shall determine reimbursements for MSA hospitals  
21 statewide that do not have admissions in the base year according  
22 to items A to E:

23 A. Multiply the adjusted allowable base year cost per  
24 admission in effect on the first day of a calendar year for each  
25 MSA hospital statewide by the number of admissions in each MSA  
26 hospital's base year, excluding outliers.

27 B. Sum the products in item A.

28 C. Divide the sum from item B by the sum of all  
29 admissions for all MSA hospitals statewide, excluding outliers,  
30 to determine the statewide adjusted allowable base year cost per  
31 admission for MSA hospitals.

32 D. The budget year pass-through cost per admission  
33 must be determined according to part 9500.1125, subpart 2. The  
34 pass-through cost per admission will be adjusted under part  
35 9500.1125, subpart 4, and must be subject to part 9500.1125,  
36 subpart 5.

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1 E. Determine the categorical rate per admission for  
2 MSA hospitals statewide as follows:

3 Categorical-Rate-per [(statewide-adjusted-base-year-cost  
4 Admission-Per-Hospitals per-admission)-multiplied-by-(the  
5 Statewide-Which-Do relative-value-of-the-appropriate  
6 Not-Have-Admissions = diagnostic-category)-plus-(budget  
7 In-The-Base-Year year-pass-through-cost-per  
8 admission)]

9 Categorical Rate per [(adjusted base year cost  
10 Admission for MSA Hospitals per admission for MSA hospitals  
11 statewide) multiplied by (the  
12 Statewide Which Do relative value of the appropriate  
13 Not Have Admissions = diagnostic category) plus (budget  
14 In The Base Year year pass-through cost per  
15 admission)]

16 F. Determine the categorical rate per admission for  
17 non-MSA hospitals by substituting non-MSA hospitals terms and  
18 data for the MSA hospitals terms and data used in items A to E.

19 Subp. 12. Payor of last resort. A hospital may not submit  
20 a claim to the department until a final determination of the  
21 recipient's eligibility for potential third party payment has  
22 been made by a hospital. Any and all available third party  
23 benefits must be exhausted prior to billing medical assistance  
24 and the amounts collected must be shown on the claim.

25 9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

26 Subpart 1. Determination of disproportionate population  
27 adjustment. The department shall increase the adjusted base  
28 year cost per admission for hospitals whose medical assistance  
29 and general assistance medical care admissions exceed 15 percent  
30 of total hospital admissions according to the following schedule:

31 Percentage of Total  
32 Hospital Admissions  
33 Which are Medical  
34 Assistance and General Increase in Adjusted Base  
35 Assistance Medical Care Year Cost Per Admission

36

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|    |                      |                                     |
|----|----------------------|-------------------------------------|
| 1  | 15-20 percent        | 1/4 percent for each percentage     |
| 2  |                      | point above 15 percent <u>up to</u> |
| 3  |                      | <u>20 percent</u>                   |
| 4  | 21-25 percent        | 1/2 percent for each percentage     |
| 5  |                      | point above 20 percent <u>up to</u> |
| 6  |                      | <u>25 percent</u>                   |
| 7  | 26-30 percent        | 3/4 percent for each percentage     |
| 8  |                      | point above 25 percent <u>up to</u> |
| 9  |                      | <u>30 percent</u>                   |
| 10 | 31 percent and above | 1 percent for each percentage       |
| 11 |                      | point above 30 percent              |

12 The department shall multiply the disproportionate  
 13 population adjustment by the adjusted base year cost per  
 14 admission after the application of any statutory limits to the  
 15 growth in hospital rates or unit costs.

16 Subp. 2. Limitation on disproportionate population  
 17 adjustment. In no case shall the disproportionate population  
 18 adjustment exceed twice the HCI as determined in part 9500.1120.  
 19 9500.1140 APPEALS.

20 Subpart 1. Appointment-of Appeals board. The-appeals  
 21 board-shall-be-appointed-by The commissioner shall appoint an  
 22 appeals board to review hospitals' requests for changes in their  
 23 reimbursement rates. The appeals board shall consist of two  
 24 public representatives, two representatives of the hospital  
 25 industry, and one representative of the business or consumer  
 26 community. Any hospital that desires to have its rate reviewed  
 27 by the appeals board shall submit to the commissioner a written  
 28 request which states the rate and reasons for the request.  
 29 Within 90 days of the request, the appeals board shall meet with  
 30 persons selected by the hospital and persons from the  
 31 department. The appeals board shall make a written report and  
 32 recommendation to the commissioner. The commissioner shall  
 33 issue a written decision on the request for a change in the  
 34 hospital's rate within 30 days after receiving the report of the  
 35 appeals board.

36 Subp. 2. Composition-of-appeals-board Contested case

1 hearing. The appeals board shall consist of two public  
 2 representatives, two representatives of the hospital industry,  
 3 and one representative of the business or consumer community.  
 4 Representatives shall serve for a period of two years. A hospital  
 5 may appeal a decision of the commissioner issued pursuant to  
 6 subpart 1, by filing a written notice of appeal with the  
 7 commissioner within 30 days of the date of service of the  
 8 decision appealed. The appeal must be conducted as a contested  
 9 case hearing under Minnesota Statutes, chapter 14 and the rules  
 10 of the Office of Administrative Hearings.

11 ~~Subp. 3. Duties of appeals board. The appeals board shall~~  
 12 ~~review a hospital's request that its reimbursement rate be~~  
 13 ~~changed and recommend to the commissioner what action should be~~  
 14 ~~taken on the request.~~

15 9500.1145 PROCEDURES OF APPEALS BOARD.

16 ~~Subpart 1. Notice of appeal. A hospital that wants to~~  
 17 ~~appeal a rate must notify the department of its intent to appeal~~  
 18 ~~within 30 days of the effective date of the rate appealed or~~  
 19 ~~within 30 days of the change in circumstances which prompted the~~  
 20 ~~appeal. The notice of appeal must state the rate appealed and~~  
 21 ~~the reasons for the appeal.~~

22 ~~A. Within 90 days of the receipt of a notice of~~  
 23 ~~appeal, the board shall conduct a hearing.~~

24 ~~B. The appeals board shall send a notice of hearing~~  
 25 ~~to the hospital at least 20 days before the hearing. The notice~~  
 26 ~~shall contain, at a minimum, the following:~~

27 ~~(1) the time, date, and place for the hearing;~~

28 ~~(2) the name, address, and telephone number of~~  
 29 ~~the department's representative to be contacted to discuss~~  
 30 ~~informal disposition of the dispute;~~

31 ~~(3) notification that a party need not be~~  
 32 ~~represented by an attorney but may choose to be represented by~~  
 33 ~~an attorney or any other person of their choice; and~~

34 ~~(4) a statement advising parties that failure to~~  
 35 ~~appear at the hearing will result in default.~~

36 ~~Subp. 2. Rights and obligations of appeals board. The~~

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1 following-are-the-rights-and-obligations-of-the-appeals-board:

2 A.--A-member-of-the-appeals-board-shall-be-free-of-any  
3 personal,-political,-or-economic-association-that-would-impair  
4 his-or-her-ability-to-function-in-a-fair-and-objective-manner.

5 Should-a-board-member-believe-that-he-or-she-cannot-comply-with  
6 this-rule,-the-member-shall-withdraw-from-hearing-the-appeal.

7 B.--A-member-of-the-appeals-board-shall-not  
8 communicate,-directly-or-indirectly,-with-any-person-or-party  
9 concerning-any-issue-of-fact-or-law-relevant-to-a-pending-case  
10 except-upon-notice-to-all-parties-and-opportunity-for-them-to  
11 participate-except-as-otherwise-permitted-by-these-rules.

12 C.--Consistent-with-law-and-parts-9500.1090-to  
13 9500.1155,-the-appeals-board-shall-perform-the-following-duties:

14 (1)-Appoint-one-of-its-members-to-act-as  
15 chairperson.

16 (2)-Examine-witnesses-as-necessary-to-make-a  
17 complete-record.

18 (3)-Issue-a-written-report-to-the-commissioner  
19 regarding-each-appeal.--The-report-shall-contain-findings-of  
20 fact,-conclusions,-and-a-recommended-disposition.

21 (4)-All-actions-of-the-appeals-board-shall-be-by  
22 majority-rule-of-the-board-members-present.

23 (5)-Do-all-things-necessary-and-proper-to-the  
24 performance-of-the-foregoing.

25 Subp.-3.--Appeal-rights.--A-hospital-may-appeal-a-decision  
26 of-the-commissioner-by-serving-a-written-notice-of-appeal-with  
27 the-commissioner-within-30-days-of-the-date-of-service-of-the  
28 decision-appealed.--The-appeal-shall-be-conducted-under-the  
29 contested-case-procedures-of-Minnesota-Statutes,-chapter-14-and  
30 the-rules-of-the-Office-of-Administrative-Hearings.

31 9500.1150 REIMBURSEMENT OF ADMISSIONS FOR HOSPITAL FISCAL YEARS  
32 BEGINNING ON OR AFTER JULY 1, 1983, UNTIL JULY-28,-1985 THE  
33 EFFECTIVE DATE OF PARTS 9500.1090 TO 9500.1155.

34 Subpart 1. Purpose Statutory limit. Under Minnesota  
35 Statutes, section 256.969, the annual increase in the cost per  
36 service unit for inpatient hospital services under medical

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1 assistance or general assistance medical care shall not exceed  
2 five percent for hospital rate years beginning during the 1985  
3 biennium.

4 Subp. 2. Definitions. As used in this part, the following  
5 terms have the meanings given to them.

6 A. "Adjusted base year costs" means an allowable base  
7 year costs cumulatively multiplied by the hospital cost index  
8 ~~for through~~ a hospital's ~~fiscal-years-prior-to-the-budget~~  
9 current year, and adjustments resulting from appeals.

10 B. "Allowable base year costs" means a hospital's  
11 reimbursable inpatient hospital costs as identified in a  
12 hospital's base year medicare/medical assistance cost report  
13 with the following adjustments:

14 (1) subtract malpractice insurance costs that  
15 have been apportioned to medical assistance;

16 (2) subtract pass-through costs (except  
17 malpractice insurance costs) apportioned to medical assistance  
18 based on the ratio of net reimbursable inpatient hospital costs  
19 to total reimbursable costs; and

20 (3) add the lower of cost or charge limitations  
21 for costs disallowed on the medicare/medical assistance cost  
22 report as provided by Public Law Number 92-603, section 223,  
23 inpatient routine service cost limitations, and Public Law  
24 Number 92-603, section 233.

25 C. "Minimal participation" means a hospital with  
26 fewer than 100 combined medical assistance and general  
27 assistance medical care admissions in the base year.

28 D. "Rate per admission" means the adjusted base year  
29 cost for each admission multiplied by the budget year HCI and  
30 adding the budget year pass-through cost per admission.

31 E. "Rate per day" means the allowable adjusted base  
32 year cost per day of inpatient hospital services multiplied by  
33 the budget year HCI and adding the budget year pass-through cost  
34 per day of inpatient hospital services.

35 Subp. 3. Determination of allowable base year costs,  
36 allowable base year cost for each admission, and allowable base

1 year cost per day. The department shall determine allowable  
2 base year costs from the base year medicare/medical assistance  
3 cost report, using data from the HCFA Form 2552 Worksheet, 1981  
4 revision. The department shall make the determination following  
5 the steps outlined in items A to P:

6 A. reimbursable inpatient hospital costs (Worksheet  
7 E-5, Part I, line 13);

8 B. reimbursable malpractice insurance costs  
9 (Worksheet E-5, Part I, line 5);

10 C. reimbursable professional services (Worksheet E-5,  
11 Part I, line 11);

12 D. net reimbursable inpatient hospital costs  
13 (subtract items B and C from item A);

14 E. total reimbursable costs (Worksheet A, column 7,  
15 line 84);

16 F. ratio of net reimbursable inpatient hospital costs  
17 to total reimbursable costs (item D divided by item E);

18 G. pass-through costs, except malpractice insurance  
19 costs;

20 H. medical assistance pass-through costs, except  
21 malpractice insurance costs (item F multiplied by item G);

22 I. routine service costs before limitation (Worksheet  
23 D-1, line 57);

24 J. reimbursable routine service costs (Worksheet D-1,  
25 line 61);

26 K. reimbursable routine service costs subject to  
27 limitation (subtract item J from item I);

28 L. allowable base year costs (subtract item H from  
29 item D and add item K);

30 M. base year admissions excluding medicare crossovers;

31 N. allowable base year cost for each admission (item  
32 L divided by item M);

33 O. base year patient days excluding medicare  
34 crossovers; and

35 P. allowable base year cost per day (item L divided  
36 by item O).

1 Subp. 4. Determination of rate per admission and rate per  
2 day. The department shall determine the rate per admission and  
3 rate per day according to items A to G.

4 A. For each hospital's budget year, each hospital  
5 shall submit to the department a written report of pass-through  
6 costs. Pass-through cost reports must include actual data for  
7 the prior year and budgeted data for the current and budget  
8 years. Pass-through cost reports are due 60 days prior to the  
9 start of each hospital's budget year and must include the  
10 following information:

| 11 |                           | Prior    | Current  | Budget   |
|----|---------------------------|----------|----------|----------|
| 12 |                           | Year     | Year     | Year     |
| 13 | Subitem                   | (Actual) | (Budget) | (Budget) |
| 14 |                           |          |          |          |
| 15 | (1) Depreciation          | _____    | _____    | _____    |
| 16 | (2) Rents and leases      | _____    | _____    | _____    |
| 17 | (3) Property taxes        | _____    | _____    | _____    |
| 18 | (4) License fees          | _____    | _____    | _____    |
| 19 | (5) Interest              | _____    | _____    | _____    |
| 20 | (6) Malpractice insurance | _____    | _____    | _____    |
| 21 | (7) TOTAL PASS-THROUGH    |          |          |          |
| 22 | COSTS [subitems           |          |          |          |
| 23 | (1) to (6)]               | _____    | _____    | _____    |

24 Pass-through costs are limited to subitems (1) to (6) as  
25 defined by medicare. Pass-through costs do not include costs  
26 derived from capital projects requiring a certificate of need  
27 for which the required certificate of need has not been granted.

28 B. The department shall determine the budget year  
29 pass-through cost per admission or per day, or both, from the  
30 submitted pass-through cost reports as specified in item A as  
31 follows:

| 32 |         | Prior    | Current  | Budget   |
|----|---------|----------|----------|----------|
| 33 |         | Year     | Year     | Year     |
| 34 | Subitem | (Actual) | (Budget) | (Budget) |
| 35 |         |          |          |          |

36 (1) Ratio of net

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|    |                           |       |       |       |
|----|---------------------------|-------|-------|-------|
| 1  | reimbursable              |       |       |       |
| 2  | inpatient                 |       |       |       |
| 3  | hospital costs to         |       |       |       |
| 4  | total reimbursable        |       |       |       |
| 5  | costs [subpart            |       |       |       |
| 6  | 3, item F]                | _____ | _____ | _____ |
| 7  | (2) Pass-through costs    |       |       |       |
| 8  | as-specified-in           |       |       |       |
| 9  | [subpart 4, item A,       |       |       |       |
| 10 | subitem (7)]              | _____ | _____ | _____ |
| 11 | (3) Base year admissions  |       |       |       |
| 12 | [subpart 3, item M]       | _____ | _____ | _____ |
| 13 | (4) Pass-through cost     |       |       |       |
| 14 | per admission             |       |       |       |
| 15 | [subitem (2) divided      |       |       |       |
| 16 | by subitem (3)]           | _____ | _____ | _____ |
| 17 | (5) Base year patient     |       |       |       |
| 18 | days [subpart 3,          |       |       |       |
| 19 | item O]                   | _____ | _____ | _____ |
| 20 | (6) Pass-through cost per |       |       |       |
| 21 | day of inpatient          |       |       |       |
| 22 | hospital services         |       |       |       |
| 23 | [subitem (2)              |       |       |       |
| 24 | divided by subitem        |       |       |       |
| 25 | (5)]                      | _____ | _____ | _____ |

26 C. The department shall determine the rate per  
 27 admission for a budget year as follows:

28 Rate [(Adjusted base year cost for each  
 29 Per = admission) multiplied by (budget year HCI),  
 30 Admission plus (budget year pass-through cost per  
 31 admission)]

32 D. The department shall determine the rate per day  
 33 for a budget year as follows:

34 Rate [(Adjusted base year cost per day of inpatient  
 35 Per = hospital services) multiplied by (budget year  
 36 Day HCI), plus (budget year pass-through cost per

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1 day of inpatient hospital services)]

2 E. After the end of each budget year, the  
 3 commissioner shall redetermine the rate per admission or rate  
 4 per day, or both. The commissioner shall substitute actual  
 5 pass-through costs as determined by medicare for budgeted costs  
 6 in item B, subitem (2) for that year. If an adjustment  
 7 indicates an overpayment to the hospital, the hospital shall pay  
 8 the ~~department~~ commissioner the overpayment within 60 days of  
 9 ~~formal~~ written notification from the ~~department~~ commissioner.  
 10 If the adjustment indicates an underpayment to the hospital, the  
 11 department shall pay ~~the~~ that hospital the underpayment within  
 12 60 days of ~~formal~~ written notification from the ~~department~~  
 13 commissioner. Interest charges will be assessed according to  
 14 part 9500.1125, subpart 5.

15 F. A hospital with minimal participation shall be  
 16 reimbursed on a rate per day in lieu of a rate per admission  
 17 unless the hospital elects to be reimbursed on a rate per  
 18 admission basis. To obtain reimbursement on a rate per  
 19 admission basis, the hospital shall submit a written request to  
 20 the commissioner at least 30 days prior to the beginning of the  
 21 budget year for which reimbursement is sought.

22 G. The department shall apply the disproportionate  
 23 population adjustment as specified in part 9500.1135, subpart 1,  
 24 substituting the term adjusted base year cost per admission with  
 25 a the term rate per admission or rate per day.

26 H. Reimbursement procedures are as specified in part  
 27 9500.1130, subparts 1 to 6.

28 I. Appeals must be made according to parts 9500.1140  
 29 and 9500.1145.

30 9500.1155 REIMBURSEMENT OF ADMISSIONS THAT OCCUR ON OR AFTER  
 31 JANUARY 1, 1982, UNTIL PART 9500.1150 BECOMES EFFECTIVE.

32 Subpart 1. Purpose. Under Minnesota Statutes 1982,  
 33 section 256.966, the annual increase in the cost per service  
 34 unit paid to any vendor under medical assistance or general  
 35 assistance medical care shall not exceed eight percent for  
 36 services provided from January 1, 1982, until part 9500.1150

1 becomes applicable.

2 Subp. 2. Definitions. As used in this part, the following  
3 terms have the meanings given them:

4 A. "Adjusted base year costs" means allowable base  
5 year costs cumulatively multiplied by the eight percent cap for  
6 a hospital's fiscal years prior to the rate year, and  
7 adjustments resulting from appeals.

8 B. "Allowable base year costs" means a hospital's  
9 reimbursable inpatient hospital costs as identified in a  
10 hospital's base year medicare/medical assistance cost report  
11 with the following adjustments:

12 (1) subtract malpractice insurance costs that  
13 have been apportioned to medical assistance;

14 (2) subtract pass-through costs (except  
15 malpractice insurance costs) apportioned to medical assistance  
16 based on the ratio of net reimbursable inpatient hospital costs  
17 to total hospital costs; and

18 (3) add the lower of cost or charge limitations  
19 for costs disallowed on the medicare/medical assistance cost  
20 report as provided by Public Law Number 92-603, section 223,  
21 inpatient routine service cost limitations, and Public Law  
22 Number 92-603, section 233.

23 C. "Allowable rate period costs" means a hospital's  
24 reimbursable inpatient hospital costs as identified in a  
25 hospital's rate period medicare/medical assistance cost report  
26 with the following adjustments:

27 (1) subtract malpractice insurance costs that  
28 have been apportioned to medical assistance;

29 (2) subtract pass-through costs, except  
30 malpractice insurance costs, apportioned to medical assistance  
31 based on the ratio of net reimbursable inpatient hospital costs  
32 to total hospital costs.

33 D. "Eight percent cap" means the limit on the annual  
34 cost increase per service unit under Minnesota Statutes, section  
35 256.966.

36 B E. "Rate per admission" means the allowable base

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1 year cost for each admission multiplied by the eight percent cap  
2 and adding the rate year pass-through cost per admission.

3 E F. "Rate per day" means the allowable base year  
4 cost per day of inpatient hospital services multiplied by the  
5 eight percent cap and adding the rate year pass-through cost per  
6 day of inpatient hospital services.

7 F G. "Rate year period" means any hospital portion of  
8 a hospital's fiscal year that includes any portion of the period  
9 from January 1, 1982, until part 9500.1150 becomes applicable.

10 G H. "Total hospital costs" means the costs  
11 identified in the hospital's base year medicare/medical  
12 assistance cost report, HCFA Form 2552, 1981 revision, Worksheet  
13 A, column 3, line 84.

14 Subp. 3. Determination of allowable base year costs,  
15 allowable base year cost for each admission, and allowable base  
16 year cost per day. The department shall determine allowable  
17 base year costs from the base year medicare/medical assistance  
18 cost report, using data from the HCFA Form 2552 Worksheet, 1981  
19 revision. The department shall make the determinations by  
20 following the steps outlined in items A to Q:

21 A. reimbursable inpatient hospital costs (Worksheet  
22 E-5, Part I, line 13);

23 B. reimbursable malpractice insurance costs  
24 (Worksheet E-5, Part I, line 5);

25 C. net reimbursable inpatient hospital costs  
26 (subtract item B from item A);

27 D. total hospital costs (Worksheet A, column 3, line  
28 84);

29 E. malpractice insurance costs (Worksheet A, column  
30 5, line 71);

31 F. net total hospital costs (subtract item E from  
32 item D);

33 G. ratio of net reimbursable inpatient hospital costs  
34 to net total hospital costs (item C divided by item F);

35 H. pass-through costs, except malpractice insurance  
36 costs;

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- 1 I. medical assistance pass-through costs, except  
 2 malpractice insurance costs (item G multiplied by item H);
- 3 J. routine service costs before limitation (Worksheet  
 4 D-1, line 57);
- 5 K. reimbursable routine service costs (Worksheet D-1,  
 6 line 61);
- 7 L. reimbursable routine service costs subject to  
 8 limitation (subtract item K from item J);
- 9 M. allowable base year costs (subtract item I from  
 10 item C and add item L);
- 11 N. base year ~~admission~~ admissions excluding medicare  
 12 crossovers;
- 13 O. allowable base year cost for each admission (item  
 14 M divided by item N);
- 15 P. base year patient days excluding medicare  
 16 crossovers; and
- 17 Q. allowable base year cost per day of inpatient  
 18 hospital services (item M divided by item P).
- 19 Subp. 4. Determination of allowable rate period costs,  
 20 allowable rate period cost for each admission, and allowable  
 21 rate period cost per day. The department shall determine  
 22 allowable rate period costs from the rate period  
 23 medicare/medical assistance cost report using data from the HCFA  
 24 Form 2552 worksheet, 1981 revision. The department shall make  
 25 the determinations by following the steps outlined in items A to  
 26 N:
- 27 A. reimbursable inpatient hospital costs (Worksheet  
 28 E-5, Part I, line 13);
- 29 B. reimbursable malpractice insurance costs  
 30 (Worksheet E-5, Part I, line 5);
- 31 C. net reimbursable inpatient hospital costs  
 32 (subtract item B from item A);
- 33 D. total hospital costs (Worksheet A, column 3, line  
 34 84);
- 35 E. malpractice insurance costs (Worksheet A, column  
 36 5, line 71);

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1 F. net total hospital costs (subtract item E from  
2 item D);

3 G. ratio of net reimbursable inpatient hospital costs  
4 to net total hospital costs (item C divided by item F);

5 H. pass-through costs, except malpractice insurance  
6 costs;

7 I. medical assistance pass-through costs except  
8 malpractice insurance costs (item G multiplied by item H);

9 J. allowable rate period costs (subtract item I from  
10 item C);

11 K. rate period admissions excluding medicare  
12 crossovers;

13 L. allowable rate period cost for each admission  
14 (item J divided by item K);

15 M. rate period patient days excluding medicare  
16 crossovers; and

17 N. allowable rate period cost per day of inpatient  
18 hospital services (item J divided by item M).

19 Subp. 5. Determination of rate per admission and rate per  
20 day. The following data shall be determined:

21 A. The department shall determine the rate year  
22 period pass-through costs per admission or per day of inpatient  
23 hospital services, or both, for the rate year period as  
24 specified in part 9500.1150, subpart 4, item B.

25 B. The department shall multiply the allowable base  
26 year costs by the eight percent cap.

27 C. The department shall determine the rate per  
28 admission for a rate year period as follows:

29 Lesser of the [(allowable base year cost for  
30 Rate each admission) multiplied by (8 eight  
31 Per = percent cap), or the allowable rate period  
32 Admission cost for each admission plus (rate year  
33 period pass-through cost per admission)]

34 ~~in-calculating-the-rate-year-pass-through-cost-per~~  
35 ~~admission;-the-department-shall-use-the-total-admissions-from~~  
36 ~~the-hospital's-base-year.~~

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1 After the initial year, adjusted base year costs are used  
2 in the rate per admission formula instead of allowable base year  
3 costs.

4 D. The department shall determine the rate per day  
5 for a rate year period as follows:

|    |  |
|----|--|
| 6  | <u>Lesser of the</u> [(allowable base year cost per day          |
| 7  | Rate of inpatient hospital services) multiplied by               |
| 8  | Per = (8 <u>eight</u> percent cap), <u>or the allowable rate</u> |
| 9  | Day <u>period cost per day of inpatient hospital</u>             |
| 10 | <u>services</u> plus (rate year <u>period</u> pass-through cost  |
| 11 | per day of inpatient hospital services)]                         |
| 12 | per day of inpatient hospital services)]                         |

13 ~~In calculating the rate year pass-through cost per day of~~  
14 ~~inpatient hospital services, the department shall use the total~~  
15 ~~days of inpatient hospital services from the hospital's base~~  
16 ~~year.~~

17 After the initial year, adjusted base year costs are used  
18 in the rate per day formula instead of allowable base year costs.

19 E. A hospital with minimal participation, as  
20 specified in part 9500.1150, subpart 4, item F, shall be  
21 reimbursed on a rate per day in lieu of rate per admission  
22 unless the hospital elects to be reimbursed on a rate per  
23 admission basis.

24 F. The department shall apply the disproportionate  
25 population adjustment as specified in part 9500.1135,  
26 substituting the term adjusted base year cost per admission with  
27 the term rate per admission or rate per day.

28 G. Reimbursement procedures are as specified in part  
29 9500.1130, subparts 1 to 6.

30 H. Appeals must be made according to parts 9500.1140  
31 and 9500.1145.

32 Subp. 5 6. **Four percent reduction.** Reimbursement for  
33 admissions is reduced four percent from January 1, 1983, through  
34 June 30, 1983, as provided in Laws of Minnesota 1982, Third  
35 Special Session, chapter 1, article 2, section 2, subdivision 4,  
36 paragraph (a), clause (4). Each rate per admission and each

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1 rate per day as determined under subpart 4 for each admission  
2 during the period from January 1, 1983, through June 30, 1983,  
3 shall be reduced by four percent.

4

5 Effective Date. Parts 9500.1090 to 9500.1155 are effective

6 August 1, 1985.

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