Department of Human Services

Adopted Rules Relating to Hospital Medical Assistance Reimbursement

Rules as Adopted

9500.1090 PURPOSE AND SCOPE.

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

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

9500.1095 STATUTORY AUTHORITY.

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

9500.1100 DEFINITIONS.

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

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

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

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

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

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

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

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

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

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

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

Subp. 11. **Case mix.** "Case mix" means ~~the~~ a distribution of admissions in the diagnostic categories.

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

Subp. 13. **Claims.** "Claims" means ~~the~~ information contained on the inpatient hospital invoices submitted to the

APPROVED BY THE REVISOR OF STATUTES OFFICE BY:

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

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

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

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

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

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

Subp. 19. **Department.** "Department" means the Minnesota Department of Human Services.

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

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

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

	the Eye	(36-48)
C.	Diseases and Disorders of the Ear, Nose, and Throat	(49-74)
D.	Diseases and Disorders of the Respiratory System	(75-97, 99-102)
E.	Diseases and Disorders of the Circulatory System	(103-145)
F.	Diseases and Disorders of the Digestive System	(146-183, 185-190)
G.	Diseases and Disorders of the Hepatobiliary System and Pancreas	(191-208)
H.	Diseases and Disorders of the Musculoskeletal System and Connective Tissues	(209-256)
I.	Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	(257-284)
J.	Endocrine, Nutritional, and Metabolic Diseases and Disorders	(285-301)
K.	Diseases and Disorders of the Kidney and Urinary Tract	(302-333)
L.	Diseases and Disorders of the Male Reproductive System	(334-352)
M.	Diseases and Disorders of the Female Reproductive System	(353-369)
N.	Pregnancy, Childbirth, and the Puerperium	(370, 374-384)
O.	Newborns and Other Neonates with Conditions Originating in the Perinatal Period	(385-390)
P.	Diseases and Disorders of the Blood and Blood-Forming Organs and Immunity Disorders	(392-399)

APPROVED BY THE REVISOR OF STATUTES OFFICE BY:

Q.	Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms NEC	(400-414)
R.	Infectious and Parasitic Diseases (Systemic or Unspecified Sites)	(415-423)
S.	Mental Diseases and Disorders	(424-425, 427-429, 432)
T.	Substance Use and Substance Induced Organic Mental Disorders (Ages 0-20)	(433-438)
U.	Substance Use and Substance Induced Organic Mental Disorders (Ages over 21)	(433-438)
V.	Injury, Poisoning, and Toxic Effects of Drugs	(439-455)
W.	Burns	(456-460)
X.	Factors Influencing Health Status and Other Contacts with Health Services	(461-467)
Y.	Bronchitis and Asthma (Ages 0-1)	(98)
Z.	Bronchitis and Asthma (Ages 2-17)	(98)
AA.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 0-1)	(184)
BB.	Esophagitis, Gastroenteritis, Miscellaneous Digestive Disorders (Ages 2-17)	(184)
CC.	Cesarean section without cormorbidities and complications	(371)
DD.	Vaginal delivery with complicating diagnosis	(372)

EE.	Vaginal delivery without complicating diagnosis and Normal newborns	(373), (391)
FF.	Depressive neurosis	(426)
GG.	Psychosis	(430)
HH.	Childhood mental disorders	(431)
II.	Unrelated Operating room procedure	(468)
JJ.	Cases which could not be assigned to other diagnostic categories	(469-470)

Subp. 21. **Discharge.** "Discharge" means a release of a recipient from a hospital.

Subp. 22. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the program established by Minnesota Statutes, section 256D.03.

Subp. 23. **Geometric mean cost per admission.** "Geometric mean cost per admission" means the nth root of the product of the reimbursable inpatient hospital costs per admission for n admissions.

Subp. 24. **Geometric mean length of stay.** "Geometric mean length of stay" means the nth root of the product of the number of days spent in a hospital for each admission for n admissions.

Subp. 25. **Hospital.** "Hospital" means an institution that, except for state-operated facilities, is approved to participate as a hospital under medicare.

Subp. 26. **Hospital cost index or HCI.** "Hospital cost index" or "HCI" means a single percentage annually multiplied by the adjusted base year cost per admission or the adjusted base year costs to adjust for inflation.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided under the supervision of a physician and furnished in a hospital for the care and treatment of a recipient. The inpatient hospital service may be furnished by a physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical

assistance reimbursement.

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

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

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

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

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

Subp. 33. **Metropolitan statistical area hospital or MSA hospital.** "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare.

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

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

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

Subp. ~~35~~ 37. **Out-of-area hospital.** "Out-of-area hospital"

means any hospital outside of Minnesota.

Subp. ~~36~~ 38. **Pass-through costs.** "Pass-through costs" means reimbursable inpatient hospital costs not subject to the HCI.

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

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

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

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

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

Subp. ~~42~~ 44. **Reimbursable inpatient hospital costs.** "Reimbursable inpatient hospital costs" means those costs allowable under Title XVIII of the Social Security Act for inpatient hospital services.

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

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

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

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

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

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

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

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

9500.1105 REIMBURSEMENT OF INPATIENT HOSPITAL SERVICES.

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

9500.1110 DETERMINATION AND PUBLICATION OF RELATIVE VALUES OF DIAGNOSTIC CATEGORIES.

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

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

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

C. exclude from item B the following claims:

(1) medicare crossover claims,

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

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

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

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

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

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

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

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

F. assign each admission to a diagnostic category;

G. identify outliers for each diagnostic category;

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

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

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

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

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

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

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

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

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

B. subtract from the amount determined in item A the

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

amounts in subitems (1) and (2):

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

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

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

D. adjust item C for case mix as follows:

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

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

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

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

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

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

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

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

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

(1) salaries

(2) employee benefits

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

(3) medical fees

(4) raw food

(5) medical supplies

(6) pharmaceuticals

(7) utilities

(8) repairs and maintenance

(9) insurance (other than malpractice)

(10) other operating costs

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

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

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

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

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION.

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

Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A. Depreciation	_____	_____	_____

B. Rents and leases	_____	_____	_____
C. Property taxes	_____	_____	_____
D. Property Insurance	_____	_____	_____
E. Interest	_____	_____	_____
F. Malpractice insurance	_____	_____	_____
G. TOTAL PASS-THROUGH COSTS (ITEMS A TO F)	_____	_____	_____

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

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

Items	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
A. Ratio of reimbursable inpatient hospital costs <u>as determined in part 9500.1115, item A</u> to total reimbursable costs ~~pursuant to part 9500.1115, item B, subitem (2)~~	_____	_____	_____
B. Pass-through costs as specified in subpart 1, item G multiplied by item A	_____	_____	_____
C. Number of base year admissions ~~excluding~~ <u>including</u> outliers ~~pursuant to part 9500.1115, item B,~~			

~~subitem (4)~~	_____	_____	_____
D. Pass-through cost per admission (item B divided by item C)	_____	_____	_____

Subp. 3. **Categorical rate per admission.** The department shall determine the categorical rate per admission as follows:

Categorical Rate Per Admission = [(Adjusted base year cost per admission) multiplied by (budget year HCI) and multiplied by (the relative value of the appropriate diagnostic category), plus (budget year pass-through cost per admission)]

Subp. 4. **Pass-through cost per admission adjustment.** After the end of each budget year, the commissioner shall redetermine the categorical rate per admission. The commissioner shall substitute actual pass-through costs as determined by medicare for budgeted pass-through costs in subpart 2, item B for that year. If the adjustment indicates an overpayment to ~~the~~ a hospital, ~~the~~ that hospital shall pay to the commissioner the ~~entire~~ overpayment within 60 days of ~~receiving~~ the written notification from the commissioner. If the adjustment indicates an underpayment to a hospital, the commissioner shall pay that hospital the underpayment within 60 days of written notification from the commissioner.

Subp. 5. **Interest.** Interest charges must be assessed on underpayment or overpayment balances for pass-through cost adjustments outstanding after the deadlines. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes in effect on the 61st day after the written notification.

Subp. 6. **Effective date.** The categorical rate per admission shall be ~~effected~~ effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

Subpart 1. **Recapture of depreciation.** The commissioner

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

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

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

9500.1130 REIMBURSEMENT PROCEDURES.

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

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

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

Subp. 4. **Adjustment to reimbursement.** Reimbursements ~~made by the department~~ shall be adjusted by the department for the reasons specified in subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 ~~[Emergency]~~. Adjustment to a hospital's account shall

be by debit.

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

A. obtain prior authorization;

B. provide documentation of a confirming second surgical opinion;

C. receive admission certification; and

D. assign a claim to one of diagnostic categories A to II in part 9500.1100, subpart 20.

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

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

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

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

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

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

specified in subpart 7.

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

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

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

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

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

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

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

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

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

medicare/medical assistance cost reports;

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

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

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

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

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

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

B. sum the products in item A;

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

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

E. sum the products in item D;

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

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

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

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

Subp. 11. **Reimbursement for MSA and non-MSA hospitals statewide ~~which~~ that do not have admissions in the base year.** ~~The department shall reimburse statewide hospitals which do not have admissions in the base year by using the statewide adjusted base year cost per admission as specified in subpart 10, item C, multiplied by the relative value of the appropriate diagnostic category plus the budget year pass through cost per admission according to part 9500.1125, subpart 2. The pass through cost per admission will be adjusted under part 9500.1125, subpart 4, and will be subject to part 9500.1125, subpart 5.~~ The department shall determine reimbursements for MSA hospitals statewide that do not have admissions in the base year according to items A to E:

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

B. Sum the products in item A.

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

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

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

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

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

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

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

9500.1135 DISPROPORTIONATE POPULATION ADJUSTMENT.

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

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

APPROVED IN THE REVISOR OF STATUTES BY:

15-20 percent	1/4 percent for each percentage point above 15 percent up to 20 percent
21-25 percent	1/2 percent for each percentage point above 20 percent up to 25 percent
26-30 percent	3/4 percent for each percentage point above 25 percent up to 30 percent
31 percent and above	1 percent for each percentage point above 30 percent

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

Subp. 2. **Limitation on disproportionate population adjustment.** In no case shall the disproportionate population adjustment exceed twice the HCI as determined in part 9500.1120.

9500.1140 APPEALS.

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

Subp. 2. **~~Composition of appeals board~~ Contested case**

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

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

~~9500.1145 PROCEDURES OF APPEALS BOARD.~~

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

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

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

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

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

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

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

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

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

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

A.--A-member-of-the-appeals-board-shall-be-free-of-any personal,-political,-or-economic-association-that-would-impair his-or-her-ability-to-function-in-a-fair-and-objective-manner. Should-a-board-member-believe-that-he-or-she-cannot-comply-with this-rule,-the-member-shall-withdraw-from-hearing-the-appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

M. base year admissions excluding medicare crossovers;

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

O. base year patient days excluding medicare crossovers; and

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

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

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

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Depreciation			
(2) Rents and leases			
(3) Property taxes			
(4) License fees			
(5) Interest			
(6) Malpractice insurance			
(7) TOTAL PASS-THROUGH COSTS [subitems (1) to (6)]			

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

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

Subitem	Prior Year (Actual)	Current Year (Budget)	Budget Year (Budget)
(1) Ratio of net			

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

reimbursable inpatient hospital costs to total reimbursable costs [subpart 3, item F]	_____	_____	_____
(2) Pass-through costs ~~as-specified-in~~ [subpart 4, item A, subitem (7)]	_____	_____	_____
(3) Base year admissions [subpart 3, item M]	_____	_____	_____
(4) Pass-through cost per admission [subitem (2) divided by subitem (3)]	_____	_____	_____
(5) Base year patient days [subpart 3, item O]	_____	_____	_____
(6) Pass-through cost per day of inpatient hospital services [subitem (2) divided by subitem (5)]	_____	_____	_____

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

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

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

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

APPROVED IN THE REVISOR OF STATUTES OFFICE BY: _____

day of inpatient hospital services)]

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

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

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

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

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

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

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

becomes applicable.

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

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

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

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

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

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

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

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

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

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

~~D~~ E. "Rate per admission" means the allowable base

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

I. medical assistance pass-through costs, except malpractice insurance costs (item G mulitplied by item H);

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

K. reimbursable routine service costs (Worksheet D-1, line 61);

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

M. allowable base year costs (subtract item I from item C and add item L);

N. base year ~~admission~~ admissions excluding medicare crossovers;

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

P. base year patient days excluding medicare crossovers; and

Q. allowable base year cost per day of inpatient hospital services (item M divided by item P).

Subp. 4. Determination of allowable rate period costs, allowable rate period cost for each admission, and allowable rate period cost per day. The department shall determine allowable rate period costs from the rate period medicare/medical assistance cost report using data from the HCFA Form 2552 worksheet, 1981 revision. The department shall make the determinations by following the steps outlined in items A to N:

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

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

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

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

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

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

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

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

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

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

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

K. rate period admissions excluding medicare crossovers;

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

M. rate period patient days excluding medicare crossovers; and

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

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

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

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

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

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

~~In calculating the rate year pass-through cost per admission, the department shall use the total admissions from the hospital's base year.~~

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

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

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

Rate Per Day = Lesser of the [(allowable base year cost per day of inpatient hospital services) multiplied by (8 eight percent cap), or the allowable rate period cost per day of inpatient hospital services plus (rate ~~year~~ period pass-through cost per day of inpatient hospital services)] per day of inpatient hospital services)]

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

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

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

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

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

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

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

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

Effective Date. Parts 9500.1090 to 9500.1155 are effective August 1, 1985.

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY: