Department of Human Services

Adopted Rules Relating to Hospital Medical Assistance and General Assistance Medical Care Reimbursement

Rules as Adopted

9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1155 establish a prospective reimbursement system for ~~the hospitals that participate in and are reimbursed by~~ inpatient hospital services provided under 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.

Effective January 1, 1987, reimbursements for medical assistance shall be partitioned into reimbursements for persons determined eligible for Aid to Families with Dependent Children or Aid to Families with Dependent Children extended medical coverage and for persons determined eligible for medical assistance on some other basis, including persons eligible because of receipt of Supplemental Security Income and Minnesota Supplemental Aid and persons eligible as medically needy.

9500.1100 DEFINITIONS.

Subpart 1. to 3. [Unchanged.]

Subp. 4. **Admission certification.** "Admission certification" means the determination pursuant to parts 9500.0750 to 9500.1080, 9505.0500 to 9505.0540, 9505.5000 to 9505.5030, 9505.5105, and 9505.1000 to 9505.1040 that inpatient hospitalization is medically necessary.

Subp. 4a. **Aid to Families with Dependent Children or AFDC.** "Aid to Families with Dependent Children" or "AFDC" means the program authorized under title IV-A of the Social Security Act to provide financial assistance and social services to needy

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families with dependent children.

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 that is adjusted for case mix, excludes pass-through costs and includes the reimbursable inpatient hospital costs of outliers up to their trim points.

Subp. 6. [Unchanged.]

Subp. 7. **Appeals board.** "Appeals board" means the board that advises the commissioner on a hospital's request for adjustments to reimbursements made under the prospective reimbursement system.

Subp. 8. [Unchanged.]

Subp. 8a. **Arithmetic mean length of stay.** "Arithmetic mean length of stay" means (the number of days spent in a hospital for all admissions, including outliers, but excluding days in excess of an outlier's trim point) divided by the number of admissions.

Subp. 9. to 11. [Unchanged.]

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 multiplied by the relative value of the appropriate diagnostic category) plus the budget year pass-through cost per admission].

Subp. 13. to 19. [Unchanged.]

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

Diagnostic Categories	DRG Numbers Within the Diagnostic Category
A. to JJ. [Unchanged.]	

Subp. 21. [Unchanged.]

Subp. 21a. **Foreseeable complication.** "Foreseeable complication" means a complication that can be predicted from a recipient's medical history and by a physician using standards

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of practice accepted by the medical community.

Subp. 22. to 24. [Unchanged.]

Subp. 24a. **Health care financing administration or HCFA.** "Health care financing administration" or "HCFA" means the division of the United States Department of Health and Human Services that administers the medicare and medical assistance programs according to titles XVIII and XIX of the Social Security Act.

Subp. 25. to 29. [Unchanged.]

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 part 9505.0540 cannot be provided on an outpatient basis.

Subp. 30a. **Medically needy.** "Medically needy" refers to the definition under the Code of Federal Regulations, title 42, section 435.4 (2), as amended through October 1, 1985.

Subp. 31. [Unchanged.]

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

Subp. 33. [Unchanged.]

Subp. 33a. **Minnesota supplemental aid.** "Minnesota supplemental aid" means the program established under Minnesota Statutes, sections 256D.35 to 256D.43.

Subp. 34. to 38. [Unchanged.]

Subp. 39. **Prior authorization.** "Prior authorization" means prior approval for inpatient hospital services by the department established under parts 9505.5000 to 9505.5030 and 9505.5105.

Subp. 40. [Unchanged.]

Subp. 41. **Prospective reimbursement system.** "Prospective reimbursement system" means a method of reimbursing hospitals for inpatient hospital services on a categorical rate per

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admission, out-of-area hospital categorical rate per admission, categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year, transfer reimbursement, rate per admission, or rate per day, or a combination thereof, determined by the department in advance of the delivery of inpatient hospital services.

Subp. 42. **Readmission.** "Readmission" means an admission that occurs within seven days of a discharge of the same recipient.

Subp. 43. [Unchanged.]

Subp. 43a. **Recipient resources.** "Recipient resources" means that amount of money owed to a provider for a claim under the spend-down provisions of the medically needy coverages of medical assistance.

Subp. 44. [Unchanged.]

Subp. 45. **Relative value.** "Relative value" means the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points in each diagnostic category in relation to the arithmetic mean of the reimbursable inpatient hospital cost per admission, excluding reimbursable inpatient hospital costs in excess of applicable trim points of all admissions in all the diagnostic categories on a statewide basis.

Subp. 46. [Unchanged.]

Subp. 47. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the need for a proposed surgery by a recommended second physician as specified in parts 9505.5035 to 9505.5105 and Minnesota Statutes, section 256B.503.

Subp. 47a. **Supplemental security income.** "Supplemental security income" means income acquired under title XVI of the Social Security Act.

Subp. 48. [Unchanged.]

Subp. 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. The 1981, 1983, and 1985 revisions of the Health Care Financing Administration Form 2552 are incorporated by reference. The forms are available at the state law library, Ford Building, St. Paul, Minnesota, and are subject to frequent change. They are published by Blue Cross and Blue Shield of Minnesota, Medicare, Part A Office, 3535 Blue Cross Road, P.O. Box 43560, St. Paul, Minnesota 55164.

Subp. 50. [Unchanged.]

Subp. 51. **Trim point.** "Trim point" means that number of days or that amount of reimbursable inpatient hospital cost beyond which an admission is an outlier.

Subp. 52. **Usual and customary.** "Usual and customary" means the type of fee charged for a health service regardless of payer.

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. to C. [Unchanged.]

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) determine the cost of routine services by multiplying the routine services charge for each admission identified in item B by the appropriate routine service cost-to-charge ratio determined from the base year medicare/medical assistance cost report, using data from HCFA Form 2552, 1981 revision, Worksheet C,

(2) 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 from the base year medicare/medical assistance cost report, using data from

HCFA Form 2552, 1981 revision, Worksheet C,

(3) and (4) [Unchanged.]

E. assign each admission identified in item B to the appropriate diagnostic related group under medicare using a version of 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, or the system in use by medicare, provided that the system of DRG assignment used must be used exclusively and uniformly throughout all ~~computations~~ determinations of rates and adjudications under parts 9500.1090 to 9500.1155;

F. and G. [Unchanged.]

H. for each cost outlier, truncate the cost at the value of the cost outlier trim point;

I. for each day outlier, truncate that day outlier's reimbursable inpatient hospital cost by multiplying (the day outlier's reimbursable inpatient hospital cost by the ratio of the admission's ~~diagnostic-category-day-outlier~~ trim point divided by the day outlier's length of stay), and then by multiplying the truncated reimbursable inpatient hospital cost by a factor 'x' determined as follows:

$$X = \frac{[\text{Length of Stay} - (0.6 \times \text{outlier days})]}{\text{Total days through the ~~diagnostic category-day-outlier~~ trim point}}$$

When diagnostic category O under part 9500.1100, subpart 20 is used in this formula, the department shall substitute 0.6 in the formula with 0.8.

J. determine the statewide arithmetic mean cost per admission for all admissions by dividing (the total reimbursable inpatient hospital costs for all admissions less the amounts determined in items H and I in excess of the applicable trim point) by the total number of admissions including outliers;

K. determine the statewide arithmetic mean cost per admission for each diagnostic category by dividing (the total reimbursable inpatient hospital costs in each diagnostic

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category less the amounts determined in items H and I in excess of the outlier trim points) by the total number of admissions in each diagnostic category including outliers; and

L. determine the relative value for each diagnostic category by dividing item K by item J.

Subp. 2. and 3. [Unchanged.]

9500.1115 DETERMINATION OF ALLOWABLE BASE YEAR COST PER ADMISSION.

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

A. [Unchanged.]

B. subtract from the amount determined in item A the amounts in subitems (1) and (2):

(1) reimbursable inpatient hospital costs for outliers in excess of their trim points as determined for outliers under part 9500.1110, subpart 1, items H and I, 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 including outliers;

D. adjust item C for case mix as follows:

(1) [Unchanged.]

(2) multiply the hospital's number of base year admissions within each diagnostic category including outliers by the relative value of that diagnostic category,

(3) [Unchanged.]

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

(5) [Unchanged.]

9500.1125 DETERMINATION OF CATEGORICAL RATE PER ADMISSION FOR A MINNESOTA HOSPITAL.

Subpart 1. **Pass-through cost reports.** For each hospital's

budget year, the hospital shall submit to the department a written report of pass-through costs, total charges billed to all payers for inpatient hospital services, total admissions for all payers, total days of inpatient hospital services for all payers, total Medical Assistance AFDC admissions, and total ~~Medical Assistance non-AFDC~~ general assistance admissions. A pass-through cost report for a hospital budget year that begins on or after July 1, 1987, must separate medical assistance admissions data into AFDC or non-AFDC admissions data. 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 before 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.	Pass-through costs			
(1)	Depreciation			
(2)	Rents and leases			
(3)	Property taxes			
(4)	Property insurance			
(5)	Interest			
(6)	Malpractice insurance			
(7)	Total Pass-Through Costs (Subitems (1) to (7))			
B.	Total charges billed to all payers for inpatient hospital services			
C.	Total admissions for all payers			
D.	Total days of inpatient hospital services for all payers			
E.	Total MA AFDC admissions			
F.	Total MA non-AFDC admissions			
G.	Total GAMC admissions			

Pass-through costs are limited to item A, 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.

A hospital shall submit to the department a copy of the HCFA Form 2552 and the amended HCFA Form 2552 that the hospital submits to ~~medicare~~ medical assistance. An HCFA Form 2552 or an amended HCFA Form 2552 must be submitted to the department

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within ten working days of the day on which the form is submitted to medicare.

If medicare stops requiring HCFA Form 2552 or if the medicare/~~medicaid~~ medical assistance cost report required by medicare no longer identifies capital or malpractice insurance costs in a way that is consistent with the 1985 version of HCFA Form 2552, the department may require a hospital to continue to complete and submit to the department the 1985 version of HCFA Form 2552, Worksheet D-8, part I; and Worksheet D, parts I and II.

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 as determined in part 9500.1115, item A to total reimbursable costs			
B. Pass-through costs as specified in subpart 1, item A, subitem (7), multiplied by item A			
C. Number of Medical Assistance admissions including outliers			
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 the budget year HCI and multiplied by the relative value of the appropriate diagnostic category), plus the budget year pass-through cost per admission]

Subp. 4. **Pass-through cost adjustment.** After the end of each budget year, the commissioner shall redetermine the budget year pass-through cost payable by medical assistance for that budget year for a Minnesota hospital as follows:

A. For each routine service, divide the capital costs as determined on HCFA Form 2552 by the total number of days of inpatient hospital service for all payers; for example, on the 1985 version of Form 2552, on Worksheet D, Part I, divide column 1 by column 5 for each routine service type. This ~~computation~~ determination produces an allowable per-day capital cost for each routine service type.

B. Multiply the allowable per-day capital cost for each routine service type as ~~computed~~ determined in item A by the number of medical assistance days of inpatient hospital services covered during the year for the corresponding routine service type. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of routine service.

C. ~~Compute~~ Determine the ratio of overall allowable capital costs to total charges for each type of ancillary service; for example, on the 1985 version of HCFA Form 2552, on Worksheet D, Part II, divide column 1 by column 5 for each type of ancillary service. Then multiply each ratio by the medical assistance charges billed during the year for the corresponding type of ancillary service. This ~~computation~~ determination produces an allowable medical assistance share of the allowable capital costs allocated to each type of ancillary service.

D. Determine the allowable medical assistance share of malpractice insurance costs, using the current method identified in HCFA Form 2552, Worksheet D-8; for example, from the 1985 version of HCFA Form 2552, Worksheet D-8, Part I, Column 3, line 1.

E. Sum the allowable medical assistance shares of capital costs and malpractice costs ~~computed~~ determined in items B to D to get the total medical assistance share of the hospital's allowable pass-through costs for the year.

F. Multiply the actual number of medical assistance admissions to the hospital during the year times the budgeted ~~per-admission~~ pass-through cost per-admission used in paying claims for inpatient hospital services during the year for which

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the adjustment is being calculated. ~~This computation produces the actual value of the pass through cost payments made during the year.~~

G. Subtract the ~~actual value of the medical assistance pass through cost payments during the completed year (computed~~ amount determined at item F~~)~~ from the medical assistance share of allowable pass-through costs for the completed year. The remainder is the pass-through cost adjustment payable to the hospital. Negative amounts must be deducted by the department from future payments to the hospital or paid to the department by the hospital separately within 60 days of final determination of the amount owed. Positive amounts must be ~~payed~~ paid by the department to a hospital within 60 days of final determination of the amount owed. If a hospital is required by the commissioner to make separate payments of adjustment amounts owed to the department, those payments must be made within 60 days of the date of notification.

H. Amounts owed by or to the department shall earn interest at the rate charged at that time by the commissioner of the Department of Revenue for late payment of taxes, beginning for the department on the 61st day following determination of an amount owed to a hospital, and for a hospital on the ~~61st~~ 66th day following the day of the determination of the amount owed by the hospital, but no interest shall be charged to a hospital unless an explicit request for separate payment has been made by the commissioner.

Subp. 5. [See Repealer.]

Subp. 6. **Effective date.** The categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year; transfer reimbursement; and an outlier reimbursement if appropriate, shall be effective for all admissions that occur on or after the effective date of parts 9500.1090 to 9500.1155.

9500.1126 RECAPTURE OF DEPRECIATION.

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Subpart 1. **Recapture of depreciation.** The commissioner shall determine the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to medical assistance, using methods and principles consistent with those used by medicare to determine and apportion the recapture of depreciation.

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 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. [Unchanged.]

Subp. 2. **Required claims.** Hospitals must submit complete medical assistance claims to the department on forms or computer tapes approved by the department. These claims must be completed according to department instructions. The charge amounts shown must be based on a hospital's usual and customary charges for the inpatient hospital services billed regardless of the hospital's anticipated reimbursement 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. Except as provided in parts 9500.1150 and 9500.1155, the department shall reimburse a hospital a categorical rate per admission; out-of-area categorical rate per admission; categorical rate per admission for MSA or non-MSA hospitals; or transfer reimbursement, and an outlier reimbursement if appropriate.

Subp. 4. **Adjustment to reimbursement.** Reimbursements shall be adjusted by the department for the reasons specified in

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subpart 5 and for inappropriate utilization as determined by the commissioner under parts 9505.1910 to 9505.2020 and as otherwise provided by law. Adjustment to a hospital's account shall be by debit.

Subp. 5. [Unchanged.]

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

Medicare Crossover Reimbursement	=	Medicare deductibles, plus Medicare coinsurance less recipient resources and amounts owed by third parties

Subp. 7. **Reimbursement for transfers.** Reimbursement for transfers shall be made as specified in items A and B.

A. Except as specified in item B, the department shall reimburse both the hospital that discharges a recipient for purposes of transfer and the hospital that admits the recipient who is transferred. Each hospital shall be reimbursed as follows:

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

In no case of a transfer may a hospital receive a reimbursement that exceeds the applicable categorical rate per admission, or out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals that do not have admissions in the base year, unless that admission is an outlier. Reimbursements for transfers under diagnostic category 0, under part 9500.1100, subpart 20, are not limited to the categorical rate per admission, the out-of-area categorical rate per admission, or the categorical rate per admission for MSA or non-MSA hospitals statewide that do not have admissions in the base year and such admissions are not eligible for

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outlier reimbursements under subpart 9.

A hospital that admits a ~~transferred~~ transfer recipient is not eligible for a transfer reimbursement under item A unless the inpatient hospital stay continues to be medically necessary.

B. A discharging hospital is not eligible for a transfer reimbursement under item A for services provided to a discharged recipient if one of the following conditions exists:

(1) the failure of the discharging hospital to provide all inpatient hospital services that are medically necessary to treat a condition that could or should have been treated during the initial admission or to treat a foreseeable complication of the original diagnoses; or

(2) except in the case of an emergency (as defined in part 9505.0500, subpart 11) admission, the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for treatment of the recipient were outside the scope of the hospital's available services and the readmission to ~~the other~~ another hospital resulted because of the recipient's need for those services.

Subp. 8. **Reimbursement for readmissions.** An admission and readmission to the same hospital for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of complications of the original diagnoses, shall be reimbursed with one applicable categorical rate per admission and as an outlier if eligible. The combined stay of the admission and readmission shall be used to determine ~~qualification~~ eligibility for outlier ~~payment~~ reimbursement. If the readmission to the same hospital is for a condition unrelated to the previous admission, including an episodic illness such as asthma or uncontrolled diabetes mellitus, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer

reimbursement; or rate per admission. An admission and subsequent readmission to a different hospital shall be reimbursed as specified under subpart 7 when the readmission is for the treatment of a condition that could or should have been treated during the initial admission, or for the treatment of foreseeable complications of the original diagnoses. If the readmission to a different hospital is due to a condition that is unrelated to the condition treated during the previous admission, including an episodic illness, the admission and readmission shall be reimbursed separately with the applicable categorical rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission.

Subp. 9. **Reimbursement for outliers.** The department shall reimburse a hospital for outliers with the applicable categorical rate per admission, out-of-area categorical rate per admission, or the categorical rate per admission for a MSA or non-MSA hospital that does not have admissions in the base year, 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 budget year HCI and by the relative value of the appropriate diagnostic category;

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

(3) [Unchanged.]

(4) subtract the day outlier trim point for the appropriate diagnostic category from the actual number of days a recipient has received inpatient hospital services to determine the number of outlier days; and

(5) [Unchanged.]

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 for all medical assistance admissions combined;

(2) [Unchanged.]

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

(4) multiply the ~~amount~~ difference determined in subitem (3) by 60 percent for diagnostic category W, 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, a hospital shall receive reimbursement as a day outlier.

Subp. 10. **Reimbursement to an out-of-area hospital.** The department shall reimburse an out-of-area ~~hospitals~~ hospital for an admission based on the lesser of billed charges for the admission or either the out-of-area hospital categorical rate per admission or the transfer reimbursement and outlier reimbursement if appropriate. The department shall determine the out-of-area categorical rate per admission as follows in items A to G:

A. multiply the adjusted base year cost per admission in effect on the first day of a calendar year for each hospital statewide by that hospital's HCI and by the number of admissions in that hospital's base year, including 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, including outliers, to determine the statewide budget year 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

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year, including 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, including 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 budget year 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 that do not have admissions in the base year.** 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 base year cost per admission in effect on the first day of a calendar year for each MSA hospital statewide by that hospital's budget year HCI by the number of admissions in each MSA hospital's base year, including outliers.

B. Sum the products in item A.

C. Divide the sum from item B by the sum of the admissions for all MSA hospitals statewide, including outliers, to determine the statewide 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 4, item H.

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

Categorical Rate per Admission for MSA Hospitals Statewide	=	[(adjusted base year cost per admission for MSA hospitals statewide multiplied by the budget year HCI and

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That Do Not Have Admissions In The Base Year	multiplied by the relative value of the appropriate diagnostic category) plus budget year pass-through cost per admission]

F. [Unchanged.]

Subp. 12. [Unchanged.]

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 during the base year, including admissions of recipients who are also eligible for medicare and excluding admissions of participants in a prepaid health plan, exceed 15 percent of total hospital admissions ~~according to the schedule below~~.

The department may redetermine disproportionate population adjustments using its own claims payments data, data reported by hospitals on medicare or medical assistance cost reports or data reported by hospitals on their pass-through cost reports.

The department may make this redetermination if the percentage of a hospital's MA or GAMC admissions, excluding admissions of participants in a prepaid health plan, changes enough to decrease or increase a hospital's adjusted base year cost per admission according to the four percentage categories in the schedule below.

Percentage of Total Hospital Admissions Which are MA and GAMC, and Recipients Who are Also Eligible for Medicare	Increase in Adjusted Base Year Cost Per Admission
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

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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. [Unchanged.]

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

Subpart 1. to 4. [Unchanged.]

Subp. 5. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, Part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

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

Subpart 1. to 5. [Unchanged.]

Subp. 5a. **Determination of reimbursements for medicare crossover claims.** The department shall determine a reimbursement for a medicare crossover claim according to items A to C:

A. Divide the reimbursable inpatient hospital cost from HCFA Form 2552, line 13 by the amount on HCFA Form 2552, part E5, II, line 27.

B. Multiply the ratio determined in item A by the amount on column 9 of the department's medicare crossover exception report less the accumulated amount in column 10 of

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that report.

C. Medicare deductibles and coinsurance paid by medical assistance on behalf of a recipient are paid in full and are not subject to this subpart.

Subp. 6. [Unchanged.]

REPEALER. Minnesota Rules, part 9500.1125, subpart 5 is repealed.

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