

256.9695 APPEALS OF RATES; PROHIBITED PRACTICES FOR HOSPITALS; TRANSITION RATES.

Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that result from the submission of appeals shall be implemented. Regardless of any appeal outcome, relative values shall not be recalculated. The appeal shall be heard by an administrative law judge according to sections 14.57 to 14.62, or upon agreement by both parties, according to a modified appeals procedure established by the commissioner and the Office of Administrative Hearings. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

(a) To appeal a payment rate or payment determination or a determination made from base year information, the hospital shall file a written appeal request to the commissioner within 60 days of the date the payment rate determination was mailed. The appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute or rule upon which the hospital relies for each disputed item; and (iii) the name and address of the person to contact regarding the appeal. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information. In the case of Medicare settled appeals, the 60-day appeal period shall begin on the mailing date of the notice by the Medicare program or the date the medical assistance payment rate determination notice is mailed, whichever is later.

(b) To appeal a payment rate or payment change that results from a difference in case mix between the base year and a rate year, the procedures and requirements of paragraph (a) apply. However, the appeal must be filed with the commissioner within 120 days after the end of a rate year. A case mix appeal must apply to the cost of services to all medical assistance patients that received inpatient services from the hospital during the rate year appealed. For case mix appeals filed after January 1, 1997, the difference in case mix and the corresponding payment adjustment must exceed a threshold of five percent.

Subd. 2. **Prohibited practices.** (a) Hospitals that have a provider agreement with the department may not limit medical assistance admissions to percentages of certified capacity or to quotas unless patients from all payors are limited in the same manner. This requirement does not apply to certified capacity that is unavailable due to contracts with payors for specific occupancy levels.

(b) Hospitals may not transfer medical assistance patients to or cause medical assistance patients to be admitted to other hospitals without the explicit consent of the receiving hospital when service needs of the patient are available and within the scope of the transferring hospital. The transferring hospital is liable to the receiving hospital for patient charges and ambulance services without regard to medical assistance payments plus the receiving hospital's reasonable attorney fees if found in violation of this prohibition.

Subd. 3. **Transition.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Subd. 4. **Study.** The commissioner shall contract for an evaluation of the inpatient and outpatient hospital payment systems. The study shall include recommendations concerning:

(1) more effective methods of assigning operating and property payment rates to specific services or diagnoses;

(2) effective methods of cost control and containment;

- (3) fiscal impacts of alternative payment systems;
- (4) the relationships of the use of and payment for inpatient and outpatient hospital services;
- (5) methods to relate reimbursement levels to the efficient provision of services; and
- (6) methods to adjust reimbursement levels to reflect cost differences between geographic areas.

The commissioner shall report the findings to the legislature by January 15, 1991, along with recommendations for implementation.

Subd. 5. **Rules.** The commissioner of human services shall adopt permanent rules to implement this section and sections 256.9685, 256.9686, and 256.969 under chapter 14, the Administrative Procedure Act.

History: 1989 c 282 art 3 s 39; 1990 c 568 art 3 s 18,19; 1991 c 292 art 4 s 30,78; 1992 c 513 art 7 s 28; 1993 c 339 s 11,12; 1Sp1993 c 1 art 5 s 26; 1994 c 465 art 3 s 571; 1997 c 203 art 4 s 17