

Payment Methodology – Hospital

Revised: [October 19, 2017](#)

This section outlines the Minnesota Health Care Programs (MHCP) payment methodologies for hospital services, including legislative changes:

- Critical Access Hospitals
- Outpatient Hospital Facility
- Non-emergency Service in Emergency Department
- Outpatient Hospital Legislative Ratable Reductions
- Inpatient Hospital Services
- Inpatient Hospital Legislative Ratable Reductions and Increase
- Charge Limitation
- Appeals

Critical Access Hospitals

Payment for Inpatient Services

Effective for discharges on or after July 1, 2015, payment to critical access hospitals (CAH) for inpatient services is a per diem payment calculated to fall into one of three cost-based payment tiers:

- Hospitals with base year payment-to-cost ratios at or below 80 percent will have a per diem payment rate set to reimburse 85 percent of base year costs.
- Hospitals with base year payment-to-cost ratios above 80 percent up to and including 90 percent will have a per diem rate set to reimburse 95 percent of base year costs.
- Hospitals with base year payment-to-cost ratios above 90 percent will have a per diem rate set to reimburse 100 percent of base year costs.

DHS rebases payments every two years. In the year that falls between the two rebasing years, DHS updates the per diem payment rates by the change in the Medicare and Medicaid Services Inpatient Hospital Market Basket Index.

Payment for Outpatient Services

Minnesota [critical access hospitals](#) (CAHs) are not paid on the outpatient hospital facility fee schedules for outpatient services. CAHs receive cost-based payments computed using information from the hospital's cost report that is two years prior to the current rate year. Beginning with the hospital's fiscal year ending in 2017, the cost-based payments will not be settled to actual costs. The cost-based payments are subject to legislative reductions and increases.

Prospective Payment System Hospitals and Other Non-Critical Access Hospitals

Outpatient Hospital Facility

Outpatient hospital facility services are paid according to the most recent Ambulatory Payment Classification (APC) system rates published by Centers for Medicare and Medicaid Services (CMS) in the Federal Register (effective August 1, 2000). This is listed in the column titled "Payment Rate."

Nonemergency Service Performed in an Emergency Department (ED)

MHCP does not cover visits to a [hospital ED](#) or pay for any services provided in a hospital ED that are not for emergency and emergency post-stabilization care or urgent care. The APC rate for the ED visit procedure code is compared to the lowest APC rate of the clinic visit procedure codes and the lowest APC rate is applied to the service line. If there is a reduction, the difference is reported on the remittance advice as claim adjustment group code CO and claim adjustment reason code 45.

Outpatient Hospital Legislative Ratable Reductions

Note the following ratable reductions:

- 8 percent for outpatient hospital facility fees and emergency department facility fees that do not have a federal maximum allowable (January 1, 2000)
- 0.5 percent for outpatient hospital facility services (July 1, 2002)
- 5 percent for outpatient hospital facility services (March 1, 2003)
- 10 percent for GAMC outpatient hospital facility services replacing the March 2003 reduction for GAMC (July 1, 2003)
- 3 percent for outpatient hospital facility services (July 1, 2008)
- 3 percent for MinnesotaCare basic care services outpatient hospital facility, excluding mental health facility services (July 1 2009)
- 4.5 percent for MA and GAMC basic care services outpatient hospital facility (July 1, 2009 – June 30, 2011)
- 63 percent for GAMC outpatient hospital facility services (April 1, 2010 – May 31, 2010)
- 3 percent for MA basic care services outpatient hospital facility (July 1, 2011)
- 5 percent for basic care services outpatient hospital facility (September 1, 2011 – June 30, 2013)

Note: The GAMC program ended February 28, 2011.

Outpatient Hospital Legislative Ratable Add-on

Note the following ratable add-on:

- 3 percent for outpatient hospital facility services (September 1, 2014)
- 90 percent for outpatient hospital facility fees, medical supplies and durable medical equipment (not subject to volume purchase agreement), physical therapy, occupational therapy, speech pathology, and prosthetic and orthotics services provided by an essential community provider that was a state hospital specializing in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems and other disabling conditions (July 1, 2015)

Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit.

Inpatient Hospital Services

Payment rates for MHCP are prospectively established on a per admission or per day basis under a diagnosis related group (DRG) system. Rates are differentiated by type of service (via policy adjuster values) and type of hospital (acute, rehabilitation, long-term). The rate setting methodology is based on the cost-finding and allowable cost principles of the Medicare program.

For prospective payment system (PPS) hospitals (acute care and rehabilitation hospitals), the rates are established using a statewide base rate and base year claims data. Minnesota and local trade area hospitals that do not have five or more admissions in a base year, as well as any hospital located outside of Minnesota and the local trade area, will be paid at the statewide average rate.

The DRG-based per admission and per day rates are effective November 1, 2014. MHCP will rebase inpatient rates for prospective payment system hospitals every two years on July 1, beginning July 1, 2017. The initial base year is calendar year (CY) 2012 which was used to set payment rates for discharges on or after November 1, 2014, through the next rebasing effective with discharges on or after July 1, 2017.

Effective November 1, 2014, payments for inpatient rehabilitation hospitals and distinct part units are based on the DRG system and a statewide rehabilitation specific base rate. Effective July 1, 2017, the rehabilitation specific statewide base rate is standardized to the acute care statewide base rate and a new rehabilitation policy adjuster is used. MHCP continues to pay long-term hospitals on a per diem basis.

Determination of Payment

Payments are made according to the following applicable formulas and an increase of two percent for the MinnesotaCare tax. Effective for discharges on or after November 1, 2014, payments are computed using 3M's All Patient Refined Diagnosis Related Groups (APR-DRG) version 31. Payment

rates for discharges on or after November 1, 2014, through the next rebasing are further adjusted by hospital-specific transition factors and DRG specific policy adjustment factors.

Effective for discharges on or after July 1, 2017, MHCP computes payments using 3M's APR-DRG version 33 and transition adjustment factors are eliminated.

For discharges on or after July 1, 2017 the standard payment formula is:

$$[\textit{Statewide Base Rate}] \times [\textit{APR-DRG Relative Value}] \times [\textit{Policy Adjuster Value}] \times [\textit{DPA Factor}]$$

MA Rate per Admission - Wage-adjusted base rate multiplied by the APR-DRG relative value multiplied by the policy adjustment factor multiplied by the disproportionate share adjustment factor.

Cost Outlier Payment – MHCP pays high cost claims using a Medicare-like, cost-outlier payment. Claims with costs that exceed the DRG payment amount by \$70,000 or more will receive an additional payment equal to 50 percent of the costs that exceed the DRG payment amount plus \$70,000. Effective for discharges on or after July 1, 2017, the additional payment for costs exceeding the \$70,000 outlier threshold is dependent on the Severity of Illness (SOI) factor for the DRG. DRGs with an SOI of 1 or 2 will receive additional payment equal to 50 percent of the costs above the outlier threshold. DRGs with an SOI of 3 or 4 will receive additional payment equal to 62.5 percent of the costs above the outlier threshold.

Refer to the [Policy Adjuster Values Table \(DHS-7619\) \(PDF\)](#) for dates November 1, 2014, to current date.

MA Transfer Payment - MA rate per admission divided by (arithmetic mean length of stay of the diagnostic category) and multiplied by (number of days of covered hospital services plus one).

An admission that directly precedes an admission to a hospital that provides extended psychiatric inpatient hospital services to MA recipients with mental illness according to a contracted rate per day with DHS is exempt from a transfer payment.

A hospital may not receive an MA transfer payment that exceeds the applicable rate per admission unless the admission is a cost outlier.

Medicare designated rehabilitation units are exempt from the transfer payment methodology.

Out-of-Area Rate per Admission - Statewide average wage adjusted base rate multiplied by the DRG relative value multiplied by the DRG specific policy adjustment factor.

Payments, including third-party liability and recipient spenddown, established for out-of-area hospitals may not exceed the charges on a claim-specific basis. Out-of-area payments may also be established at cost in lieu of the rate.

Long-Term Care Hospital MA Rate per Day - (allowable rate per day) multiplied by (disproportionate population adjustment) and multiplied by the (number of covered days of inpatient services).

Disproportionate Population Adjustment (DPA) Eligibility

DPA is also known as disproportionate share hospital (DSH).

For MA, Minnesota hospitals that are not critical access hospitals that meet the following are eligible for a DPA adjustment to the payment rate:

- A hospital that offers obstetric services must have at least two obstetricians (or any two physicians if the hospital is located in a non-MSA) with staff privileges who have agreed to provide obstetric services to MA recipients
- A hospital that did not offer nonemergency obstetric services as of December 21, 1987, or a hospital whose inpatients are predominately under 18 years old is not subject to the requirement in the item above
- A hospital must have an MA inpatient utilization rate that exceeds the mean for Minnesota and local trade area hospitals or a low-income inpatient utilization rate that exceeds 25 percent, determined as follows:
 - **MA Inpatient Utilization Rate** = (MA days) divided by (total inpatient days)
 - **Low Income Utilization Rate** = [(MA revenues plus any cash subsidies received by the hospital directly from state and local government) divided by (total inpatient revenues plus the cash subsidies amount)] plus [(inpatient charity care charges minus the cash subsidies amount) divided by (total inpatient charges)]

Also see [Medicaid Disproportionate Share Hospital \(DSH\) Audit](#).

Hearing Detection Fee Increase

Payment rates are adjusted to include the increase to the fee for the early hearing detection and intervention program recipients that is paid by the hospital for MA recipients. This payment increase is in effect until the increase is fully recognized within the base year cost. Five dollars will be added to final payment. Ratable reductions do not apply but two percent rate increase will apply.

Effective for admissions occurring on or after July 1, 2013, payment rates will be adjusted to include the increase to the fee for the early detection and intervention program recipients that is paid by the hospital for MA recipients. This payment increase is in effect until the increase is fully recognized within the base year cost. Fifteen dollars will be added to the final payment. Ratable reductions do not apply but two percent rate increase will apply.

Charge Limitation

Individual hospital payments, excluding DPA payments, for covered inpatient services in addition to third party liability for admissions occurring in a rate year will not exceed, in aggregate, the charges for covered inpatient services paid for the same period of time to a hospital. The limitation will be calculated separately for MA and separately from other services for a Medicare designated rehabilitation unit.

Hospital-Acquired and Provider-Preventable Conditions

No payment will be made for the care, additional treatment or procedures, readmission to the hospital after discharge, increased length of stay, change to a higher diagnosis category, or transfer to another hospital when the charges are attributable to a hospital-acquired or provider-preventable condition. In the event of a transfer to another hospital, the hospital where the hospital-acquired or provider-preventable condition was acquired is responsible for any cost incurred at the hospital to which the patient with the condition is transferred.

Appeals

Within the time limits established in Minnesota statutes 256.9695, a hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. DHS will implement both overpayments and underpayments that result from the submission of appeals. Regardless of any appeal outcome, DHS will not change relative values, Medicare wage indexes, Medicare cost-to-charge ratios and policy adjusters.

An administrative law judge will hear the appeal according to Minnesota Statutes, chapter 14, 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, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the commissioner within 60 days of the date the preliminary payment rate determination was mailed. The appeal request must specify the:

- Disputed items
- Authority in federal or state statute or rule upon which the hospital relies for each disputed item
- Name and address of the person to contact regarding the appeal

DHS – Payment Policy Division
PO Box 64984
St. Paul, MN 55164-0984

The facts to be considered in any appeal of base year information are limited to those in existence twelve months after the last day of the calendar year that is the base year for the payment rates in dispute.

Definitions

Adjusted base year operating cost: A hospital's allowable base year operating cost adjusted by the hospital cost index.

Admission: "The time of birth at a hospital or the act that allows 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.

Allowable base year operating cost: A hospital's base year inpatient hospital cost per discharge, admission or per day that is adjusted for case mix and excludes property costs.

Base year: A hospital's fiscal year or years that is recognized by Medicare, or a hospital's fiscal year specified by the Commissioner if a hospital is not required to file information with Medicare from which cost and statistical data are used to establish rates.

Charges: The usual and customary payment requested by the hospital of the public.

Cost outlier: A claim with significantly higher costs.

Discharge: The act that allows a recipient to officially leave a hospital.

Fixed-loss amount: The amount added to the base DRG payment to establish the outlier threshold amount. For rates set using 2014 as the base year, the fixed loss amount is \$70,000 dollars.

Hospital-acquired or provider-preventable condition: A condition represented by an ICD diagnosis code, that is listed on the Centers for Medicare & Medicaid Services annual hospital-acquired conditions list that is not identified by the hospital as present on admission and is designated as a complicating condition or major complicating condition.

Hospital outlier index: A hospital adjustment factor used to calculate outlier payments to prevent the artificial increase in cost outlier payments from the base year to the rate year resulting from charge or cost increases above the Medicare estimated projected increases.

Inpatient hospital costs: A hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare including direct and indirect medical education costs.

Labor-related share: An adjustment to the payment rate by a factor that reflects the relative differences in labor costs among geographic areas.

Local trade area hospital: A hospital that is located in a state other than Minnesota, but in a county that is contiguous to the Minnesota border.

Long-term hospital: A Minnesota hospital or a local trade area hospital that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

Marginal cost factor: A percentage of the estimated costs that are greater than the outlier threshold amount and recognized for payment. For rates set using 2014 as the base year, the marginal cost factor is 50 percent for DRGs with a Severity of Illness factor (SOI) of 1 or 2, and 62.5 percent for DRGs with an SOI of 3 or 4.

Operating costs: All allowable operating costs.

Outlier threshold amount: Amount equal to the sum of the hospital's standard payment rate and the fixed-loss amount.

Out-of-area hospital: A hospital that is located in a state other than Minnesota, excluding local trade area hospitals.

Policy Adjuster: An adjustment made to a specific range or subset of APR-DRGs based on category of service, age, or hospital type to allow for a payment adjustment to the specific APR-DRG claims.

Property Costs: Inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes and property insurance.

Policy Adjustment Factor: The base value of the specific policy adjuster as adopted by the department.

Rate year: A state fiscal year from July 1 through June 30 in which the discharge occurred.

Rehabilitation Hospital: Inpatient hospital services that are provided by a hospital or unit designated by Medicare as a rehabilitation hospital or rehabilitation distinct part. The term "rehabilitation hospital" encompasses rehabilitation hospitals and rehabilitation distinct parts.

Relative value: Weighted adjustments applied to the APR-DRG to reflect the resources required to provide a given service. The relative values of APR-DRG hospitals and rehabilitation hospitals are based on APR-DRG "standard" national weights, developed by 3M based on Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (NIS) discharge data.

Transfer: The movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation hospital.

Transitional Period: The initial period for APR-DRG hospitals in Minnesota or local trade areas for discharges occurring on or after November 1, 2014, through June 30, 2017.

Transition Adjustment Factor: A facility-specific payment adjustment factor that is incorporated into the payment methodology for PPS hospitals during the transitional period. The factor mathematically

limits the aggregate change in payment for a hospital to an increase up to five percent or a decrease up to 3.2 percent when compared to the hospital's aggregate payments in the base year.

Wage Index: An adjustment to compensate for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. For areas with frontier state status the "Pre-floor Wage Index" is used.

Legal References

[Minnesota Rules 9500.1090 to 9500.1140 Hospital Medical Assistance Reimbursement](#)

[Minnesota Statutes 256.9685 Establishment of Inpatient Hospital Payment System](#)

[Minnesota Statutes 256.9686 Definitions](#)

[Minnesota Statutes 256.969 Payment Rates](#)

[Minnesota Statutes 256.9691 Technology Assistance Review Panel](#)

[Minnesota Statutes 256.9692 Effect of Integration Agreement of Division of Cost](#)

[Minnesota Statutes 256.9693 Inpatient Treatment for Mental Illness](#)

[Minnesota Statutes 256.9695 Appeals of Rates; Prohibited Practices for Hospitals; Transition Rates](#)

[Minnesota Statutes 256B.32 Facility fee for hospital emergency room and clinic visit](#)

[Minnesota Statutes 256B.0625, Subd. 1a Services provided in a hospital emergency room](#)

[Minnesota Statutes 256B.75 Hospital Outpatient Reimbursement](#)

[Minnesota Statutes 256B.766 Reimbursement for Basic Care Services](#)

[Minnesota Statutes 256D.03, Subd. 4 GAMC Payment Rates for July 2003](#)

[Minnesota Statutes 256D.031, subd.5 GAMC Payment Rates for April and May 2010](#)

[Minnesota Statutes 144.125, subd 1 Hearing Detection Fee Increase](#)

[Minnesota Statutes 62Q.19 Essential Community Provider](#)