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Financial Management Group

NOV 23 2015

Marie Zimmerman
State Medicaid Director
Minnesota Department of Human Services 540 Cedar Street
P.O. Box 64983
St. Paul, MN 55164-0983

RE: Minnesota State Plan Amendment (SPA) 14-0015

Dear Ms. Zimmerman:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0015. Effective for services on or after November 1, 2014, this amendment revises methodologies and standards for Inpatient Hospital rates. Specifically, this SPA significantly revises the inpatient hospital payment methodology. Critical access hospitals will be reimbursed using a cost-based methodology; long- term hospitals will be reimbursed using a per-diem methodology; rehabilitation and rehabilitation distinct part hospitals will be reimbursed by replicating the existing payment methodology under the new diagnostic classification system; and all other hospitals will be reimbursed using the all patient-refined diagnosis-related groups (APR-DRG) classification system.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 14-0015 is approved effective November 1, 2014. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

Kristin Fan
Director

Enclosure

Methods and Standards for Determining Payment Rates for Inpatient Hospital Services Provided by Non-State Owned Facilities

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SECTION 1.0 PURPOSE AND SCOPE

The Minnesota inpatient hospital payment system for the Medical Assistance Program is authorized by state statute. Payment rates for rehabilitation and most other large hospitals are based on the 3M All Patient Refined Diagnosis Related Grouper (APR-DRG) to reflect a per discharge payment schedule. Additional rate methodologies are established for critical access hospitals (CAH) and long-term hospitals.

Rates for the other payment methodologies are based on the cost finding principles of the Medicare program in the base period. The rates are established for each rate period year using hospital specific Medical Assistance claims and cost data.

To be eligible for payment, inpatient hospital services must be medically necessary, and if required, have the necessary prior approval from the Department.

Minnesota has in place a process for public comment that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

SECTION 2.0 DEFINITIONS

Accommodation service. "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. They are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency units.

Adjusted base year operating cost. "Adjusted base year operating cost" means a hospital's allowable base year operating cost adjusted by the hospital cost index.

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

Ancillary service. "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical dependency services customarily charged in addition to an accommodation service charge.

Base year. "Base year" means 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. "Charges" means the usual and customary payment requested by the hospital of the general public.

Cost outlier. "Cost outlier" means a claim with significantly higher costs.

Cost-to-charge ratio (CCR). "Cost-to-charge ratio" means a ratio of a hospital's allowable inpatient hospital costs to its allowable charges for inpatient hospital services, from the appropriate Medicare cost report.

Critical Access Hospital. "Critical access hospital" means inpatient hospital services that are provided by a hospital designated by Medicare as a critical access hospital.

Diagnostic categories. "Diagnostic categories" means the assignment of all patient-refined diagnosis-related groups (APR-DRGs). The DRG classifications must be assigned according to the base year discharge for inpatient hospital services under the APR-DRG, rehabilitation, and long term hospital methodologies.

Diagnostic categories for Critical Access Hospitals. Critical access hospitals will use the MS-DRG categories listed in Table X.

Discharge. "Discharge" means the act that allows a recipient to officially leave a hospital.

Fixed-loss amount. “Fixed-loss amount” means the amount added to the base DRG payment to establish the outlier threshold amount. For rates set using 2012 as the base year, the fixed loss amount is 70,000 dollars.

Frontier State. “Frontier state” means a state where at least 50 percent of the counties have a population density of less than six people per square mile.

Frontier State Adjustment. The frontier state adjustment is a provision of the Affordable Care Act that requires CMS to adopt a hospital wage index that is not less than 1.0 for hospitals located in frontier states.

Healthcare Cost and Utilization Project (HCUP). “HCUP” is a family of health care databases and related tools for research and decision making. HCUP is sponsored by the Agency for Healthcare Research and Quality. It is the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988.

Hospital-acquired condition. "Hospital-acquired condition" means a condition represented by an ICD-9-CM or ICD-10-CM diagnosis code, that is listed on the Centers for Medicare and 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. "Hospital outlier index" means 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. "Inpatient hospital costs" means 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.

Inpatient hospital service. "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital. This includes outpatient services provided by the same hospital that directly precede the admission.

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

Local trade area hospital. "Local trade area hospital" means a hospital that is located in a state other than Minnesota, but in a contiguous county.

Long-term hospital. "Long-term hospital" means 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).

Low-Medicaid-volume Hospital. "Low-Medicaid-volume hospital" means a Minnesota or local trade area hospital with less than twenty Medical Assistance admissions in the base year.

Marginal cost factor. "Marginal cost factor" means a percentage of the estimated costs recognized above the outlier threshold amount. For rates set using 2012 as the base year, the marginal cost factor is 50 percent.

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 for the October 1 prior to the most current rebased rate year.

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan

statistical area hospital" or "non-MSA hospital" means a hospital that is not located in a Metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means all allowable operating costs.

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

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

Policy Adjuster. "Policy adjuster" means 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 or CAH claims.

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

Policy Adjustment Factor. "Policy adjustment factor" means the base value of the specific policy adjuster as adopted by the Department.

Provider-Preventable Condition. "Provider–Preventable Condition" means a condition identified by the state for non-payment under Section 5.a. of Attachment 4.19-B which includes:

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient.

In compliance with 42 CFR 447.26(c), the State provides:

1. That no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. That reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.
   c. Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

Rate year. "Rate year" means a calendar year from January 1 through December 31 in which

the discharge occurred.

Rehabilitation Hospital. "Rehabilitation hospital" means 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. “Relative values” are 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.

Seven-county metropolitan area. “Seven-county metropolitan area” includes the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Severity of Illness. “Severity of illness” (SOI) means the extent of physiologic decompensation or organ system loss of function the extent of which is noted by the four distinct subclasses: 1 - Mild; 2 – Moderate; 3 – Major; 4 – Extreme. The higher SOI subclasses reflect higher utilization of hospital resources and are generally expected to incur greater costs.

Transfer. "Transfer" means 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. “Transitional period” applies to the initial period of time for APR-DRG Hospitals and CAH Hospitals in Minnesota or local trade areas for discharges occurring on or after November 1, 2014 until June 30, 2016.

Trim point. "Trim point" means the number of inpatient days beyond which an admission is a day outlier.

Wage Index. “Wage index” means 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.

SECTION 3.0 MEDICAL ASSISTANCE COST REPORTS

All Minnesota and local trade area hospitals receiving a disproportionate population adjustment payment, and all hospitals classified as a Critical Access Hospital must annually submit a

Medical Assistance cost report within six months of the end of the hospital's fiscal year. The Department shall suspend payments to any hospital that fails to submit the required cost report. Payments will remain suspended until the report is filed with, and accepted by, the Department.

SECTION 4.0 ALL PATIENT-REFINED DIAGNOSIS-RELATED GROUP (APR-DRG) HOSPITALS

4.01 Establishment of base years.

Effective for discharges occurring on or after November 1, 2014, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012.

The rebasing in 2014 will be budget neutral, to ensure that the total aggregate payments under the rebased system are equal to the total aggregate payments made for the same number and types of services in the base year. Existing applicable rate increases or decreases applied to the hospitals being rebased during the entire base period will be incorporated into the budget neutrality calculation.

Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. The base year for each rebasing period is established by considering the most recent year for which filed Medicare cost reports are available.

4.02 Determination of relative values. The APR-DRG relative values of the diagnostic categories will be based on the "standard" national weights developed by 3M utilizing the HCUP NIS discharge data applicable to the base year.

4.03 Statewide Standardized APR-DRG amount. The statewide standardized amount is set such that aggregate simulated new APR-DRG system payments are equal to aggregate DRG model claim allowed amounts under the DRG system in effect on October 31, 2014. For rates effective November 1, 2014, the model claims data will be CY 2012. The wage index and labor portions are based on factors in the FFY 2014 Medicare Inpatient Prospective Payment System (IPPS). The wage indices include provider-specific reclassifications in the FFY 2014 Medicare IPPS, but do not include the frontier state adjustment in their FFY 2014 Medicare IPPS wage index.

4.04 Wage-adjusted Base Rate. APR-DRG wage-adjusted base rates are calculated using a statewide standardized amount with the labor percentage adjusted by the applicable Medicare IPPS wage index for the rate year. MSA hospitals use the standard wage index.
Non-MSA hospitals use the rural wage index, but the Frontier State adjustment is not applied.

Wage-adjusted	(Statewide standardized APR-DRG amount multiplied by the labor

Base Rate =	percentage, multiplied by the applicable wage index) plus the (Statewide standardized APR-DRG amount multiplied by (1.0 minus the labor percentage))

A. Labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the product of the labor percentage and the applicable wage index

B. Non-labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the difference between one and the labor percentage

C. Sum the results of A and B.

SECTION 4.1 POLICY ADJUSTMENT FACTOR

Policy Adjustment factors are category-specific adjustments made to the payment. They are defined in terms of APR-DRG Base Groupings and include all SOI Categories. Policy Adjustment factors have a base value of 1.0 unless an adjustment factor has been adopted and indicated below by the Department.

Effective for the discharges on or after November 1, 2014, policy adjustments are applied to the following APR-DRG categories:

A. Mental Health: 740, 750, 751,752, 753, 754, 755, 756, 757, 758, 759,760
   - A policy adjustment factor of 2.25 will be applied when the SOI is equal to one .
   - A policy adjustment factor of 2.05 will be applied with the SOI is equal to two.
   - A policy adjustment factor of 1.7 will be applied when the SOI is equal to three.
   - A policy adjustment factor of 1.55 will be applied when the SOI is equal to four.

B. Neonate: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 630, 631, 633, 634, 636, 639, 863

C. Normal New Born: 626, 640

D. Obstetrics – Vaginal Deliveries: 560
   - A policy adjustment factor of 1.35 will be applied to vaginal deliveries in a hospital located outside the seven county metro area.

E. Obstetrics Cesarean: 540

F. Obstetrics Other: 541, 542, 544, 545, 546, 561, 563, 564, 565, 566

G. Transplant: 001, 002, 003, 006, 440
H. Trauma: 020, 055, 135, 308, 384, 910, 911, 912
I. Other Pediatric: all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and provided in a Children's hospital
   - A policy adjustment factor of 1.60 will be applied regardless of SOI.
J. Other Pediatric all other APR-DRGs not listed in paragraphs A through H with patient age < 18 years old, and not provided in a Children's hospital
   - A policy adjustment factor of 1.15 will be applied regardless of SOI.
K. Other Adult all other Base Groups with Age >18 years old

SECTION 4.2 TRANSITION ADJUSTMENT FACTOR

The transition adjustment factor is a provider-specific prospective value applied during the transitional period to ensure that a provider's aggregate simulated payments under rebased rates using base period claims data do not increase or decrease by more than five percent from aggregate base period payments.

SECTION 4.3 CALCULATION OF PAYMENT RATES

4.31 Standard Payment for Minnesota and Local Trade Area Hospitals

Standard Payment =	Wage-adjusted base rate, multiplied by the APR-DRG relative value, multiplied by the DPA factor, multiplied by the policy adjustment factor, multiplied by the transition adjustment factor

A. Calculate wage-adjusted base rate
B. Multiply by the APR-DRG relative value
C. Multiply by the policy adjustment factor
D. Multiply by Disproportionate Population Adjustment factor
E. Multiply by the transition adjustment factor

4.32 Transfer Payment for Minnesota, Local Trade Area, and Out-of-area Hospitals

Transfer Payment =	(Standard payment, divided by the average length of stay for the APR-DRG discharge), multiplied by the (actual length of stay plus 1.0)

A. Divide the standard payment by the average length of stay for the APR-DRG
B. Multiply by the sum of the actual length of stay plus 1.0

The value calculated in B cannot exceed the average length of stay for the APR-DRG. Average lengths of stay for APR-DRG discharges are listed in the HCUP data file. A hospital may not receive a transfer payment that exceeds the hospital's applicable standard payment rate unless that discharge is an outlier.

A discharge that directly precedes an admission to a non-state operated hospital that provides inpatient hospital psychiatric services pursuant to Section 4.57 that is paid according to a contracted rate per day with the Department is ineligible for a transfer payment.

4.33 Outlier Payment for Minnesota, Local Trade Area, and Out-of-area Hospitals

Outlier Payment =	The marginal cost factor multiplied by the DPA factor multiplied by the difference between (allowable charges, multiplied by the hospital's overall cost to charge ratio) and the [(wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor) plus the fixed loss amount]

A. Calculate cost

(1) Multiply allowable charges by the hospital's base year cost to charge ratio

B. Calculate facility outlier threshold amount

(1) Multiply the wage-adjusted base rate by the relative value
(2) Multiply the result in item (1) by the policy adjustment factor
(3) Add the fixed loss amount to the result in item (2)

C. Subtract B from A.

D. If the result in C is positive, multiply the difference by the marginal cost factor and the DPA factor to determine the outlier payment. If result in C is negative, the outlier payment is zero.

4.34 Out-of-area Hospitals

Out-of-area Payment =	Statewide average wage-adjusted base rate, multiplied by the relative value, multiplied by the policy adjustment factor

A. Determine the average statewide wage-adjusted base rate for the APR-DRG discharge
B. Multiply by the relative value

C. Multiply by the policy adjustment factor

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

4.35 Interim Payment Methodology. The Department shall pay an interim payment based on the methodologies existing prior to the rebasing effective November 1, 2014. If the methodology described in this attachment cannot be implemented prior to October 1, 2015, the Department will employ a second interim payment methodology.

The second interim payment methodology will pay discounted costs calculated as follows: Submitted charges multiplied by the facility specific aggregate cost-to-charge ratio from the most recently filed Medicare Cost Report as of March 2014, for the cost report period ending in 2012, multiplied by the facility specific estimated payment-to-cost ratio from the state's model of the payment rates described in this attachment.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under an interim payment methodology.

SECTION 4.4 RATE ADJUSTMENT

Effective for discharges on or after Nov 1, 2014, except for children's hospitals whose patients are predominantly under 18 years of age, the total payment, after third-party liability and spend down is increased by 10 percent.

SECTION 4.41 RATE ADJUSTMENT

For hospitals located in Minnesota, the total payment, after third-party liability and spend down is increased by 2 percent.

SECTION 4.5 OTHER PAYMENT FACTORS

4.51 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

4.52 Limit on payment rate for certain deliveries. A hospital's payment rate for the services listed below shall be no greater than $3,528, exclusive of the adjustments under sections 8.01 to 8.05 and 4.56.

APR-DRG Base Groups – All SOI categories

(1) 540 Cesarean Delivery
(2) 541 Vaginal Delivery with sterilization and/or D and C
(3) 542 Vaginal Delivery with procedure without sterilization and/or D and C

4.53 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

4.54 Non-payment for 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 diagnostic 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.

4.55 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

4.56 Hospital payment adjustment. If federal financial participation is not available for all payments made under Sections 8.01 to 8.04 and payments are made under Section 8.05; or a hospital does not meet the criteria of Section 8.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 8.01, item C, then a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 8.01, item D, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 8.01 to 8.04.

4.57 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payer of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts: If the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

4.58 Medical Education Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to

the formula in Supplement 3 of this attachment.

4.59 Payments for Unusually Long Length of Stay. For inpatient services provided beyond 180 days, the following payment, in addition to the rate under Section 4.31 and the outlier rate under Section 4.33, is provided:

Payment =	Statewide average hospital cost-to-charge ratio, multiplied by the usual and customary charge

4.60 Additional adjustment for Certain Hospitals
Hennepin County Medical Center and Regions Hospital. Effective July 15, 2001, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment, in total for Hennepin County Medical Center and for Regions Hospital, will be made each year, after the close of the federal fiscal year, that is the difference between the non-State government-owned or operated hospital Medicare upper payment limit, as specified in Code of Federal Regulations, title 42, section 447.272, using current Medicare payment methods for hospitals, and the non-State government-owned or operated hospital payments of this Attachment.

Effective for the payment attributable to FFY 2010, and thereafter, out of the total available funding, payments to each of the two hospitals will be determined by:

A. Calculating an upper payment limit for each of the hospitals receiving payment under this section using the same methodology applied to the entire group of non-State government-owned hospitals.

B. Calculating a ratio for each of the hospitals receiving a payment under this section that is equal to:

(1) the difference between the upper payment limit for each hospital computed in A and total Medicaid payments to that hospital and, if positive,

(2) divided by the sum of the positive amounts of the differences between the upper payment limit and the Medicaid payments to each of the hospitals.

C. Applying the ratio computed in B to the difference between the upper payment limit for the non-State government-owned group of hospitals and total Medicaid payments to that group of hospitals.

SECTION 5.0 REHABILITATION HOSPITALS AND REHABILITATION DISTINCT PARTS

5.01 Establishment of base years.

Effective for discharges occurring on or after November 1, 2014, payment rates for services provided by hospitals located in Minnesota or the local trade area shall be paid using a base year of calendar year 2012.

The rebasing in 2014 will be budget neutral, to ensure that the total aggregate payments under the rebased system are equal to the total aggregate payments made for the same number and types of services in the base year. Existing applicable rate increases or decreases applied to the hospitals being rebased during the entire base period will be incorporated into the budget neutrality calculation.

Effective for discharges occurring on or after July 1, 2017, and every two years thereafter, payment rates shall be rebased to reflect only those changes in hospital costs between the existing base year and the next base year. The base year for each rebasing period is established by considering the most recent year for which filed Medicare cost reports are available.

5.02 Determination of relative values.
The rehabilitation provider APR-DRG relative values of the diagnostic categories will be based on the "standard" national weight developed by 3M utilizing the HCUP NIS discharge data applicable to the base year.

5.03 Statewide Standardized APR-DRG amount. The statewide standardized amount for rehabilitation services is set such that aggregate simulated new APR-DRG system payments are equal to aggregate rehabilitation model claim allowed amounts under the DRG system in effect on October 31, 2014. For rates effective November 1, 2014, the model claims data will be CY 2012. The wage index and labor portions are based on factors in the FFY 2014 Medicare IPPS. The wage indices include provider-specific reclassifications in the FFY 2014 Medicare IPPS, but do not include the frontier state adjustment to their FFY 2014 Medicare IPPS wage index.

5.04 Wage-adjusted Base Rate. Rehabilitation DRG wage-adjusted base rates are calculated using a statewide standardized amount with the labor percentage adjusted by the applicable Medicare PPS wage index for the rate year. MSA hospitals use the standard wage index. Non-MSA hospitals use the rural wage index, but the Frontier State adjustment is not applied.

Wage-adjusted Base Rate =	(Statewide standardized APR-DRG amount, multiplied by the labor percentage, multiplied by the applicable wage index) plus the (Statewide standardized APR-DRG amount multiplied by (1.0 minus the labor percentage))

A. Labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the product of the labor percentage and the applicable wage index

B. Non-labor portion:

(1) Determine the Statewide standardized APR-DRG amount for the discharge
(2) Multiply by the difference between one and the labor percentage

C. Sum the results of A and B.

SECTION 5.1 TRANSITION ADJUSTMENT FACTOR

The transition adjustment factor is a provider-specific prospective value applied during the transitional period to ensure that a provider's aggregate simulated payments under rebased rates using base period claims data do not increase or decrease by more than five percent from aggregate base period payments. For payments to hospitals under this section the transition factor is 1.0.

SECTION 5.2 CALCULATION OF PAYMENT RATES

5.21 Standard Payment for Minnesota and Local Trade Area Hospitals

Standard Payment =	Wage-adjusted base rate, multiplied by the relative value, multiplied by the DPA factor, multiplied by the transition adjustment factor

A. Calculate wage-adjusted base rate
B. Multiply by the relative value
C. Multiply by Disproportionate Population Adjustment factor
D. Multiply by the transition adjustment factor

5.22 Transfer Payment Rate for Minnesota, Local Trade Area, and Out-of-area Hospitals

Transfer Payment =	(Standard payment, divided by the average length of stay for the APR-DRG discharge), multiplied by the (actual length of stay plus 1.0)

A. Divide the standard payment by the average length of stay for the APR-DRG
B. Multiply by the sum of the actual length of stay plus 1.0

The value calculated in B cannot exceed the average length of stay for the APR-DRG. Average lengths of stay for APR-DRG discharges are listed in the HCUP data file. A hospital may not receive a transfer payment that exceeds the hospital's applicable standard payment rate unless that discharge is an outlier.

A discharge that directly precedes an admission to a non-state operated hospital that provides inpatient hospital psychiatric services pursuant to Section 4.57 that is paid according to a contracted rate per day with the Department is ineligible for a transfer payment.

5.23 Outlier Payment for Minnesota, Local Trade Area, and Out-of-area Hospitals

Outlier Payment =	The marginal cost factor multiplied by the DPA factor multiplied by the difference between (allowable charges, multiplied by the hospital's overall cost to charge ratio) and the [(wage-adjusted base rate, multiplied by the relative value, plus the fixed loss amount]

A. Calculate cost

(1) Multiply allowable charges by the hospital's base year cost to charge ratio

B. Calculate facility outlier threshold amount

(1) Multiply the wage-adjusted base rate by the relative value
(2) Add the fixed loss amount to the result in item (1)

C. Subtract B from A.

D. If the result in C is positive, multiply the difference by the marginal cost percentage and the DPA factor to determine the outlier payment. If result in C is negative, the outlier payment is zero.

5.24 Out-of-area Hospitals

Out-of-area Payment =	Statewide average base rate, multiplied by the relative value

A. Determine the statewide average base rate for the APR-DRG discharge
B. Multiply by the relative value

Payments to out-of-area hospitals may be established based on a negotiated rate if the Department contracts directly with the hospital. Payments, including third party liability, may not exceed the charges on a claim-specific basis for inpatient hospital services that are covered by Minnesota Medical Assistance.

5.25 Interim Payment Methodology.
The Department shall pay an interim payment based on the methodologies existing prior to the rebasing effective November 1, 2014. If the methodology described in this attachment cannot be implemented prior to October 1, 2015, the Department will employ a second interim payment methodology.

The second interim payment methodology will pay discounted costs calculated as follows: Submitted charges multiplied by the facility specific aggregate cost-to-charge ratio from the most recently filed Medicare Cost Report as of March 2014, for the cost report period ending in 2012, multiplied by the facility specific estimated payment-to-cost ratio from the state's model of the payment rates described in this attachment.

Upon implementation of the methodology described in this attachment, the Department shall reprocess all claims paid under an interim payment methodology.

SECTION 5.3 RATE ADJUSTMENT

For hospitals located in Minnesota, the total payment, after third-party liability and spend down is increased by 2 percent.

SECTION 5.4 OTHER PAYMENT FACTORS

5.41 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

5.42 Non-payment for 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 diagnostic 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.

5.43 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

5.44 Medical Education Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

5.45 Payments for Unusually Long Length of Stay. For inpatient services provided beyond 180 days, the following payment, in addition to the rate per admission under Section 5.21, is provided:

Payment =	Statewide average cost-to-charge ratio multiplied by the usual and customary charge

SECTION 6.0 CRITICAL ACCESS HOSPITALS (CAH)

6.01 Establishment of base years.

A. The base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year data will be moved forward three years beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995, except for 1997, 2005, 2009, and 2011 or every one year if notice is provided at least six months prior to the rate year by the Department. Effective January 1, 2013, and after, rates for all hospitals shall not be rebased.

6.02 Determination of Relative Values of the Diagnostic Categories.

The Department determines the relative values of the diagnostic categories as follows:

A. Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

B. Exclude the claims and charges in subitems (1) to (7):

(1) Medicare crossover claims;

(2) claims paid on a transfer rate per day according to Section 6.33;

(3) inpatient hospital services for which Medical Assistance payment was not made;

(4) inpatient hospital claims paid to a long-term care hospital;

(5) inpatient hospital services not covered by the Medical Assistance program on October 1 prior to a rebased rate year;

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges; and

(7) inpatient hospital services with a length of stay over 365 days.

C. Combine claims into the admission that generated the claim according to readmissions at Section 9.02.

D. Determine operating costs for each hospital admission using each hospital's base year data according to subitems (1) to (5).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist costs and charges if the hospital determines that certified registered nurse anesthetist services will be paid separately.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

(4) Add subitems (1) to (3).

(5) Multiply the result of subitem (4) by the hospital cost index at Section 6.1 that corresponds to the hospital's fiscal year end.

E. Assign each admission and operating cost identified in item D, subitem (5), to the appropriate diagnostic category in routine inpatient hospital services, rehabilitation distinct part or neonatal transfers at receiving hospitals with a neonatal intensive care unit.

F. Determine the mean cost per admission within routine inpatient hospital services and the rehabilitation distinct part for routine inpatient hospital services and the rehabilitation distinct

part admissions identified in item E by dividing the sum of the operating costs by the total number of admissions.

G. Determine the mean cost per admission for each diagnostic category identified in item E for routine inpatient hospital services and for the rehabilitation distinct part specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

H. Determine the relative value for each diagnostic category by dividing item G by the corresponding result of item F for routine inpatient hospital services and the rehabilitation distinct part specialty group and round the quotient to five decimal places.

I. Determine the mean length of stay for each diagnostic category identified in item E for routine inpatient hospital services and rehabilitation distinct part by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

J. Determine the day outlier trim point for each diagnostic category for routine inpatient hospital services and the rehabilitation distinct part specialty group and round to whole days.

6.03 Determination of adjusted base year operating cost per admission and per day outlier

6.031 The Department determines the adjusted base year operating cost per admission routine inpatient hospital services and the rehabilitation distinct part specialty group for each hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to Section 6.02, items A to E.

B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments. For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within routine inpatient hospital services and rehabilitation distinct part specialty group, and divide this amount by the number of admissions within routine inpatient hospital services and the rehabilitation distinct part specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions for routine inpatient hospital services and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

6.032 The Department determines the adjusted base year operating cost per day outlier for routine inpatient hospital services and the rehabilitation distinct part specialty group for each hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in Section 6.031, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days for routine inpatient hospital services and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

6.033 Out-of-area hospitals. The Department determines the adjusted base year operating cost per admission and per day outlier for routine inpatient hospital services according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier for each Minnesota and local trade area hospital determined in Sections 6.031 and 6.032 by the number

of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

6.034 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions or five or more day outlier Medical Assistance admissions in the base year and low volume local trade area hospitals. The Department determines the adjusted base year operating cost per admission or per day outlier for routine inpatient hospital services according to items A to C.

A. Multiply each adjusted base year cost per admission and per day outlier for each Minnesota MSA and local trade area hospital determined in Sections 6.031 and 6.032 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

6.035 Non**-MSA hospitals that do not have five or more Medical Assistance admissions or five or more day outlier Medical Assistance admissions in the base year.** The Department determines the adjusted base year operating cost per admission or per day outlier for routine inpatient hospital services for non-MSA hospitals by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.034.

6.036 Minnesota and local trade area hospitals that do not have five or more Medical Assistance rehabilitation distinct part specialty group admissions or five or more day outlier Medical Assistance rehabilitation distinct part specialty group admissions in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals by substituting Minnesota and local trade area hospital terms and data for the metropolitan statistical area hospital terms and data under Section 6.034.

6.037 Non-seven-county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital adjusted base year operating cost per admission or per day outlier, for routine inpatient hospital services and the rehabilitation distinct part specialty group under Section 15.10, by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.034.

6.038 Limitation on separate payment. Out-of-area hospitals that have a rate established under Section 6.033 may not have certified registered nurse anesthetists services paid separately from this Attachment.

SECTION 6.1 DETERMINATION OF HOSPITAL COST INDEX (HCI)

6.11 Adoption of HCI. The most recent *Health Care Costs* published by Data Resources Incorporated (DRI) is used.

6.12 Determination of HCI. For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the Department determines the HCI according to items A to C.

A. For each rate year, the Department obtains from DRI the average annual historical and projected cost change estimates in a decimal format for the operating costs by applying the change in the Consumer Price Index - All Items (United States city average) (CPI-U) in the third quarter of the prior rate year.

B. Add one to the amounts in item A and multiply these amounts together. Round the result to three decimal places.

C. For the 2002 rate year and after, the HCI is zero.

SECTION 6.2 DETERMINATION OF PROPERTY COST PER ADMISSION

6.21 Minnesota **and local trade area hospitals.** The Department determines the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each admission in Section 6.02, item C, using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost-to-charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in Section 6.02, item C, using each hospital's base year data and recent year Medicare cost report data that was submitted by the October 1 prior to a rebased rate year according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission for routine hospital services and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3) to routine inpatient hospital services, the rehabilitation distinct part or neonatal transfers at receiving hospitals with a neonatal intensive care unit.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within routine inpatient hospital services, the rehabilitation distinct part or neonatal transfers at receiving hospitals with a neonatal intensive care unit in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

6.22 Out-of-area hospitals. The Department determines the property cost per admission for routine inpatient hospital services according to items A to C.

A. Multiply each property cost per admission for each Minnesota and local trade area hospital determined in Section 6.21, item D, subitem (3), by the number of corresponding admissions in

that hospital's base year.

B. Add the products in item A.

C. Divide the total from B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

6.23 Minnesota MSA and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year and low volume local trade area hospitals. The Department determines the property cost per admission for routine inpatient hospital services according to items A to C.

A. Multiply each property cost per admission for each Minnesota MSA and local trade area hospital determined in Section 6.21, item D, subitem (3), by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total admissions for all Minnesota MSA hospitals and local trade area hospitals and round the resulting amount to whole dollars.

6.24 Non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year. The Department determines the property cost per admission for routine inpatient hospital services for non-MSA hospitals that do not have five or more Medical Assistance admissions in the base year by substituting non-MSA area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.23.

6.25 Minnesota and local trade area hospitals that do not have five or more Medical Assistance rehabilitation distinct part specialty group admissions in the base year. The Department determines the property cost per admission for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals that do not have five or more Medical Assistance admissions in the base year substituting Minnesota and local trade area hospital terms and data for the Minnesota MSA and local trade area hospital terms and data under Section 6.23.

6.26 Non-seven county metropolitan area hospitals. The Department determines the non-seven-county metropolitan area hospital property cost per admission for routine inpatient hospital services and the rehabilitation distinct part specialty group under Section 6.792 by substituting seven-county metropolitan area hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under Section 6.23.

SECTION 6.3 DETERMINATION OF RATE PER ADMISSION AND PER DAY

6.31 Rate per admission. The Department determines the routine inpatient hospital services or rehabilitation distinct part specialty group rate per admission for Minnesota and local trade area hospitals as follows:

The payment rates are based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year HCI.

Rate Per Admission = [{(Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission} and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment]

6.32 Rate per day outlier. The day outlier rate is in addition to the rate per admission and will be determined for routine inpatient hospital services or the rehabilitation distinct part specialty group as follows:

A. The rate per day for day outliers is determined as follows:

Outlier Rate Per Day = {Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment}

B. The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services, excluding days paid under Section 6.793.

6.33 Transfer rate. A transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:

Transfer Rate Rate Per Day = {(The rate per admission in item A, below, divided by the arithmetic mean length of stay of the diagnostic category)}

A. A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission unless that admission is a day outlier.

B. An admission that directly precedes an admission to a non-state operated hospital that provides inpatient hospital psychiatric services pursuant to Section 6.77 that is paid according to a contracted rate per day with the Department is exempt from a transfer payment.

SECTION 6.4 Interim Payment Methodology.
If the methodology described in this attachment cannot accommodate the ICD-10 implementation on October 1, 2015, the Department will employ an interim payment methodology.

The Department shall pay an interim payment methodology of discounted costs calculated as follows: Submitted charges multiplied by the facility specific aggregate cost-to-charge ratio from the most recently filed Medicare Cost Report as of March of 2014, for the cost report period ending in 2012, multiplied by the facility specific estimated pay-to-cost ratio from the state's model of the payment rates described in this attachment.

Upon implementation of ICD-10, the Department shall reprocess all claims paid under an interim payment methodology.

SECTION 6.5 RATE ADJUSTMENT
Effective for discharges on or after Nov 1, 2014, except for children's hospitals whose patients are predominantly under 18 years of age, the total payment, after third-party liability and spend down is increased by 10 percent.

SECTION 6.6 RATEABLE ADJUSTMENTS

6.61 Reduction. For admissions on or after July 1, 2002, the total payment, before third-party liability and spenddown, is reduced by .5 percent.

6.62 Reduction. In addition to the reduction in Section 6.61, for admissions on or after March 1, 2003, except those paid under Section 7.43 and the psychiatric diagnostic categories, the total payment, before third-party liability and spenddown, is reduced by five percent.

6.63 Increase. Effective with admissions on or after January 1, 2004, the total payment, after third-party liability and spenddown, and Sections 6.61, 6.62, 6.64, 6.65, 6.66, 6.67, 6.68, 6.69, and 6.691 is increased by two percent for Minnesota hospitals.

6.64 Reduction. In addition to the reductions in Sections 6.61 and 6.62, effective with admissions on or after August 1, 2005, except those paid under Section 6.75 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by six percent.

6.65 Reduction. In addition to the reductions in Sections 6.61, 6.62, and 6.64 effective with

admissions on or after July 1, 2008 through June 30, 2009, except those paid under Section 6.75 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 3.46 percent.

6.66 Reduction. In addition to the reductions in Sections 6.61, 6.62, 6.64, and 6.68 effective with admissions on or after July 1, 2009 through June 30, 2011, except those paid under Section 6.75 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.9 percent.

6.67 Reduction. In addition to the reductions in Sections 6.61, 6.62, 6.64, and 6.68 effective with admissions on or after July 1, 2011, except those paid under Section 6.75 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.79 percent.

6.68 Reduction In addition to the reduction in Section 6.61, 6.62, 6.64, 6.66 and 6.67 when applicable, for admissions on or after July 1, 2009, except those paid under Section 6.75 the total payment, after third-party liability and spenddown, is reduced by one percent.

6.69 Hearing detection fee increase. Effective for admissions occurring on or after July 1,2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under Minnesota Statutes §141.125, subdivision 1, that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

Effective for admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2013, for the early hearing detection and intervention program recipients under Minnesota Statutes §144.125, subdivision 1, paragraph (d) that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

6.691 Reduction In addition to the reduction in Section 6.61, 6.62, 6.64, 6.67 and 6.68, for admissions on or after July 1, 2011, except those paid under Section 6.75, the total payment, after third-party liability and spenddown, is reduced by 1.96 percent.

SECTION 6.7 OTHER PAYMENT FACTORS

6.71 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

6.72 Limit on payment rate for certain deliveries. Effective for admissions on or after October 1, 2009, a hospital's payment rate for the services listed below shall be no greater than $3,528, exclusive of the adjustments under sections 8.01 to 8.05 and 6.36.

(1) cesarean section without complicating diagnosis 371
(2) vaginal delivery with complicating diagnosis 372
(3) vaginal delivery without complicating diagnosis or operating room procedures 373

6.73 Neonatal respiratory distress syndrome. For discharges to be paid under inpatient hospital rates that include the diagnosis of neonatal respiratory distress syndrome, services must be provided in a level II or above inpatient hospital nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

6.74 Non-payment for hospital-acquired or 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 diagnostic 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.

6.75 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

6.76 Hospital payment adjustment. If federal financial participation is not available for all payments made under Sections 8.01 to 8.04 and payments are made under Section 8.05; or a hospital does not meet the criteria of Section 8.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 8.01, item C, then a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 8.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 8.01 to 8.04.

6.77 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days (or, effective August 1, 2005, additional days beyond 45 based on the Department's individual review of medical necessity). In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payer of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts: If the attending physician indicates that the patient is in need of continued mental health inpatient treatment and that the patient is competent to consent to treatment (or has a substitute decision maker with the authority to consent to treatment).

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and

length of stay differences.

6.78 Medical Education Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

6.79 Hospital payment adjustment. If federal financial participation is not available for all payments made under Sections 8.01 to 8.04 and payments are made under Section 8.05; or a hospital does not meet the criteria of Section 8.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 8.01, item C, then a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 8.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 8.01 to 8.04.

6.791 Small rural payment adjustment.

A. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20 percent.

B. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds and greater than 100 but fewer than 250 Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15 percent.

The payment adjustment does not include Medicare crossover admissions in the admissions count nor are Medicare crossover admissions eligible for the percentage increase. Minnesota hospitals located in a city of the first class are not eligible for the payment adjustment in this section. Minnesota hospitals that receive the non-seven-county metropolitan area hospital payment adjustment under Section 6.792 are also not eligible for the payment adjustment in this section.

The small rural payment adjustment is reduced by the amount of the hospital's DPA under Sections 8.01 to 8.05 and the hospital payment adjustment under Section 6.79.

6.792 Non-seven-county metropolitan area hospital payment adjustment. For a Minnesota hospital located outside of the seven-county metropolitan area, effective for admissions occurring on or after July 1, 2001 for the DRGs listed below, if 90 percent of the seven-county metropolitan area hospital payment is greater than the hospital's payment, exclusive of Sections 8.01 to 8.05 and 6.79, then payment is made at 90 percent of the seven-county metropolitan area hospital payment, inclusive of the hospital's adjustment under Sections 8.01 to 8.05 and 6.79. This payment adjustment will not exceed the Medicare upper limit as specified in Code of Federal Regulations, title 42, section 447.272.

(1)	cesarean section with complicating diagnosis	370
(2)	cesarean section without complicating diagnosis	371
(3)	vaginal delivery with complicating diagnosis	372
(4)	vaginal delivery without complicating diagnosis or operating room procedures	373
(5)	extreme immaturity	386
(6)	prematurity without major problems	388
(7)	full term neonates with other problems	390
(8)	normal newborns	391
(9)	neonates, died on birth date	385
(10)	acute adjustment reaction and psychosocial dysfunction	425
(11)	psychosis	430
(12)	childhood mental disorders	431
(13)	appendectomy	164-167

6.793 Admissions with length of stay exceeding 365 days. Effective January 29, 2002, the following payment is in addition to the rate per admission under Section 6.31 and the rate per day outlier under Section 6.32 for inpatient hospital services provided beyond 365 days:

Payment = [(Hospital operating cost-to-charge ratio determined in Section 6.02, item D, subitem (4) for all admissions, including General Assistance Medicare Care, a State-funded program) multiplied by (charges for those inpatient hospital services beyond 365 days) multiplied by (disproportionate population adjustment) and multiplied by (the small, rural hospital adjustment) multiplied by (the hospital payment adjustment)]

SECTION 7.0 LONG-TERM HOSPITALS

7.01 Establishment of base years.
For the January 1, 2011, rebased rate year, rates for Minnesota long term hospitals (section 7.0) only will be rebased to the most recent hospital fiscal year ending on or before September 1, 2008, not including payments described in section 8.01 or section 7.45. Effective January 1, 2013, and after, rates for all long-term hospitals will not be rebased. For long-term hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report.

7.02 Determination of Base Year Operating Cost and Rate per Diem
The Department determines the base year operating cost per day for long term hospitals for the rate year according to items A and B.

A. Determine the operating cost per day as follows:

(1) Select Medical Assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

(2) Exclude the claims and charges in subitems a to e:

a. Medicare crossover claims;

b. inpatient hospital services for which Medical Assistance payment was not made;

c. inpatient hospital services not covered by the Medical Assistance program on October 1 prior to a rebased rate year;

d. inpatient hospital charges for non-covered days calculated as the ratio of non-covered days to total days multiplied by charges; and

e. inpatient hospital services paid under Section 7.46.

(3) Combine claims into the admission that generated the claim according to readmissions at Section 9.02.

(4) Determine operating costs for each hospital admission using each hospital's base year data according to subitems (a) to (e).

a. Determine the operating cost of accommodation services by multiplying the

number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

b. Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist costs and charges if the hospital determines that certified registered nurse anesthetist services will be paid separately.

c. Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (a) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

d. Add subitems a to c.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

SECTION 7.1 CALCULATION OF PAYMENT RATES

7.11 Standard Payment Rate for Minnesota, Local Trade Area, and Out-of-area Hospitals

Standard Payment =	Operating rate per diem, multiplied by the DPA factor, multiplied by the rateable reduction factor, multiplied by Medicaid-eligible patient days

A. Determine the hospital's operating rate per diem for the base year
B. Multiply by the Disproportionate Population Adjustment factor
C. Multiply by the rateable reduction factor
D. Multiply by the number of Medicaid-eligible patient days

7.12 Transfer Payment Rate for Minnesota, Local Trade Area, and Out-of-area Hospitals

A hospital's transfer payment rate is equal to the standard payment rate described in section 7.11.

SECTION 7.2 RATEABLE ADJUSTMENTS

7.21 Reduction. For admissions on or after July 1, 2002, the total payment, before third-party liability and spenddown, is reduced by .5 percent.

7.22 Reduction. In addition to the reduction in Section 7.21, for admissions on or after March 1, 2003, except those paid under Section 7.43 and the psychiatric diagnostic categories, the total payment, before third-party liability and spenddown, is reduced by five percent.

7.23 Increase. Effective with admissions on or after January 1, 2004, the total payment, after third-party liability and spenddown, and Sections 7.21, 7.22, 7.24, 7.25, 7.26, 7.27, 7.28, 7.29, and 7.291 is increased by two percent for Minnesota hospitals.

7.24 Reduction. In addition to the reductions in Sections 7.21 and 7.22, effective with admissions on or after August 1, 2005, except those paid under Section 7.43 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by six percent.

7.25 Reduction. In addition to the reductions in Sections 7.21, 7.22, and 7.24 effective with admissions on or after July 1, 2008 through June 30, 2009, except those paid under Section 7.43 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 3.46 percent.

7.26 Reduction. In addition to the reductions in Sections 7.21, 7.22, 7.24, and 7.28 effective with admissions on or after July 1, 2009 through June 30, 2011, except those paid under Section 7.43 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.9 percent.

7.27 Reduction. In addition to the reductions in Sections 7.21, 7.22, 7.24, and 7.28 effective with admissions on or after July 1, 2011, except those paid under Section 7.43 and the psychiatric diagnostic categories, the total payment, after third-party liability and spenddown, is reduced by 1.79 percent.

7.28 Reduction In addition to the reduction in Section 7.21, 7.22, 7.24, 7.26 and 7.27 when applicable, for admissions on or after July 1, 2009, except those paid under Section 7.43 the total payment, after third-party liability and spenddown, is reduced by one percent.

7.29 Hearing detection fee increase. Effective for admissions occurring on or after July 1,2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under Minnesota Statutes §141.125, subdivision 1, that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

Effective for admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2013, for the early hearing detection and intervention program recipients under Minnesota Statutes §144.125, subdivision 1, paragraph (d) that is paid by the hospital for Medical Assistance recipients. This payment increase shall be in effect until the increase is fully recognized within the base year cost.

7.291 Reduction In addition to the reduction in Section 7.21, 7.22, 7.24, 7.27 and 7.28, for admissions on or after July 1, 2011, except those paid under Section 7.43, the total payment, after third-party liability and spenddown, is reduced by 1.96 percent.

SECTION 7.3 (Reserved)

SECTION 7.4 OTHER PAYMENT FACTORS

7.41 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

7.42 Non-payment for 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 diagnostic 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.

7.43 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title I of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, as amended, or Title V of the Indian Self-Determination and Education Assistance Act, Public Law 106-260, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

7.44 Medical Education Research Costs. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional annual payment according to the formula in Supplement 3 of this attachment.

7.45 Hospital payment adjustment. If federal financial participation is not available for all payments made under Sections 8.01 to 8.04 and payments are made under Section 8.05; or a

hospital does not meet the criteria of Section 8.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in Section 8.01, item C, then a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 8.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under Sections 8.01 to 8.04.

7.46 Payments for Unusually Long Length of Stay. For inpatient services provided beyond 180 days, the following payment, in addition to the rate per admission under Section 7.11 for inpatient hospital services, is provided:

Payment =	Statewide average cost-to-charge ratio multiplied by the usual and customary charge

SECTION 7.5 APPEALS

A long term 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. Both overpayments and underpayments that are discovered as a result of the submission of appeals will be implemented.

The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Department and the Office of Administrative Hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Department'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 must file a written appeal request to the Department within 60 days of the date the payment rate determination was mailed to the hospital. The appeal request shall specify:

   (1) The disputed items.

(2) The authority in federal or state statute or rule upon which the hospital relies for each disputed item.

(3) The name and address of the person to contact regarding the appeal.

B. To appeal a payment rate or payment change that results from a difference in case mix between the base year and the rate year, the procedures and requirements listed above apply. However, the appeal must be filed with the Department or postmarked within 120 days after the end of the rate year. A case mix appeal must apply to the cost of services to all Medical Assistance patients who received inpatient services from the hospital for which the hospital received Medical Assistance payment, excluding Medicare crossovers. The appeal is effective for the entire rate year. A case mix appeal excludes Medical Assistance admissions that have a relative value of zero for its DRG.

For a case mix appeal filed after July 1, 1997, the combined difference in case mix for Medical Assistance and General Assistance Medical Care, a State-funded program, must exceed five percent. For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.

C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins 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.

D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.

SECTION 8.0 DISPROPORTIONATE POPULATION ADJUSTMENT

8.01 Disproportionate population adjustment or DPA eligibility. A Minnesota or local trade area hospital that is not state-owned, that is not a facility of the federal Indian Health Service, and that meets the criteria of items A to D is eligible for an adjustment to the payment rate.

A. A hospital must have at least two obstetricians with staff privileges who have agreed to

provide obstetric services to Medical Assistance recipients. For non-MSA hospitals the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. A hospital that did not offer non-emergency obstetric services as of December 21, 1987 or a hospital whose inpatients are predominately under 18 years of age is not subject to item A.

C. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds 1 percent.

D. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds the arithmetic mean for Minnesota and local trade area hospitals or a low-income inpatient utilization rate that exceeds .25, determined as follows:

MA Inpatient Utilization Rate =	Medical Assistance inpatient days, divided by total inpatient days

If the hospital's Medical Assistance inpatient utilization rate is at the mean, the calculation is carried out to as many decimal places as required to show a difference.

Low Income Utilization Rate =	[(Medical Assistance revenues plus any cash subsidies received by the hospital directly from state or local government) divided by total inpatient revenues] Plus [(inpatient charity care charges minus any cash subsidy amount) divided by total patient charges]

Note: the LIUR formula is the sum of two fractions.

For purposes of this section, "charity care" is care provided to individuals who have no source of payment from third party or personal resources.

8.02 Medical **Assistance inpatient utilization DPA.** If a hospital meets the criteria of Section 8.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean in Section 8.01, item D, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient utilization rate.

B. Add 1.0 to the amount in item A.

C. If a hospital meets the criteria of Section 8.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in Section 8.01, item D, the payment adjustment determined under item A is multiplied by 1.1, and added to 1.0.

8.03 Low income inpatient utilization DPA. If a hospital meets the criteria of Section 8.01, items A or B and the low-income inpatient utilization rate under item D, the payment adjustment is determined as follows:

A. Subtract .25 from the hospital's low-income inpatient utilization rate.

B. Add 1.0 to item A if item A is positive.

8.04 Other DPA. If a hospital meets the criteria of Section 8.01, items A or B and both the Medical Assistance inpatient utilization rate criteria and the low-income inpatient utilization rate criteria, the DPA is determined as described in Section 8.02.

8.05 Rateable reduction to DPA. If federal financial participation is not available for all provider payments in aggregate made under Sections 8.01 to 8.04, the payments made shall be rateably reduced a percentage sufficient to ensure that federal financial participation is available for those payments as follows:

A. Divide the federal DPA limit by the total DPA payments to determine an allowable DPA payment ratio.

B. Multiply the result of item A by each hospital's DPA under Sections 8.02 to 8.03.

8.06 Additional DPA. Effective for admissions on or after September 1, 2011, a DPA will be paid to eligible hospitals in addition to any other DPA payment calculated under Sections 8.01 to 8.04. Payments by the State from the MinnesotaCare Program to qualifying hospitals for services provided to individuals not eligible for Medicaid will be considered DPA payments under this section, within the following limitations:

A. Only to the extent that federal funding remains in Minnesota’s allotment for disproportionate share hospitals under §1923(f) of the Act after DPA payments in Section 8.02 to 8.04 have been made for the federal fiscal year.

B. Only to the extent that the DPA payments under this section, combined with all other DPA payments, would not exceed the hospital’s individual disproportionate share hospital limit under §1923 of the Social Security Act.

MinnesotaCare payments will be counted against Minnesota’s disproportionate share hospital

allotment in the following order:

(1) fee-for-service inpatient claims;

(2) fee-for-service payments for outpatient hospital services;

A qualifying hospital under this section is one that meets the requirements of Section 8.01, items A or B, and item C. A hospital may elect on an annual basis to not be a disproportionate share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 8.01 to 8.04.

C. The payment rate for MinnesotaCare admissions for persons not eligible for Medicaid for purposes of calculating the DPA under this section is the same rate as the rate under this Attachment for medical assistance, except that the adjustments in sections 4.58, 4.60, 5.44, 6.38 and 7.44 are not included.

8.07 Additional DPA. Effective for costs incurred on or after July 1, 2006, a DPA payment in addition to those payments described in 8.01 to 8.06 will be transferred to the state's general fund. The amount of the payment will be equal to the remaining uncompensated care costs of the hospital after taking into account the payments described in 8.01 to 8.06 as determined by the certified audit described in 42 C.F.R. §§ 455.300 – 455.304. Payment will be distributed in the quarter following the quarter in which the certified DSH audit is completed.

Payments under this section will be limited by each hospital's facility specific DSH limit, as defined in section §1923(g)(1) of the Social Security Act, and the state's overall DSH allotment.

For the purposes of this section, an eligible hospital is defined as a seven county metropolitan area hospital that:

A. Meets the criteria for payment under section 8.02 (C), and
B. is owned or operated by a county.

SECTION 9.0 PAYMENT PROCEDURES

9.01 Submittal of Claims. Hospital billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the diagnostic category.

9.02 Readmission. An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment

according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)

A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:

(1) A recipient leaving the hospital of the first admission against medical advice;

(2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or

(3) A recipient having a new episode of an illness or condition.

B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:

(1) Hospital or physician scheduling conflict;

(2) Hospital or physician preference other than medical necessity;

(3) Patient preference; or

(4) Referral.

C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.

Table X

A. Diagnostic categories for routine inpatient hospital services. The following diagnostic categories are for all admissions, except as provided in items B:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS CODES
A. Nervous System Diseases and Disorders		
(1) Intracranial vascular procedures with PDx of hemorrhage	528	
(2) Craniotomy for multiple significant trauma, Implant of chemotherapeutic agent or complex CNS diagnosis	484, 543	
(3) Ventricular shunt, all ages, with CC and Craniotomy, age >17, with CC	001, 003, 529	003 includes shunt with CC as the principal procedure
(4) Spinal and Extra cranial procedures, and Stroke with thrombolytic agent	531-533, 559	
(5) Craniotomy, age 0-17	003	003 excludes shunt as the principal procedure
(6) Craniotomy, age >17 without CC and Other nervous system procedures with CC	002, 007	
(7) Other nervous system, Ventricular shunt and Extra cranial procedures without CC	003, 008, 530, 534	003 includes shunt without CC as the principal procedure
(8) Spinal disorders and injury, Nervous system infection, and Hypertensive encephalopathy	009, 020, 022	
(9) Intracranial hemorrhage or Cerebral infarction	014	
(10) Neoplasms and Degenerative disorders of the nervous system, Stupor with coma >1 hour	010, 012, 027	
(11) Nonspecific cerebrovascular disorders and Stupor with coma <1 hour with CC, and Other disorders of the nervous system	016, 028, 034, 035	
(12) Nonspecific CVA, Cranial and peripheral nerve disorder, Other stupor and coma	015, 018, 023, 030	
(13) Seizure and headache, age >17, with CC	024	
(14) Nervous system neoplasm without		

CC, Multiple Sclerosis, and Cerebral Ataxia	011, 013	
(15) Other nervous system diseases and disorders	017, 019, 021, 026, 029, 033, 524	
(16) Seizure and headache without CC and Concussion, age >17	025, 031, 032	
B. Eye Diseases and Disorders		
(1) Surgical procedures of Eyes	036-042	
(2) Eyes disorders and diseases	043-048	
C. Ear, Nose, Throat, and Mouth Diseases and Disorders		
(1) [Reserved for future use]		
(2) [Reserved for future use]		
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) Other ENT and mouth O.R. procedures	063	
(6) Miscellaneous and major ear, nose, throat and mouth procedures	049, 055	Codes in DRG 049 except 20.96-20.97
(7) Cochlear Implants only	049	Codes 20.96-20.97
(8) Sinus, mastoid, salivary gland and nose procedures	050, 053, 054, 056	
(9) T & A, Myringotomy, and Salivary gland procedures	051, 057, 060, 061, 062	
(10) Cleft lip and palate repair and Other T & A procedures	052, 058, 059	
(11) Epiglottis, Nasal trauma, and ENT and mouth malignancy	064, 067, 072, 073	
(12) Other ENT and mouth diagnoses and other mouth procedures	066, 068, 074, 168, 169, 185, 187	
(13) Disequilibrium, Otitis media with CC, age 0-17, and Other dental and throat disease	065, 069, 070, 071, 186	
D. Respiratory System Diseases and Disorders		
(1) With ventilator support < 96 hrs	475	Excludes 96.72
(2) With ventilator support 96+ hrs	475	Includes 96.72
(3) [Reserved for future use]		
(4) [Reserved for future use]		
(5) [Reserved for future use]		
(6) Respiratory neoplasms	082	
(7) [Reserved for future use]		
(8)	[Reserved for future use]	
(9) COPD, Simple pneumonia with CC, Chest trauma w/o CC, and Other respiratory disorders	084, 088, 089, 093, 094, 099	

(10) Tracheostomy for face, mouth and
neck diagnoses 482
(11) Bronchitis and asthma with CC or Simple
pneumonia and pleurisy
except with CC 090, 091, 096
(12) Pleural effusion, Infection and
inflammation with CC, Pulmonary
edema and respiratory failure 079, 085, 087
(13) Pulmonary embolism and
Other respiratory diseases with CC 078, 101
(14) [Reserved for future use]
(15) Specific respiratory system
diseases and disorders 080. 081, 083, 092
(16) Pleural effusion, Pneumothorax,
Bronchitis and Other
diagnoses without CC 086, 095, 097, 098, 100, 102
(17) [Reserved for future use]
(18) [Reserved for future use]
(19)Ventilator 96+ hours With
ECMO/Tracheostomy with major
surgery or With extensive
burns with skin graft 504, 541
(20) Tracheostomy with ventilator 96+
hours or without major surgery 542
(21-74) [Reserved for future use]
(75) Major chest procedures 075
(76) Other respiratory system O.R.
procedures with CC 076
(77) Other respiratory system O.R.
procedures without CC 077

E. Circulatory System Diseases and Disorders
(1) Major cardiac surgeries 105, 106, 108, 110, 547, 549
(2) [Reserved for future use]
(3) Permanent cardiac pacemaker
except device replacement without
major CV disease, and other
procedures for
circulatory disease 114, 117, 552
(4) Major cardiac surgery and
implantable defibrillator 104
515, 535, 536
(5) Other cardiac interventional
and vascular procedures,
and Pacemaker device replacement
118, 120, 479, 518, 554, 556
(6) Amputation for circulatory disease
except upper limb and toe 113
(7) Drug-eluding stent, Other vascular
procedures, Cardiac pacemaker

with major CV diagnosis or AICD lead or generator	551, 553, 557, 558
(8) Heart failure and shock and Unexplained cardiac arrest	127, 129
(9) AMI without major complications, Cardiac cath without complex diagnoses, and Hypertension	122, 125, 134
(10) Peripheral vascular disease with CC	130
(11) Acute MI and Other circulatory diagnoses with CC, Endocarditis	121, 126, 134
(12) ASHD with CC, Other circulatory conditions without CC, and Vein ligation and stripping	119, 132 139, 140, 143, 145
(13) Deep vein thrombophlebitis, peripheral vascular disorders without CC, Congenital valve disease, age>17, and Arrhythmia with CC	128, 131, 135, 136, 138
(14) Major CV procedure without CC, Acute MI, expired, and Cardiac cath with complex diagnosis	111, 123, 124
(15) Syncope and collapse with and without CC	141, 142
(16) Atherosclerosis with CC, Congenital and valvular disorders, age 0-17	133, 137
(17) Coronary bypass with and without cath, without major CV diagnosis	548, 550
(18) Percutaneous cardiovascular procedure with major CV diagnosis	555

F. Digestive System Diseases and Disorders

(1) Anal/stomal, Hernia, Appendectomy and other procedures	158, 162, 163, 167
(2) Hernia procedures age > 17, Appendectomy without complicating diagnosis with CC	160, 161, 166
(3) Bowel and other digestive system surgery	147, 151, 153, 155, 157, 159, 165, 171
(4) Stomach and esophagus procedures and Digestive disease, age 0-17	149, 156, 164, 172, 190
(5) Other surgical procedures of the digestive system with CC	152, 170
(6) Rectal resection, Lysis of peritoneal adhesions and Other major bowel surgery	146, 148, 150, 154
(7) Digestive system conditions	

including malignancy, hemorrhage and obstruction	173, 174, 180, 188
(8) Other bowel, stomach, digestive system diseases with and without CC	176, 177, 179, 182, 189
(9) Digestive system Obstruction, Uncomplicated ulcer, and G.I. hemorrhage	175, 178, 181, 183, 184

G. Hepatobiliary System Diseases and Disorders

(1) Liver and Biliary tract disorders without CC	206, 208
(2) Disorders of the pancreas except malignancy	204
(3) Other disorders of liver except malignancy , cirrhosis, and alcoholic hepatitis with CC	205
(4) Malignancy of hepatobiliary system or pancreas and Cirrhosis and alcoholic hepatitis	202, 203
(5) Biliary tract disorders, laparoscopic chole without CDC, without CC	194, 207, 494
(6) Cholecystectomy except lap without CC and laparoscopic chole with CC	196, 198, 493
(7) Other surgery for liver, gall bladder and pancreas disease	192, 195, 197, 199, 200
(8) Biliary, Pancreas and Liver procedures with CC	191, 193, 201

H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues

(1) Combined anterior/posterior spinal fusion	496, 546
(2) Spinal fusion except cervical without CC	497
(3) Hip and femur procedures with CC and other musculoskeletal surgery	210, 217, 233, 471, 498, 501
(4) Surgeries of hip and lower extremity and cervical fusion without CC	212, 213, 216, 519, 544, 545
(5) Back and neck except fusion and Lower extremity procedures	211, 218, 220, 228, 234, 491, 499
(6) Other surgeries for soft tissue and removal of fix device	226, 227, 520, 537
(7) Other orthopedic procedures on lower extremity	219, 225, 230, 502, 502
(8) Upper extremity and back procedures without CC	223, 500, 538
(9) Carpal tunnel release and Minor arm procedures	006, 224, 229, 232
(10) Connective tissue disorders	240, 244

(11) Pathological fracture, musculoskeletal malignancy and Septic arthritis — 239, 242
(12) Fractures, sprains and other injuries — 235-238, 241, 243, 245, 248, 250, 253, 255, 256
(13) [Reserved for future use]
(14) [Reserved for future use]
(15) [Reserved for future use]
(16) [Reserved for future use]
(17) [Reserved for future use]

I. Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast
(1) Skin graft and debridement with CC and Malignant breast disease — 263, 265, 274
(2) Treated with skin graft, biopsy, or debridement — 262, 264, 266, 269, 271
(3) Other skin and subcutaneous diseases and procedures — 257, 258, 261, 267, 270, 272, 273, 275, 277
(4) Subtotal mastectomy and Other skin, subcutaneous tissue, and breast conditions — 259, 260, 268, 278-280, 282, 283
(5) Non-malignant breast and Minor skin disorders without CC — 276, 281, 284

J. Endocrine, Nutritional, and Metabolic Diseases and Disorders
(1) Major surgical procedures — 285-288, 292, 293
(2) Diabetes, age > 35 — 294
(3) Nutritional and miscellaneous metabolic conditions, age > 17 and inborn metabolic errors — 296, 299
(4) Metabolic disorders, age 0-17 and Diabetes, age 0-35 — 295, 298
(5) Metabolic disorders, age > 17 and Endocrine disorders without CC — 297, 301
(6) Other endocrine, nutritional, and metabolic conditions — 289-291, 300

K. Kidney and Urinary Tract Diseases and Disorders
(1) Kidney, ureter, or major bladder procedures — 303, 304, 315
(2) Prostatectomy and kidney procedures for non-neoplasm — 305 306, 308, 312
(3) Neoplasms with CC and other kidney and urinary tract conditions without CC or age 0-17 — 318, 331, 333
(4) Renal failure — 316
(5) Other kidney and urinary tract conditions and Admission for renal dialysis — 317, 320-322, 325, 328, 332

(6) Kidney stones and other kidney and urinary symptoms without CC	319, 324, 326, 327, 329, 330
(7) TURP and other prostate surgeries	307, 309-311, 313, 314, 323

L. Male Reproductive System Diseases and Disorders

(1) Treated with major surgery or with CC	334, 336, 338, 340, 341, 344
(2) Treated with minor surgery or without CC	335, 337, 339, 342, 343, 345
(3) Malignancy and other diseases treated without surgery	346-352

M. Female Reproductive System Diseases and Disorders

(1) Tubal interruption and Reconstructive procedures, D&C, conization except for malignancy	356, 361, 362, 364
(2) Uterine and adnexa procedures without CC	355, 359, 363, 367
(3) Menstrual and Other female reproductive system infections and disorders	368, 369
(4) [Reserved for future use]	
(5) Other female reproductive system procedures	358,360, 365
(6) Pelvic evisceration, radical hysterectomy, surgery and medical treatment for malignancy	353, 354, 357, 366

N. Pregnancy Related Conditions

(1) Postpartum and post-abortion diagnoses with surgery	377
(2) Ectopic pregnancy and other antepartum diagnoses without CC	378, 384
(3) Postpartum and post abortion conditions treated without surgery	376
(4) Abortion with surgery	381
(5) [Reserved for future use]	
(6) Threatened abortion	379
(7) Abortion without D & C, False labor, and Other conditions without surgery	380, 382, 383

O. [Reserved for future use]

P. Blood and Immunity Disorders

(1) Splenectomy and Other surgical procedures of blood forming organs	392, 393 , 394
(2) [Reserved for future use]	
(3) Red blood cell disorders age >17	395
(4) Red blood cell disorders age 0-17	396
(5) Coagulation, reticuloendothelial and immunity disorders with CC	397, 398

(6) Reticuloendothelial and immunity disorders without CC	399	
Q. Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms		
(1) [Reserved for future use]		
(2) Treated with chemotherapy with acute leukemia as secondary diagnosis	492	
(3) [Reserved for future use]		
(4) Treated with radiotherapy or chemotherapy without acute leukemia	409, 410	
(5) [Reserved for future use]		
(6) Surgical treatments for myeloproliferative diseases and disorders	401, 402, 406-408, 539, 540	
(7) Other nonsurgical treatments for myeloproliferative diseases and disorders	403-405, 411-414, 473	
R. Infections and Parasitic Diseases		
(1) Treated with surgical procedure	415	
(2) Other infection and parasitic diseases	423	
(3) Septicemia age >17	416	
(4) Septicemia age 0-17	417	
(5) Post-op and post-traumatic infections and Fever of unknown origin (FUO), age >17 with CC	418, 419	
(6) Viral illness and fever of unknown origin, age 0-17	422	
(7) FUO without CC and Viral illness, age > 17	420, 421	
S. Mental Diseases and Disorders		
(1) Treated with surgical procedure (ages 0+)	424	
(2) (Ages 0-17)	425, 427-429, 432	
(3) (Ages > 17)	425, 427-429, 432	
T. Substance Use and Substance Induced Organic Mental Disorder		
(1) (Ages 0-20) with CC	521	DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
(2) (Ages > 20) with CC	521	DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
(3) Age 0-20, without CC and Rehab	523	
(4) Age > 20, without CC and Rehab	523	
U. [Reserved for future use]		
V. Injuries, Poisonings, and Toxic Effects of Drugs		
(1) Treated with surgical procedure	439, 440, 442	
(2) Other surgery without CC and Hand		

procedures for injuries	441, 443
(3) [Reserved for future use]	
(4) Traumatic injury age 0-17, Allergic reactions, and other poisoning without CC	446 447, 448, 451, 453, 455
(5) Other toxic effects and Complications of treatment with CC	449, 452, 454
(6) Traumatic injury age >17 and Toxic effects age >17 without CC	444, 445, 450
W. Burns	
(1) [Reserved for future use]	
(2) [Reserved for future use]	
(3) Extensive or full thickness with ventilation 96+ hours without skin graft or Extensive with other inhalation injury or significant trauma	505, 507, 508
(4) Nonextensive burns with or without CC or significant trauma	509, 510, 511
X. Factors Influencing Health Status	
(1) O.R. procedures with diagnosis of other contact with health services	461
(2) Rehabilitation, Aftercare, and Signs and symptoms	462-467
Y. [Reserved for future use]	
Z. [Reserved for future use]	
AA. [Reserved for future use]	
BB. [Reserved for future use]	
CC. Caesarean Sections	
(1) With complicating diagnosis	370
(2) Without complicating diagnosis	371
DD. Vaginal Delivery	
(1) With complicating diagnosis	372
(2) Without complicating diagnosis or operating room procedures	373
(3) With operating room procedure	374, 375
EE. [Reserved for future use]	

FF. Depressive Neuroses	426	
GG. Psychoses		
(1) (Ages 0-17)	430	
(2) (Ages > 17)	430	
HH. Childhood Mental Disorders	431	
II. Unrelated Operating Room Procedures		
(1) Extensive	468	
(2) Nonextensive	476, 477	
JJ. [Reserved for future use]		
KK. Extreme Immaturity		
(1) Weight < 750 Grams	386	76501, 76502
(2) [Reserved for future use]		
(3) [Reserved for future use]		
(4) Weight 750 to 1499 Grams	386	76503-76505
	387	76500
(5) Neonate respiratory distress syndrome	386	Codes in DRG 386 except 76501-76505
LL. Prematurity with Major Problems		
(1) Weight < 1250 Grams	387	76511-76514
(2) Weight 1250 to 1749 Grams	387	76506, 76510, 76515, 76516
(3) Weight > 1749 Grams	387	Codes in DRG 387 except 76500, 76506, 76510-76516
MM. Prematurity Without Major Problems and Neonates Died	385, 388	DRG 385 includes neonates who expire in the birth hospital, and the discharge date is the same as the birth date
NN. Full Term Neonates With		
(1) Major problems (Age 0)	389	
(2) Other problems	390	
OO. Multiple Significant Trauma		
(1) Limb reattachment and Hip and femur OR procedures	485	
(2) Other multiple significant trauma without O.R.	487	
(3) Full thick burn with skin graft or inhalation injury with CC or significant trauma and Other surgery for multiple significant trauma	486, 506	
PP. [Reserved for future use]		
QQ. Normal Newborns	391	

RR. [Reserved for future use]
SS. [Reserved for future use]
TT. [Reserved for future use]

UU. Organ and Cell Transplants

(1) Heart transplant	103
(2) Liver and/or intestinal, Bone marrow, Lung, Simultaneous pancreas and kidney, Pancreas transplants and Other heart assist system implant	480, 481, 495, 512, 513, 525
(3) Kidney transplant	302

VV. [Reserved for future use]

WW. Human Immunodeficiency Virus

(1) Treated with extensive operating room procedure	488
(2) With major related condition	489
(3) With or without other related condition	490

B. Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part. The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed. CLINICAL MODIFICATIONS CODES
A. Nervous System Diseases and Disorders	001- 003, 006-035, 524 524, 528-534, 543, 559	except codes in category Y and Z
C. [Reserved for future use]		
D. [Reserved for future use]		
E. [Reserved for future use]		
F. [Reserved for future use]		
G. [Reserved for future use]		
H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues	210-213, 216-220, 223-230, 232-256, 471, 491, 496-503, 519, 520, 537, 538, 544-546	except codes in category Y and Z
I-Q [Reserved for future use]		
R. Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders	424-432, 521, 523	except codes in category Y and Z; DRG 521 excludes procedures 94.61, 94.61, 94.63, 94.64, 94.66, 94.67, 94.69
S. Multiple Significant Trauma/ Unrelated Operating Room Procedures	468, 476, 477,	except codes in category Y and Z
T. Other Conditions Requiring Rehabilitation Services	036-106, 108, 110, 111, 113, 114, 117-208, 257-399, 401-423, 439-455, 461-467, 473, 475, 479-482, 488-490, 492-495, 504-513, 515, 518, 525, 535, 536, 539, 540-542, 547-558	except codes in category Y & Z

U. [Reserved for future use]
V. [Reserved for future use]
W. [Reserved for future use]
X. [Reserved for future use]

Y. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in paraplegia	All DRGs	Diagnosis codes 344.1, 806.21, 806.26 806.31, 806.36, 952.11, 952.16 in combination with 905.0, 907.0, or 907.2, excluding cases with 781.0, 781.2, 781.3, & 781.4
Z. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in quadriplegia or hemiplegia	All DRGs	Diagnosis codes 344.01-344.04, 344.09, 806.0x, 806.1x, or 952.0x in combination with 907.2, excluding cases with 781.0, 781.2, & 780.03; or Diagnosis codes 344.00-344.04, 344.09, 342.01, 342.81, or 342.91 in combination with 907.0 or 905.0, excluding cases 781.0, 781.3, & 780.03

C. Additional DRG requirements.

1. Version 23 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

2. The discharge status will be changed to "discharge to home" for DRG 433.

3. A diagnosis with the prefix "v57" will be excluded when grouping under item B.

4. The discharge status will be changed to "discharge to home" when grouping under item A for a transfer to a Medicare rehabilitation distinct part.

5. A transfer from a hospital paid under a diagnostic category in item A, which includes ICD-9-CM procedure code 86.06 (implantation of a totally implantable infusion pump) for the treatment of spasticity, to a Medicare rehabilitation distinct part must include ICD-9-CM diagnosis code 781.0 when grouping under item B.

6. The discharge status will be changed to "discharge to home" for all neonates in DRG 385, except for neonates that expire at the birth hospital and the discharge date is the

same as the date of birth.

7. For payment of admissions that result from the unavailability of a home health nurse, and there is one or more acute episodes of illness during the admission resulting in changes in physician orders and the treatment plan, the principal diagnoses V58.89, Other Specified Aftercare and V63.1, Medical Services in Home not Available will be excluded.

8. For patients in DRG 386-390 and the age is greater than zero, the principal diagnosis from ICD-9-CM Chapter 15, Certain conditions originating in the perinatal period (diagnoses codes 760-779), will be excluded when grouping under item A.

9. For payment under DRG 521, alcohol/drug abuse or dependence with complications or comorbidities, payment is not made for patients engaged in alcohol and/or drug rehabilitation.

10. For DRG 003, the patient age will be changed to 18 years. If the admission subsequently groups to DRG 529 or 530, that DRG will be assigned. Otherwise the admission will remain in DRG 003.

11. The admission source will be changed to “admitted as a transfer from a different acute care hospital” for all newborns admitted to the hospital within the first 28 days after birth with a principal diagnosis of V29.0-V29.9.

12. The prematurity subcategory diagnosis codes 765.20 and 765.26 through 765.29 will be ignored when assigning a DRG if a diagnosis code from 764, 765 or 765.1 is not included on the claim.