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State of Minnesota  
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH  
SESSION

HOUSE FILE NO. 782

February 8, 2007

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The bill was read for the first time and referred to the Committee on Finance

1.1 A bill for an act  
1.2 relating to human services; eliminating certain hospital payment reductions;  
1.3 appropriating money; amending Minnesota Statutes 2006, sections 256.969,  
1.4 subdivisions 3a, 27; 256B.75.

1.5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.6 Section 1. Minnesota Statutes 2006, section 256.969, subdivision 3a, is amended to  
1.7 read:

1.8 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical  
1.9 assistance program must not be submitted until the recipient is discharged. However,  
1.10 the commissioner shall establish monthly interim payments for inpatient hospitals that  
1.11 have individual patient lengths of stay over 30 days regardless of diagnostic category.  
1.12 Except as provided in section 256.9693, medical assistance reimbursement for treatment  
1.13 of mental illness shall be reimbursed based on diagnostic classifications. Individual  
1.14 hospital payments established under this section and sections 256.9685, 256.9686, and  
1.15 256.9695, in addition to third party and recipient liability, for discharges occurring during  
1.16 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered  
1.17 inpatient services paid for the same period of time to the hospital. This payment limitation  
1.18 shall be calculated separately for medical assistance and general assistance medical  
1.19 care services. The limitation on general assistance medical care shall be effective for  
1.20 admissions occurring on or after July 1, 1991. Services that have rates established under  
1.21 subdivision 11 or 12, must be limited separately from other services. After consulting with  
1.22 the affected hospitals, the commissioner may consider related hospitals one entity and  
1.23 may merge the payment rates while maintaining separate provider numbers. The operating  
1.24 and property base rates per admission or per day shall be derived from the best Medicare

2.1 and claims data available when rates are established. The commissioner shall determine  
2.2 the best Medicare and claims data, taking into consideration variables of recency of the  
2.3 data, audit disposition, settlement status, and the ability to set rates in a timely manner.  
2.4 The commissioner shall notify hospitals of payment rates by December 1 of the year  
2.5 preceding the rate year. The rate setting data must reflect the admissions data used to  
2.6 establish relative values. Base year changes from 1981 to the base year established for the  
2.7 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited  
2.8 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision  
2.9 1. The commissioner may adjust base year cost, relative value, and case mix index data  
2.10 to exclude the costs of services that have been discontinued by the October 1 of the year  
2.11 preceding the rate year or that are paid separately from inpatient services. Inpatient stays  
2.12 that encompass portions of two or more rate years shall have payments established based  
2.13 on payment rates in effect at the time of admission unless the date of admission preceded  
2.14 the rate year in effect by six months or more. In this case, operating payment rates for  
2.15 services rendered during the rate year in effect and established based on the date of  
2.16 admission shall be adjusted to the rate year in effect by the hospital cost index.

2.17 (b) For fee-for-service admissions occurring ~~on or after~~ from July 1, 2002, to June  
2.18 30, 2007, the total payment, before third-party liability and spenddown, made to hospitals  
2.19 for inpatient services is reduced by .5 percent from the current statutory rates.

2.20 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service  
2.21 admissions occurring ~~on or after~~ from July 1, 2003, to June 30, 2007, made to hospitals for  
2.22 inpatient services before third-party liability and spenddown, is reduced five percent from  
2.23 the current statutory rates. Mental health services within diagnosis related groups 424 to  
2.24 432, and facilities defined under subdivision 16 are excluded from this paragraph.

2.25 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for  
2.26 fee-for-service admissions occurring ~~on or after~~ from July 1, 2005, to June 30, 2007, made  
2.27 to hospitals for inpatient services before third-party liability and spenddown, is reduced  
2.28 6.0 percent from the current statutory rates. Mental health services within diagnosis  
2.29 related groups 424 to 432 and facilities defined under subdivision 16 are excluded from  
2.30 this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this  
2.31 paragraph, medical assistance does not include general assistance medical care. Payments  
2.32 made to managed care plans shall be reduced for services provided on or after January  
2.33 1, 2006, to reflect this reduction.

2.34 Sec. 2. Minnesota Statutes 2006, section 256.969, subdivision 27, is amended to read:

3.1 Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment  
3.2 under this section, the commissioner shall make the following payments effective July  
3.3 1, 2007:

3.4 (1) for a hospital located in Minnesota and not eligible for payments under  
3.5 subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8  
3.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal  
3.7 to 13 percent of the total of the operating and property payment rates;

3.8 (2) for a hospital located in Minnesota in a specified urban area outside of the  
3.9 seven-county metropolitan area and not eligible for payments under subdivision 20, with  
3.10 a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total  
3.11 patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent  
3.12 of the total of the operating and property payment rates. For purposes of this clause, the  
3.13 following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria,  
3.14 Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids,  
3.15 Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena; and

3.16 (3) for a hospital located in Minnesota but not located in a specified urban area under  
3.17 clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8  
3.18 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to  
3.19 four percent of the total of the operating and property payment rates. A hospital located in  
3.20 Woodbury and not in existence during the base year shall be reimbursed under this clause.

3.21 (b) The state share of payments under paragraph (a) shall be equal to federal  
3.22 reimbursements to the commissioner to reimburse nonstate expenditures reported under  
3.23 section 256B.199. The commissioner shall ratably reduce or increase payments under this  
3.24 subdivision in order to ensure that these payments equal the amount of reimbursement  
3.25 received by the commissioner under section 256B.199, ~~except that payments shall be~~  
3.26 ~~ratably reduced by an amount equivalent to the state share of a four percent reduction in~~  
3.27 ~~MinnesotaCare and medical assistance payments for inpatient hospital services.~~

3.28 (c) The payments under paragraph (a) shall be paid quarterly beginning on July  
3.29 15, 2007, or upon federal approval of federal reimbursements under section 256B.199,  
3.30 whichever occurs later.

3.31 (d) The commissioner shall not adjust rates paid to a prepaid health plan under  
3.32 contract with the commissioner to reflect payments provided in paragraph (a).

3.33 (e) The commissioner shall maximize the use of available federal money for  
3.34 disproportionate share hospital payments and shall maximize payments to qualifying  
3.35 hospitals. In order to accomplish these purposes, the commissioner may, in consultation  
3.36 with the nonstate entities identified in section 256B.199, adjust, on a pro rata basis

4.1 if feasible, the amounts reported by nonstate entities under section 256B.199 when  
4.2 application for reimbursement is made to the federal government, and otherwise adjust  
4.3 the provisions of this subdivision.

4.4 (f) By January 15 of each year, beginning January 15, 2006, the commissioner  
4.5 shall report to the chairs of the house and senate finance committees and divisions with  
4.6 jurisdiction over funding for the Department of Human Services the following estimates  
4.7 for the current and upcoming federal and state fiscal years:

4.8 (1) the difference between the Medicare upper payment limit and actual or  
4.9 anticipated medical assistance payments for hospital services;

4.10 (2) the amount of federal disproportionate share hospital funding available to  
4.11 Minnesota and the amount expected to be claimed by the state; and

4.12 (3) the methodology used to calculate the results reported for clauses (1) and (2).

4.13 (g) For purposes of this subdivision, medical assistance does not include general  
4.14 assistance medical care.

4.15 (h) This section sunsets on June 30, 2009. The commissioner shall report to  
4.16 the legislature by December 15, 2008, with recommendations for maximizing federal  
4.17 disproportionate share hospital payments after June 30, 2009.

4.18 Sec. 3. Minnesota Statutes 2006, section 256B.75, is amended to read:

4.19 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

4.20 (a) For outpatient hospital facility fee payments for services rendered on or after  
4.21 October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted  
4.22 charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those  
4.23 services for which there is a federal maximum allowable payment. Effective for services  
4.24 rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital  
4.25 facility fees and emergency room facility fees shall be increased by eight percent over the  
4.26 rates in effect on December 31, 1999, except for those services for which there is a federal  
4.27 maximum allowable payment. Services for which there is a federal maximum allowable  
4.28 payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum  
4.29 allowable payment. Total aggregate payment for outpatient hospital facility fee services  
4.30 shall not exceed the Medicare upper limit. If it is determined that a provision of this  
4.31 section conflicts with existing or future requirements of the United States government with  
4.32 respect to federal financial participation in medical assistance, the federal requirements  
4.33 prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to  
4.34 avoid reduced federal financial participation resulting from rates that are in excess of  
4.35 the Medicare upper limitations.

5.1 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and  
5.2 ambulatory surgery hospital facility fee services for critical access hospitals designated  
5.3 under section 144.1483, clause (10), shall be paid on a cost-based payment system that is  
5.4 based on the cost-finding methods and allowable costs of the Medicare program.

5.5 (c) Effective for services provided on or after July 1, 2003, rates that are based  
5.6 on the Medicare outpatient prospective payment system shall be replaced by a budget  
5.7 neutral prospective payment system that is derived using medical assistance data. The  
5.8 commissioner shall provide a proposal to the 2003 legislature to define and implement  
5.9 this provision.

5.10 (d) For fee-for-service services provided ~~on or after~~ from July 1, 2002, to June 30,  
5.11 2007, the total payment, before third-party liability and spenddown, made to hospitals for  
5.12 outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

5.13 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service  
5.14 services provided ~~on or after~~ from July 1, 2003, to June 30, 2007, made to hospitals for  
5.15 outpatient hospital facility services before third-party liability and spenddown, is reduced  
5.16 five percent from the current statutory rates. Facilities defined under section 256.969,  
5.17 subdivision 16, are excluded from this paragraph.

5.18 Sec. 4. **APPROPRIATION.**

5.19 \$..... is appropriated from the general fund to the commissioner of human services  
5.20 for the biennium beginning July 1, 2007, for the purposes of sections 1 to 3.