Change Item: Inpatient Hospital Payment Changes

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	2,282	2,935	3,279	3,501
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,282	2,935	3,279	3,501
FTEs	**0**	**0**	**0**	**0**

Request:

Effective July 1, 2015, the Governor recommends changes to payments made for inpatient hospital services under Medical Assistance (MA) to refine changes to the hospital payment systems authorized during the 2014 legislative session. Additionally, this proposal responds to federal changes to disproportionate share hospital (DSH) payments that impact safety net hospitals and hospitals that serve larger numbers of MA and uninsured. The changes include changing Critical Access Hospital (CAH) rates, revising the criteria that qualify a hospital for DSH payments, establishing a redistribution process for DSH funds, and other technical changes.

This proposal has a General Fund cost of $5.2 million in the FY2016-17 biennium and $6.8 million in the FY2018-19 biennium.

Rationale/Background:

During the 2014 Legislative session, DHS received authority to rebase inpatient hospital rates in the MA program for the first time in over seven years. This proposal continues the work authorized last year by changing payments to critical access hospitals and updating the criteria for DSH payments.

The critical access designation was created by the federal Centers for Medicare and Medicaid Services (CMS) to ensure that rural beneficiaries would have access to acute care hospital services. Nearly six in ten hospitals across Minnesota are designated critical access hospitals by CMS. In 2012, Minnesota Health Care Program recipients recorded over 2,500 admissions at 81 federally designated critical access hospitals, almost all of which were located in Minnesota. The 2014 legislation authorized payment for non critical access hospitals using the All Patient Refined Diagnostic Related Group (APR-DRG) grouper, and payments under this system factor in patient complexity and case mix. CAH have lower patient volume and generally treat patients with lower complexity. While the use of a cost based rate maintained stable payments to these providers, variation in cost across critical access hospitals was much greater than expected. Revising the methodology will achieve the level of stability in payments necessary to ensure access in rural areas.

Current state law limits the rate paid to hospitals for vaginal and C-section deliveries in Medical Assistance. This limit does not allow the payment system to produce a rate that recognizes complex deliveries and surgical births. Keeping the cap in place does not allow for payment based on patient complexity and prohibits effective evaluation of potential policy adjustments for obstetric services, particularly those services delivered in rural areas.

This proposal also changes Disproportionate Share Hospital (DSH) payments made to hospitals that provide a high volume of uncompensated care. The federal government has begun enforcing hospital specific DSH limits which means that a hospital is not able to be paid in excess of the amount necessary to cover the uncompensated costs associated with Medicaid and uninsured patients. With the enforcement of DSH limits, it is necessary to create a method to redistribute DSH funds to other eligible hospitals when, based on the results of the required DSH audit, it is determined that a hospital is unable to keep all of the DSH funds paid to them. Changes to the DSH methodology will also relieve small rural hospitals from the significant expense of filing DSH reports when the DSH funding they receive may not cover the cost of completing the report.

This proposal will help ensure that hospital rates are aligned with state and federal policy objectives.

Proposal:

The 2014 legislation also strengthened requirements for the timely submission of hospital cost reports. With more complete cost information, DHS is able to update rate for critical access hospitals using more recent cost data. Under this proposal, critical access hospitals will be reimbursed at a percentage of 2012 Medicare costs for services provided under the Medical Assistance program. Using this cost-based methodology ensures that facilities with lower patient volume are less impacted by current and future hospital rebasing which recognizes patient volume and complexity as a factor in payment rates.

This proposal also provides a method to redistribute DSH funds in the event that cost report data finds that specific hospitals are over the DSH limits. Without authority to redistribute DSH funds, DHS may be required to remove critical funds from the hospital system and return the federal share of these payments.

Finally, this proposal removes the statutory limits on deliveries and C-sections so that rates can reflect patient complexity.

Results:

A typical measure that will be used to monitor the sufficiency of the rates and payments will be the ratio of cost to payment. This can be measured as a statewide average across each hospital type (DRG hospital, critical access hospital (CAH), long term hospital, and rehab hospital).

Federal law requires that state Medicaid plans make Disproportionate Share Hospital Payments (DSH) to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. The proposed change in DSH distribution methodology ensures that the state of Minnesota has a mechanism to distribute federal DSH payments available to the state in the event that any hospitals hit their hospital specific limit and is unable to accept further payment. The department will monitor the percentage and amount of total DSH payments that are redistributed on an annual basis. This measure will inform whether inpatient rates and DSH criteria are aligned with state and federal policy objectives.

Statutory Change(s):

256.969, 256B.19

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund (dollars in thousands)			FY 15	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund Totals				2,282	2,935	5,217	3,279	3,501	6,780
HCAF									
Federal TANF									
Other Fund									
Total All Funds			$0	$0	$0	$0	$0	$0	$0
Fund	**BACT #**	**Description**	**FY 15**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33 ED	MA Grants		1,065	1,365	2,430	1,512	1,628	3,141
GF	33 AD	MA Grants		0	57	57	136	168	304
GF	33 FC	MA Grants		1,217	1,513	2,730	1,631	1,705	3,336
Requested FTE's									
				0	0		0	0	