MA INPATIENT HOSPITAL SYSTEM SUMMARY
January 2011

The following information relates to the inpatient hospital payment system under the fee for service Medical Assistance (MA) program.

Inpatient Hospital Rates

Inpatient hospital patient days under the MA program approximate 10% of total statewide patient days.

Inpatient hospital rates are set based on hospital specific cost from a base year. Rates are established using a precise method of calculating each hospital's inpatient MA cost within the base year. The rate setting system essentially uses all base year allowable inpatient MA costs of a hospital and divides by the corresponding number of MA admissions or patient days to calculate an average cost per admission or cost per day. The cost is then trended forward to the current year using legislatively allowed inflation which was removed beginning in 2002. The result for each individual hospital is that the rates reflect the cost, services and utilization provided to MA patients. Current rates are set using 2002 as the base year.

A rate that is based on average costs would not closely target payments to the costs of treating an individual person. Thus, the rate and payment is adjusted by a diagnosis related group (DRG) factor that reflects the cost of treating a specific diagnosis. This DRG adjustment is simply a tool that allows the payment of multiple rates from a single average rate and adjusts for changes in the type of diagnoses treated. The number of DRGs is budget neutral to the hospitals and the Department.

A hospital specific cost based payment system is generally considered to be equitable because it recognizes hospital specific, regional and other cost differences. Since inpatient hospital rates are based on each individual hospital's cost, costs that are not specific to all hospitals are embedded in the rates. The cost of medical education and differing wage levels are examples that contribute greatly to the current variation in MA rates between hospitals. It should be noted that other payers such as the Medicare program also pay using DRG based rates, but these rates are calculated as averages of multiple hospitals within a geographic area.

The payment system is designed to maximize federal upper payment limits and disproportionate share payment limits through payment add-ons, intergovernmental transfers and certified public expenditures. Due to this approach, it is labor intensive to assure compliance with federal limits and to respond to federal audits.

Payment Additions

Payments are made for each admission to the hospital based on each patient's diagnosis with extra payment for exceptionally long lengths of stay. In some cases payments are

made based on a per day rate. This includes neonatal intensive care unit services and services of long term hospitals. In addition to the cost based rates, additional payments are made to hospitals with each diagnosis based payment based on specific criteria.

- A fifteen or twenty percent rateable increase is made under MA for small, non-metro hospitals. Eighty nine hospitals receive this increase.

- A disproportionate share payment (DSH) is paid to fifty eight hospitals as a rateable increase. The percentage increase factor increases as the hospital's MA business increases above the statewide average and varies from less than 1% to almost 60%. DSH payments are limited under federal requirements to an aggregate amount and each hospital is limited to its costs of uncompensated care.

- One hundred eleven non-seven county metro hospitals are eligible to receive an increase for sixteen DRGs. Rates for these hospitals are set at the greater of the hospital's individual rate or 90% of the seven county metro average rates.

Payment Limits

Payment for uncomplicated cesarean and vaginal delivery with and without a complicating diagnosis is limited to $3,528 as reduced for rateable reductions and increased by the DSH factor of the hospital.

Rebasing Hospital Costs

Rebasing of inpatient rates to more current cost data generally occurs every two years. This means that rates are reset using each hospital's cost data that is updated two years. The statutes provide for rebasing every two years except for 1997, 2005, 2009 and, except for two long term hospitals, 2011. Rebasing to more current data was effective in 2007 with hospital cost increases that encompass four years instead of two because of not rebasing in 2005. The base year of the rate setting cost and utilization data is 2002. Rates will be rebased to 2008 individual cost data in 2013, a six year increase.

The rebasing process results in rates that incorporate hospital specific inflation. The last rebasing occurred in 2007 and increased rates statewide an average of 26% for MA and 24% under GAMC reflecting a four year increase.

Intergovernmental Transfers

A transfer is made that involves Hennepin and Ramsey counties. The amount varies each year depending on how high Minnesota rates are compared to the federal Medicare upper payment limit. The transfer results in additional payments to Hennepin County Medical Center and Regions Hospital for the difference between the aggregate MA payments and what would have been paid under the Medicare payment principles.

Certified Public Expenditures

Federal financial participation results from a certified public expenditure by two hospitals.

Rateable Reductions

Hospital payments are currently subject to rateable reductions. A hospital's payment is calculated in full, but then a reduction factor is applied. This is 14.4% for non-mental health services and 1.5% for mental health services under MA.

Statutory References

256.969 : Inpatient Hospital Rate Setting and Payments
256B.197 : Intergovernmental Transfers
256B.199 : Certified Public Expenditures