..... moves to amend H.F. No. 2150, the first engrossment, as follows:

Pages 15 to 22, delete sections 2 to 11 and insert:

"Sec. 2. Minnesota Statutes 2012, section 256.9685, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner shall establish procedures for determining medical assistance and general assistance medical care payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04, subdivision 15, ~~or 256D.03, subdivision 7, paragraph (b),~~ to be eligible for payment.

(b) The commissioner may reduce the types of inpatient hospital admissions that are required to be certified as medically necessary after notice in the State Register and a 30-day comment period.

Sec. 3. Minnesota Statutes 2012, section 256.9685, subdivision 1a, is amended to read:

Subd. 1a. **Administrative reconsideration.** Notwithstanding sections 256B.04, subdivision 15, ~~and 256D.03, subdivision 7,~~ the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 days after receiving notice of the decision. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by physicians that are independent of the case under reconsideration. A majority decision by the physicians is necessary to make a determination that the services were not medically necessary.

Sec. 4. Minnesota Statutes 2012, section 256.9686, subdivision 2, is amended to read:

Subd. 2. **Base year.** "Base year" means a hospital's fiscal year that is recognized by the Medicare program or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information by the Medicare program from which cost and statistical data are used to establish medical assistance ~~and general assistance medical care~~ payment rates.

Sec. 5. Minnesota Statutes 2012, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) ~~For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care, except that the inflation adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply through calendar year 2001. The index for calendar year 2000 shall be reduced 2.5 percentage points to recover overprojections of the index from 1994 to 1996.~~ The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance ~~and general assistance medical care,~~ based upon the hospital cost index.

Sec. 6. Minnesota Statutes 2012, section 256.969, subdivision 2, is amended to read:

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, ~~including~~ such as the ~~system used by the Medicare program~~ all patient refined diagnosis-related groups (APR-DRGs) or other similar classification programs to determine the relative values of inpatient services and case mix indices. The commissioner may combine diagnostic classifications into diagnostic categories and may establish separate categories and numbers of categories based on ~~program eligibility or~~ hospital peer group. Relative values shall be ~~recalculated~~ recalibrated when the base year is changed. Relative value determinations shall include paid claims for admissions during each hospital's base year. The commissioner may ~~extend the time period forward to obtain sufficiently valid information to establish relative values~~ supplement the diagnostic classification systems data with national averages.

Relative value determinations shall not include ~~property cost data,~~ Medicare crossover data, and data on admissions that are paid a per day transfer rate under subdivision 14. The computation of the base year cost per admission must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs recognized in outlier payments beyond that point. The commissioner may recategorize the diagnostic classifications and ~~recalculate~~ recalibrate relative values and case mix indices to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register and a 30-day comment period. ~~The commissioner shall recategorize the diagnostic classifications and recalculate relative values and case mix indices based on the two-year schedule in effect prior to January 1, 2013, reflected in subdivision 2b. The first recategorization shall occur January 1, 2013, and shall occur every two years after. When rates are not rebased under subdivision 2b, the commissioner may establish relative values and case mix indices based on charge data and may update the base year to the most recent data available.~~

Sec. 7. Minnesota Statutes 2012, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **~~Operating~~ Hospital payment rates.** (a) For discharges occurring on and after September 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according to the following:

(1) critical access hospitals as defined by Medicare shall be paid using a cost-based methodology;

(2) long-term care hospitals as defined by Medicare shall be paid on a per diem methodology under subdivision 25;

(3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation distinct parts as defined by Medicare shall be paid according to the methodology under subdivision 12; and

(4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

(b) ~~In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009.~~ For the ~~rebased~~ period beginning January 1, 2011, through August 31, 2014, rates shall not

be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For ~~subsequent~~ rate setting periods after September 1, 2014, in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. ~~Effective January 1, 2013, and after, rates shall not be rebased.~~

(c) Effective for discharges occurring on and after September 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except those hospitals paid under the methodologies under paragraph (a), clauses (2) and (3), shall be rebased incorporating cost and payment methodologies in a manner similar to Medicare. The base year for the rates effective September 1, 2014, shall be state fiscal year 2012. The rebasing must be budget neutral, ensuring 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. Separate budget neutrality calculations shall be determined for payments made to critical access hospitals and payments made to hospitals paid under the DRG system. Any rate increases or decreases under subdivision 3a that applied to the hospitals being rebased during the base period shall be incorporated into the budget neutrality calculation. Any rate increases or decreases that did not apply to the base period shall not be considered in the budget neutrality calculation.

(d) For discharges occurring September 1, 2014, through and including June 30, 2016, the rebased rates shall include necessary adjustments to the projected rates that result in no greater than a five percent increase or decrease from the base year payments for any hospital. In addition to such adjustments, the commissioner may make adjustments to rates and must consider the impact of changes on at least the following when evaluating whether additional adjustments should be made:

(1) pediatric services;

(2) behavioral health services;

(3) trauma services as defined by the National Uniform Billing Committee;

(4) transplant services;

(5) obstetric services, newborn services, and behavioral health services provided by hospitals outside the seven-county metropolitan area;

(6) outlier admissions;

(7) low volume providers; and

(8) services provided by small rural hospitals that are not critical access hospitals.

(e) Hospital payment rates established under paragraph (c) shall incorporate the following:

(1) for hospitals paid under the DRG methodology, the base year ~~operating~~ payment rate per admission is standardized by the ~~case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment.~~ applicable Medicare wage index and adjusted by the hospital's disproportionate population adjustment;

(2) for critical access hospitals, interim per diem payment rates shall be based on the ratio of cost and charges reported on the base year Medicare cost report or reports and applied to medical assistance utilization data. Final settlement payments for a state fiscal year will be determined based on a review of the Medicaid cost report for the applicable state fiscal year;

(3) the cost and charge data used to establish ~~operating~~ hospital payment rates shall only reflect inpatient services covered by medical assistance ~~and shall not include property cost information and costs recognized in outlier payments~~; and

(4) in determining hospital payment rates for discharges occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per discharge must be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

Sec. 8. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 2d. **Budget neutrality factor.** For the rebased period effective September 1, 2014, when rebasing rates under subdivision 2b, paragraph (c), the commissioner must apply a budget neutrality factor if applicable to all hospitals' rebased rates to ensure that total DRG and critical access hospital payments to hospitals do not exceed total DRG and critical access hospital payments that would have been made to hospitals for the same number and types of services if the relative rates and weights had not been recalibrated and cost-based payments for critical access hospitals had not been established. For the purposes of this section, budget neutrality factor equals the percentage change from total aggregate payments calculated under a new payment system to total aggregate payments calculated under the old system for the same number and types of services.

Sec. 9. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 2e. **Interim payments.** Notwithstanding subdivision 2b, for discharges occurring on or after September 1, 2014, and no later than June 30, 2015, the commissioner may implement an interim payment process to pay hospitals, including payments based on each hospital's average payments per claim for state fiscal years 2011 and 2012. These

interim payments may be used to pay hospitals if the new payment system and rebasing under subdivision 2b is not complete by September 1, 2014. Claims paid at interim payment rates shall be reprocessed and paid at the rates established under the new system upon implementation of the new system.

Sec. 10. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 2f. **Report required.** (a) The commissioner shall annually report to the legislature beginning March 1, 2015, and ending March 1, 2016, on the financial impacts by hospital and policy ramifications, if any, resulting from payment methodology changes implemented after August 31, 2014 and before December 31, 2015.

(b) The commissioner shall provide, at a minimum, the following information:

(1) case-mix adjusted calculations of net payment impacts for each hospital resulting from the difference between the payments each hospital would have received under the payment methodology for discharges before August 31, 2014, and the payments each hospital has or is expected to receive for the same number and types of services under the payment methodology implemented effective September 1, 2014;

(2) any adjustments authorized under subdivision 2b, paragraph (d), that were made and the impacts of those adjustments; and

(3) recommendations for further refinement or improvement of the hospital inpatient payment system or methodologies.

Sec. 11. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. ~~This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991.~~ Services that have rates established under

subdivision ~~11 or~~ 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates ~~by December 1 of the year preceding the rate year~~ 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. ~~Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1.~~ The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 or corresponding APR-DRGs and facilities defined under subdivision 16 are excluded from this paragraph. ~~Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care.~~

Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 or corresponding APR-DRGs and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are

excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

(j) Effective for discharges on and after September 1, 2014, from hospitals paid under subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision shall be incorporated into the rebased rates established under subdivision 2b, paragraph (c), and shall not be applied to each claim.

Sec. 12. Minnesota Statutes 2012, section 256.969, subdivision 3b, is amended to read:

Subd. 3b. **Nonpayment for hospital-acquired conditions and for certain treatments.** (a) The commissioner must not make medical assistance payments to a hospital for any costs of care that result from a condition ~~listed~~ identified in paragraph (c), if the condition was hospital acquired.

(b) For purposes of this subdivision, a condition is hospital acquired if it is not identified by the hospital as present on admission. For purposes of this subdivision, medical assistance includes ~~general assistance medical care and~~ MinnesotaCare.

(c) The prohibition in paragraph (a) applies to payment for each hospital-acquired condition ~~listed~~ identified in this paragraph that is represented by an ICD-9-CM or ICD-10-CM diagnosis code ~~and is designated as a complicating condition or a major complicating condition:~~. The list of conditions shall be the hospital-acquired conditions list defined by the Centers for Medicare and Medicaid Services on an annual basis.

~~(1) foreign object retained after surgery (ICD-9-CM codes 998.4 or 998.7);~~

~~(2) air embolism (ICD-9-CM code 999.1);~~

~~(3) blood incompatibility (ICD-9-CM code 999.6);~~

~~(4) pressure ulcers stage III or IV (ICD-9-CM codes 707.23 or 707.24);~~

~~(5) falls and trauma, including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock (ICD-9-CM codes with these ranges on the complicating condition and major complicating condition list: 800-829; 830-839; 850-854; 925-929; 940-949; and 991-994);~~

~~(6) catheter-associated urinary tract infection (ICD-9-CM code 996.64);~~

~~(7) vascular catheter-associated infection (ICD-9-CM code 999.31);~~

~~(8) manifestations of poor glycemic control (ICD-9-CM codes 249.10; 249.11; 249.20; 249.21; 250.10; 250.11; 250.12; 250.13; 250.20; 250.21; 250.22; 250.23; and 251.0);~~

~~(9) surgical site infection (ICD-9-CM codes 996.67 or 998.59) following certain orthopedic procedures (procedure codes 81.01; 81.02; 81.03; 81.04; 81.05; 81.06; 81.07;~~

~~81.08; 81.23; 81.24; 81.31; 81.32; 81.33; 81.34; 81.35; 81.36; 81.37; 81.38; 81.83; and 81.85);~~

~~(10) surgical site infection (ICD-9-CM code 998.59) following bariatric surgery (procedure codes 44.38; 44.39; or 44.95) for a principal diagnosis of morbid obesity (ICD-9-CM code 278.01);~~

~~(11) surgical site infection, mediastinitis (ICD-9-CM code 519.2) following coronary artery bypass graft (procedure codes 36.10 to 36.19); and~~

~~(12) deep vein thrombosis (ICD-9-CM codes 453.40 to 453.42) or pulmonary embolism (ICD-9-CM codes 415.11 or 415.19) following total knee replacement (procedure code 81.54) or hip replacement (procedure codes 00.85 to 00.87 or 81.51 to 81.52).~~

(d) The prohibition in paragraph (a) applies to any additional payments that result from a hospital-acquired condition ~~listed~~ identified in paragraph (c), including, but not limited to, additional treatment or procedures, readmission to the facility after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital. In the event of a transfer to another hospital, the hospital where the condition ~~listed~~ identified under paragraph (c) was acquired is responsible for any costs incurred at the hospital to which the patient is transferred.

(e) A hospital shall not bill a recipient of services for any payment disallowed under this subdivision."

Pages 23 to 28, delete sections 13 to 20 and insert:

"Sec. 14. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually file medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments; or

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9. For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The Department of Human Services must suspend payments to any hospital that fails to file a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the Department of Human Services inpatient rates unit.

Sec. 15. Minnesota Statutes 2012, section 256.969, subdivision 6a, is amended to read:

Subd. 6a. **Special considerations.** In determining the payment rates, the commissioner shall consider whether the circumstances in subdivisions ~~7~~ 8 to 14 exist.

Sec. 16. Minnesota Statutes 2012, section 256.969, subdivision 8, is amended to read:

Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day outlier thresholds for each diagnostic category established under subdivision 2 at two standard deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold shall be in addition to the operating and property payment rates per admission established under subdivisions 2~~,~~ and 2b~~, and 2c~~. Payment for outliers shall be at 70 percent of the allowable operating cost, after adjustment by the case mix index, hospital cost index, relative values and the disproportionate population adjustment. The outlier threshold for neonatal and burn diagnostic categories shall be established at one standard deviation beyond the mean length of stay, and payment shall be at 90 percent of allowable operating cost calculated in the same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier payment that is at a minimum of 60 percent and a maximum of 80 percent if the commissioner is notified in writing of the request by October 1 of the year preceding the rate year. The chosen percentage applies to all diagnostic categories except burns and neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall be added back to the base year operating payment rate per admission.

(b) Effective for transfers occurring on or after September 1, 2014, the commissioner shall establish payment rates for acute transfers that are based on Medicare methodologies.

Sec. 17. Minnesota Statutes 2012, section 256.969, subdivision 8a, is amended to read:

Subd. 8a. **Short length of stay.** ~~Except as provided in subdivision 13, for admissions occurring on or after July 1, 1995, payment shall be determined as follows and shall be included in the base year for rate setting purposes:~~

~~(1) for an admission that is categorized to a neonatal diagnostic related group in which the length of stay is less than 50 percent of the average length of stay for the category in the base year and the patient at admission is equal to or greater than the age of one, payments shall be established according to the methods of subdivision 14;~~

~~(2)~~ For an admission that is categorized to a diagnostic category that includes neonatal respiratory distress syndrome, the hospital must have a level II or level III nursery and the patient must receive treatment in that unit or payment will be made without regard to the syndrome condition.

Sec. 18. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 8c. **Hospital residents.** Payments for hospital residents shall be made as follows:

(1) payments for the first 180 days of inpatient care shall be the DRG system payment plus any appropriate outliers; and

(2) payment for all medically necessary patient care subsequent to 180 days shall be reimbursed at a rate equal to 80 percent of the product of the statewide average cost-to-charge ratio multiplied by the usual and customary charges.

Sec. 19. Minnesota Statutes 2012, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. ~~The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care.~~ The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class;.

~~(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and~~

~~(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.~~

~~(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).~~

~~(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.~~

~~(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.~~

~~(f) For hospital services occurring on or after July 1, 2005, to June 30, 2007:~~

~~(1) general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be considered Medicaid disproportionate share hospital payments, except as limited below:~~

~~(i) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used for general assistance medical care expenditures;~~

~~(ii) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;~~

~~(iii) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and~~

~~(iv) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act. All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures; and~~

~~(2)~~ (c) certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

~~(g)~~ (d) Upon federal approval of the related state plan amendment, paragraph ~~(f)~~ (c) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Sec. 20. Minnesota Statutes 2012, section 256.969, subdivision 10, is amended to read:

Subd. 10. **Separate billing by certified registered nurse anesthetists.** Hospitals ~~may~~ must exclude certified registered nurse anesthetist costs from the operating payment rate ~~as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of even-numbered years to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services~~.

~~For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.~~

Sec. 21. Minnesota Statutes 2012, section 256.969, subdivision 12, is amended to read:

Subd. 12. **Rehabilitation distinct parts.** (a) Units of hospitals that are recognized as rehabilitation distinct parts by the Medicare program shall have separate provider numbers under the medical assistance program for rate establishment and billing purposes only. These units shall also have operating ~~and property~~ payment rates and the disproportionate population adjustment, if allowed by federal law, established separately from other inpatient hospital services.

(b) The commissioner ~~may~~ shall establish separate relative values under subdivision 2 for rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for discharges on or after September 1, 2014, the commissioner, to the extent possible, shall replicate the existing payment rate methodology under the new diagnostic classification system. The result must be budget neutral, ensuring that the total aggregate payments under the new system are equal to the total aggregate payments made for the same number and types of services in the base year, state fiscal year 2012.

(c) For individual hospitals that did not have separate medical assistance rehabilitation provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the information needed to separate rehabilitation distinct part cost and claims data from other inpatient service data.

Sec. 22. Minnesota Statutes 2012, section 256.969, subdivision 14, is amended to read:

Subd. 14. **Transfers.** ~~Except as provided in subdivisions 11 and 13,~~ (a) Operating and property payment rates for admissions that result in transfers and transfers shall be established on a per day payment system. The per day payment rate shall be the sum of the adjusted operating and property payment rates determined under this subdivision and subdivisions 2, 2b, ~~2e,~~ 3a, 4a, 5a, and 7 to 12, divided by the arithmetic mean length of stay for the diagnostic category. Each admission that results in a transfer and each transfer is considered a separate admission to each hospital, and the total of the admission and transfer payments to each hospital must not exceed the total per admission payment that would otherwise be made to each hospital under this subdivision and subdivisions 2, 2b, ~~2e,~~ 3a, 4a, 5a, and ~~7 to 13~~ 8 to 12.

(b) Effective for transfers occurring on and after September 1, 2014, the commissioner shall establish payment rates for acute transfers that are based on Medicare methodologies.

Sec. 23. Minnesota Statutes 2012, section 256.969, subdivision 17, is amended to read:

Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are located within a Minnesota local trade area and that have more than 20 admissions in the base year or years shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by ~~rule~~ statute. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Sec. 24. Minnesota Statutes 2012, section 256.969, subdivision 18, is amended to read:

Subd. 18. **Out-of-state hospitals outside local trade areas.** Hospitals that are not located within Minnesota or a Minnesota local trade area shall have ~~operating and property~~ inpatient hospital rates established at the average of statewide and local trade area rates or, at the commissioner's discretion, at an amount negotiated by the commissioner. Relative values shall not include data from hospitals that have rates established under this subdivision. Payments, including third-party and recipient liability, established under this subdivision may not exceed the charges on a claim specific basis for inpatient services that are covered by medical assistance.

Sec. 25. Minnesota Statutes 2012, section 256.969, subdivision 25, is amended to read:

Subd. 25. **Long-term hospital rates.** (a) Long-term hospitals shall be paid a per diem rate established by the commissioiner.

(b)For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

Sec. 26. Minnesota Statutes 2012, section 256.969, subdivision 30, is amended to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after ~~October 1, 2009,~~ September 1, 2014,the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the ~~diagnostic~~ APR-DRG categories: (1) ~~371 cesarean section without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis,~~ 5401, 5402, 5403, and 5404 cesarean section, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery."

Page 32, delete section 25 and insert:

"Sec. 31. Minnesota Statutes 2012, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) ~~Effective July 1, 2007,~~ The commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). ~~Effective September 1, 2011, the commissioner shall apply for matching funds for expenditures in paragraph (c).~~

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, and Regions Hospital~~, the University of Minnesota, and Fairview-University Medical Center~~ shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds~~. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27~~; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

~~(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:~~

~~(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:~~

~~(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and~~

~~(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and~~

~~(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.~~

~~(d)~~ (c) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. ~~These funds shall be made available as the state share of payments under section 256.969, subdivision 28.~~ The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.

~~(c)~~ (d) For services provided on or after September 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program ~~according to the requirements and conditions of paragraph (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 256.969, subdivision 9, paragraph (b)."

Page 35, delete section 29 and insert:

"Sec. 35. **REPEALER.**

Minnesota Statutes 2012, sections 256.969, subdivisions 2c, 8b, 9a, 9b, 11, 13, 20, 21, 22, 26, 27, and 28; and 256.9695, subdivisions 3 and 4, are repealed."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly