06 - 0138

REPORT TO THE LEGISLATURE

MEDICAL ASSISTANCE INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMITS DISPROPORTIONATE SHARE FUNDING

DEPARTMENT OF HUMAN SERVICES
HEALTH CARE ADMINISTRATION

JANUARY 2006

REPORT TO THE LEGISLATURE REQUIREMENT

Laws of Minnesota, 2005, First Special Session, Chapter 4, Article 8, Section 15 added Minnesota Statutes 256.969, subdivision 27 (f) which requires a report to the legislature related to inpatient hospital payments under the Medical Assistance program. The language states:

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

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

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

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

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

REPORT COST REQUIREMENT

Minnesota Statutes 3.197 requires the reporting of costs related to legislative reports. This report does not have a cost of preparation outside of normal agency operating costs.

MEDICARE UPPER PAYMENT LIMITS

Attachment A : Methodology

This attachment describes the methodology used to calculate the inpatient hospital Medicare upper payment limit (UPL) and the Medical Assistance (MA) rates.

- The description relates to federal fiscal year (FFY) 2005 which is the most recently completed UPL. Although the dates and data within the text of the description may change for future estimates, the methodology remains the same.

Attachment B : Current State Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period July 1, 2005 to June 30, 2006. Privately owned and operated hospitals are $42,566,000 below the limit and non-state owned or operated government hospitals are $29,684,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2005. The MA data was adjusted to eleven months for a 6% rateable reduction and for increased payments to non-metro hospitals due to state law. Payments to the medical education trust fund (MERC) have been reduced 41% from state fiscal year (SFY) 2005 due to a federal audit and state plan change that requires actual MERC payments to be included instead of an assigned amount. Medicare rates and diagnosis weights (DRG) have been increased 2.4% for nine months (10/2005 – 6/2006) to reflect the FFY06 payment schedule. However, rates for long term care hospitals and psychiatric hospitals and units are unknown at this time so FFY05 rates are continued.

Attachment C : Upcoming State Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period July 1, 2006 to June 30, 2007. Privately owned and operated hospitals are $44,775,000 below the limit and non-state owned or operated government hospitals are $29,473,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2005. The MA data was adjusted to a full year for a 6% rateable reduction and for increased payments to non-metro hospitals due to state law. Payments to the medical education trust fund (MERC) have been reduced 41% from SFY05 due to a federal audit and state plan change that requires actual MERC payments to be included instead of an assigned amount. The MA rates were also increased 3.9% to reflect six months (1/2007 –

6/2007) of the estimated increase due to rebasing rates to more current data. Medicare rates and DRG weights have been increased an estimated 2.4% over FFY06 to estimate nine months (10/2006 – 6/2007) of the currently unknown FFY07 payment schedule.

- The estimate is subject to a wide variation from what actually may occur. Individual hospital MA rates and DRG weights for each diagnosis will be rebased to more current data effective January 1, 2007. Since the UPL is based on hospital specific data and the rebased data is unknown at this time, actual MA payments could vary considerably from the estimates. Actual FFY07 Medicare rates and DRG weights are also unknown at this time. In addition, MA admission counts that are used to weight both the MA and Medicare rates of each hospital to determine average rates will be updated to more recent data that is not available at this time.

Attachment D : Current Federal Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period October 1, 2005 to September 30, 2006. Privately owned and operated hospitals are $48,467,000 below the limit and non-state owned or operated government hospitals are $30,405,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2005. The MA data was adjusted to a full year for a 6% rateable reduction and for increased payments to non-metro hospitals due to state law. Payments to the medical education trust fund (MERC) have been reduced 41% from SFY05 due to a federal audit and state plan change that requires actual MERC payments to be included instead of an assigned amount. Medicare rates and DRG weights have been increased 3.1% for a full year to reflect the FFY06 payment schedule. However, rates for long term care hospitals and psychiatric hospitals and units are unknown at this time so FFY05 rates are continued.

- The estimate is subject to a wide variation from what actually may occur. MA admission counts that are used to weight both the MA and Medicare rates of each hospital to determine average rates will be updated to more recent data that is not available at this time.

Attachment E : Upcoming Federal Fiscal Year Estimate

This attachment estimates the inpatient hospital UPL and MA rates for the period October 1, 2006 to September 30, 2007. Privately owned and operated hospitals are $44,901,000 below the limit and non-state owned or operated government hospitals are $29,750,000 below the limit.

- The estimate is based on the most recently completed UPL for the FFY ending September 30, 2005. The MA data was adjusted to a full year for a 6% rateable reduction and for increased payments to non-metro hospitals due to state law. Payments to the medical education trust fund (MERC) have been reduced 41% from SFY05 due to a federal audit and state plan change that requires actual MERC payments to be included instead of an assigned amount. The MA rates were increased 5.9% to reflect nine months (1/2007 – 9/2007) of the estimated increase due to rebasing rates to more current data. Medicare rates and DRG weights have been increased an estimated 3.1% over FFY06 to estimate a full year of the currently unknown FFY07 payment schedule.

- The estimate is subject to a wide variation from what actually may occur. Individual hospital MA rates and DRG weights for each diagnosis will be rebased to more current data effective January 1, 2007. Since the UPL is based on hospital specific data and the rebased data is unknown at this time, actual MA payments could vary considerably from the estimates. Actual FFY07 Medicare rates and DRG weights are also unknown at this time. In addition, MA admission counts that are used to weight both the MA and Medicare rates of each hospital to determine average rates will be updated to more recent data that is not available at this time.

DISPROPORTIONATE SHARE FUNDING

Federal law establishes the maximum amount a state can claim as a disproportionate share hospital payment (DSH). The following shows the amount of federal DSH funding available and the amount that is estimated will be claimed under current Minnesota law.

Current State Fiscal Year Estimate

The following estimates the federal share of DSH funding and payments for the period July 1, 2005 to June 30, 2006.

- $50,479,000 in DSH funding is available.

- $19,687,000 is expected to be claimed based on SFY05 payments under law in effect on June 30, 2005 and a MA forecast increase of 1.0% over SFY05.

- $30,792,000 is expected to be claimed under Minnesota Statutes, 256.969, subdivision 9(f). This requires SFY06 and SFY07 payments that are made under the General Assistance Medical Care program to be made as DSH payments. Although not yet approved by the federal government, it is anticipated that this approach will use up all available funding in the limit when it is approved.

Upcoming State Fiscal Year Estimate

The following estimates the federal share of DSH funding and payments for the period July 1, 2006 to June 30, 2007.

- $58,556,000 in DSH funding is available.
- $22,212,000 is expected to be claimed based on SFY05 payments under law in effect on June 30, 2005 and a MA forecast increase of 14.8% over SFY06, including an increase for rebasing inpatient rates.
- $36,344,000 is expected to be claimed under Minnesota Statutes, 256.969, subdivision 9(f). This requires SFY06 and SFY07 payments that are made under the General Assistance Medical Care program to be made as DSH payments. Although not yet approved by the federal government, it is anticipated that this approach will use up all available funding in the limit when it is approved.

Current Federal Fiscal Year Estimate

The following estimates the federal share of DSH funding and payments for the period October 1, 2005 to September 30, 2006.

- $52,282,000 in DSH funding is available.
- $20,318,000 is expected to be claimed based on SFY05 payments under law in effect on June 30, 2005 and a MA forecast increase of 3.7% over SFY06.
- $31,964,000 is expected to be claimed under Minnesota Statutes, 256.969, subdivision 9(f). This requires SFY06 and SFY07 payments that are made under the General Assistance Medical Care program to be made as DSH payments. Although not yet approved by the federal government, it is anticipated that this approach will use up all available funding in the limit when it is approved.

Upcoming Federal Fiscal Year Estimate

The following estimates the federal share of DSH funding and payments for the period October 1, 2006 to September 30, 2007.

- $60,647,000 in DSH funding is available.
- $23,149,000 is expected to be claimed based on SFY05 payments under law in effect on June 30, 2005 and a MA forecast increase of 16.0% over FFY06.

- $28,124,000 is expected to be claimed under Minnesota Statutes, 256.969, subdivision 9(f). This requires SFY06 and SFY07 payments that are made under the General Assistance Medical Care program to be made as DSH payments. Although not yet approved by the federal government, it is anticipated that this approach will use up all available funding in the limit when it is approved.

- $9,374,000 is expected to be claimed under Minnesota Statutes, 256B.199. This requires the use of certified public expenditures (CPE) to increase payments to hospitals during SFY08 and SFY09. Although not yet approved by the federal government, it is anticipated that the CPEs will use up all available funding in the limit when it is approved.

Attachment A

STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW FFY 2005

COMPARISON

42 CFR § 447.272 states that Medicaid payments may not exceed the amount that can reasonably be estimated would have been paid for the services using Medicare payment principles. The Medicare and Medicaid payments are calculated using base rates which are then adjusted for individual hospital case-mix averages. Deviations from this method are explained.

The case-mix averages for individual hospitals are calculated by multiplying each diagnostic related grouping (DRG) admission/day by its relative weight to arrive at a total weight for the DRG. All the total weights are then added together and divided by the total admissions/days to arrive at the average weight. For hospitals that provide services paid by admissions and days, an average weight is calculated separately for each payment method.

When calculating payments, case-mix weights are to be applied to prospective payment system (PPS) base rates including rehabilitation services. However, for this review the case-mix weights have not been applied to the rehabilitation services because of an incompatibility between the different grouper systems used by Medicare and Medicaid. Medicare uses a case mix grouping (CMG) whereas Medicaid uses a DRG. Because it is not possible to convert the admission DRGs to CMGs, it is impossible to compare what Medicaid would pay for rehabilitation services using Medicare principles. Therefore, estimated payments for rehabilitation services will be calculated using the base payment rate without adjusting for case-mix weights. (Because the rehabilitation admissions account for 286 of the 42,678 total admissions, or 0.7% of the total, the effect of not adjusting for case-mix is immaterial.)

ADMISSIONS

The number of Medicaid admissions/days used for the upper limit calculation is from calendar year 2003. Admissions/days to acute hospitals, long-term care hospitals, critical access hospitals, transfers to Neonate Intensive Care Units (NICU), rehabilitative and psychiatric Medicare distinct part units and hospitals, and contracted 45-day mental health services are included as are Local Trade Area (LTA) hospitals. After payments have been calculated, they are then converted to an estimated average rate per admission for comparison by dividing the total payments by total admissions. Total admissions are 42,678 (11,131 for non-state owned or operated government hospitals and 31,547 for privately owned and operated hospitals) for the Medicare and Medicaid calculations.

MEDICARE RATE CALCULATION:

The Medicare average operating and capital payment per admission was calculated with rate components that are based on various Medicare payment systems. Sources include the FFY 2005 PPS acute care rate schedule, the FFY 2005 PPS rate schedule for

Attachment A

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Medicare rehabilitation distinct part units (IRF), the rate year (RY) 2005 and 2006 PPS rate schedules for the long-term care hospitals (LTCH) which are still in a transition period to full PPS, the final rule for PPS inpatient psychiatric facilities (IPF) that have just started a transition period to full PPS beginning with the cost reporting year beginning on or after January 1, 2005, and updated per diem rates based on the most recent Medicare cost report data for hospitals subject to TEFRA reasonable cost principles. The TEFRA per diem rates are used for children's hospitals and also as part of the blended rates for IPFs transitioning to full PPS. The interim Medicare per diem rates used for critical access hospitals (CAH) are supplied by the Medicare intermediary (Noridian) on an ongoing basis.

The inpatient PPS final rule for the acute care hospitals was initially published in the Federal Register on August 11, 2004. Corrections to the final rule were published in the Federal Register on October 7, 2004, and December 30, 2004. Hospital specific wage indexes are from the public use files on the Centers for Medicare & Medicaid Services (CMS) website posted on December 30, 2004. The PPS capital rate was increased 3% in the Minneapolis – St. Paul Metropolitan Statistical Area. Inpatient acute hospitals not submitting quality information to CMS receive a lower base payment rate than those submitting the information. In a press release issued September 2, 2004, CMS announced that 98.3% of the hospitals had submitted the information and qualified for the full payment rate. A representative from the Minnesota Hospital Association informed this agency that all of their members were submitting the information to CMS. Therefore, the full payment rate will be used for all hospitals in performing the UPL review.

The PPS final rule for IRFs was published in the Federal Register on July 30, 2004. Correction of the final rule was published in the Federal Register on October 7, 2004.

The PPS final rule for LTCH rate year 2005 was published in the Federal Register on May 7, 2004. The PPS final rule for LTCH rate year 2006 was published in the Federal Register on May 6, 2005. Because the LTCH rate year (July – June) does not match the Federal fiscal year (October – September), it is necessary to prorate rate year 2005 payment rates to nine months and the rate year 2006 payment rates to three months in order to match the Federal fiscal year of this review. Four LTCHs participate in Minnesota's Medicaid program. Based on data posted on CMS's web site, Healtheast Bethesda was projected to be paid blended payment rates for LTCH rate year 2005 and full PPS rates for LTCH rate year 2006, and Kindred, SCCI, and Select Specialty were projected to be paid full PPS payment rates for both LTCH rate years.

The PPS final rule for IPFs was published in the Federal Register on November 15, 2004. There will be a three year transition period from TEFRA to PPS. There will be no option to choose to be paid full PPS prior to the end of the transition period as there was with other PPS payment systems. PPS payments will be made based on a per diem with adjustments for the DRG assigned, the age of the patient, comorbid conditions, whether

the hospital has a teaching program, whether the hospital is rural, and whether the hospital has an emergency department.

Hospitals subject to the TEFRA rates were adjusted to per diem rates in accordance with a finding by CMS in its audit of the upper payment limits (UPL) for FFY 2002. The Medicare allowable inpatient cost, which includes capital-related costs and incentives, was divided by Medicare days to calculate a per diem from the hospital's most recent Medicare cost report. (The cost reports range from report years ending during in the years 1998 – 2003, with most ending in 2001.) The per diem was inflated to FFY 2005 based on CMS's annual prospective payment rate update at full market basket for acute care hospitals.

The average rate is calculated by multiplying each hospital's operating, capital, and TEFRA rates by Medicaid admissions/days to the hospital and adjusting for average case-mix weights except where otherwise noted and then dividing the sum of all hospitals by the statewide total Medicaid admissions.

OUTLIERS

The estimated average rates per admission for Medicare do not include payments for outliers. Estimated Medicare outlier payments equal 5.1% of total PPS operating payments and 4.8% of total PPS capital payments for the acute inpatient hospital services, 3.0% of the total PPS rehabilitation unit payments, 8.0% of the total PPS long term care hospital payments, and 2.0% of total PPS psychiatric unit payments. We adjusted for outlier payments using these percentages.

MEDICAL EDUCATION

The indirect medical education (IME) operating and capital adjustment factors are from CMS's public use file referenced earlier. One hospital, Children's Health Care – St. Paul, was not in the data file. Children's Health Care – St. Paul does not have a TEFRA rate. IME costs are not reflected in the Medicare rate per admission but would be in the Medicaid rate per admission. To compensate for this discrepancy, an IME adjustment was calculated and included in the Medicare calculation.

Children's Health Care – St. Paul's adjustment factor was calculated using data from its most recent Medicare cost report which is the reporting year ending in 1998. Its operating adjustment factor was calculated using the operating formula specified in CMS's final rule with the Resident to Bed Ratio coming from Worksheet E, Part A, Line 3.20, of the cost report. The formula multiplier is 1.42 for FFY 2005. The capital adjustment factor is from Worksheet L, Part I, Line 4.02, of the cost report.

For those hospitals that meet the criteria for the IME adjustment, both the operating and capital portions of their payments are adjusted. Each hospital's total operating and

capital payments are multiplied by the applicable IME factor. However, this factor was not used for the TEFRA rates since IME costs are included in these rates. These totals are added together and divided by total Medicaid admissions to derive a per admission amount.

Direct medical education was calculated applying the Medicare formula for a Minnesota Medicaid-only inpatient volume from the most recent Medicare cost report periods. The Minnesota Medicaid inpatient days, inpatient charges, and outpatient charges used in the calculation were generated with a query from this agency's data warehouse. The amount calculated for each hospital was then trended forward to FFY 2005. The indexes as calculated in prior years are 7.1% for FFY 2000; 2.8% for FFY 2001; 7.5% for FFY 2002; 1.1% for FFY 2003; and 3.2% for FFY 2004. For FFY 2005, the amount was increased by 7.7% which is the Medicare percentage change in total operating, capital and outlier rates from FFY 2004 to FFY 2005 ($6,338 + $237 / $5,880 + $226 = 7.7%. (The FFY 2005 inflation index calculation includes the effects of applying case-mix for an entire year. While the UPL for FFY 2004 was calculated using case-mix adjustment for only the period July 1, 2004 – September 30, 2004, a separate calculation was performed using case-mix for a full year for informational purposes only. The informational calculation will be used here since the FFY 2005 UPL uses case-mix for the entire year.)

DISPROPORTIONATE SHARE / LOW INCOME PATIENTS

CMS has determined that the Medicare Disproportionate Share Hospital (DSH) payments may be included even though the Medicaid DSH is not included. The PPS acute operating and capital rates are adjusted, but the TEFRA and LTCH rates are not eligible for DSH payments. The operating and capital DSH adjustment factors are from CMS's public use file referenced earlier. For hospitals not included in that file, the adjustment factors were calculated based on information in the most recent Medicare cost report.

Gillette Children's and Children's Health Care – Minneapolis hospitals have a TEFRA rate so a DSH adjustment is not applicable. Since Children's Health Care – St. Paul does not have a TEFRA rate, DSH costs would not be reflected in the Medicare rate per admission. To compensate, Children's Health Care – St. Paul's 1998 Medicare report was reviewed and it was determined that its DSH percentage (the combined SSI and Medicaid ratios) was 47.04%; therefore, a DSH adjustment was calculated and included in the Medicare calculation.

The PPS rate schedule for the IRFs includes an adjustment for units serving low income patients (LIP). This is similar to DSH payments, and in fact, the LIP percentage is calculated the same as the DSH percentage, but for rehabilitative services provided. The supplemental security income (SSI) component for the inpatient rehabilitative services is from CMS's data file posted on their web site on August 11, 2004. The Medicaid ratio was calculated from Schedule S-3 of each hospital's most recent Medicare cost report.

Attachment A

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FFY 2005

ORGAN ACQUISITION COSTS

Organ acquisition costs of Medicaid organ transplant admissions are calculated from the most recent Medicare cost reports. The costs are added together and divided by total Medicaid admissions to derive a per-admission amount because Medicare rates do not include these costs.

MEDICAID RATE CALCULATION:

The Medicaid average payment per admission is based on hospital operating and capital rates and contracted mental health service rates in effect in calendar years 2004 and 2005. The rates were weighted 25% for 2004 rates and 75% for 2005 rates to correspond to the federal fiscal year. The average rate is calculated by multiplying each hospital's operating and property / contracted rates by Medicaid admissions / days. The operating payments were then adjusted by hospital specific weighted average case-mix factors. Long term care hospitals and hospitals with contracted mental health services are paid per diem rates without adjustment for case-mix weights. As explained earlier, no adjustment for case-mix was applied to hospitals for rehabilitation services. The total payments for each hospital are then summed with the overall total being divided by the sum of the statewide total Medicaid admissions.

The contracted mental health service per diem rates include hospital and physician services. Documentation provided by Hennepin County Medical Center, which provided approximately 29 percent of the calendar year 2003 contracted days, indicates that approximately 15 percent of the per diem was used to pay physician services. Consequently, the contracted mental health per diem rates have been reduced by 15 percent since the Medicare rate does not include physician services. However, for contracted rates entered into on or after January 1, 2005, the physician service payments are made separate from the hospital payments. Therefore, new contract rates effective on or after January 1, 2005, will not be adjusted.

SMALL, RURAL

The applicable 2004 / 2005 15% or 20% Medicaid adjustment to small, rural hospitals as reduced by the disproportionate population adjustment was added to each hospital's payment.

NICU

Admissions resulting from transfers to neonatal intensive care units (NICUs) are paid on a per diem basis. For each hospital with neonate transfers, the NICU days were multiplied by the operating and property per diem rates. The operating payments were

then adjusted by applying the hospital specific weighted average case-mix factors. The total adjusted operating payments and property payments were summed and divided by total admissions to determine the average NICU payment per admission.

OUTLIERS

The estimated average rates per admission for Medicaid do not include payments for outliers. Medicaid outlier payments as a percent of total Medicaid payments are calculated based on payments made in CY 2003. The outlier rates are 3.82% for non-state owned or operated government hospitals and 5.5% for privately owned and operated hospitals (5.02% overall).

MEDICAL EDUCATION (MERC)

$24,600,342 in legislative appropriation and estimated tobacco endowment money was available to be included in the rates. This is $576 per admission. Of this amount, $1,111 is in the non-state owned or operated government hospital rate and $388 is in the privately owned and operated hospital rate.

OUTSTATE PAYMENT AT 90% METRO AVERAGE

Hospitals located outside of the seven-county metropolitan area are paid the greater of their rates including the small, rural adjustment, or 90% of the average seven-county metropolitan rate for sixteen DRGs. The DRGs are primarily composed of birth, neonate, and mental health admissions.

This 16-DRG adjustment was effective July 1, 2001. Total payments are contingent upon how much the payments for non-state owned or operated government hospitals are under the Medicare upper limit. The 2003 legislature froze the total payment at an amount not to exceed the amount recognized in March 2003. This amount is $848,388 ($20 per admission) which was 69% of the metro average at that time.

The 2005 legislature increased the 16-DRG adjustment to the full 90 percent of the average seven-county metro rate effective August 1, 2005. Based on payment data for SFY 03, this results in additional payments of $556,851 ($14 per admission) over the frozen amount for the remaining two months of FFY 05 (August – September 2005).

Since IGT still funds $848,388 and the rest is funded by the general fund, this is shown as two lines.

RATEABLE REDUCTION

The payments were reduced by 0.5% effective July 1, 2002. The payments were further

reduced by the governor through the unallotment process by 5.0% effective March 1, 2003, by 5.0% effective July 1, 2003, and by 6.0% effective August 1, 2005. Mental health admissions were excluded from the 5.0% and 6.0% payment reductions. In addition to being excluded from the 5.0% and 6.0% payment reductions, contracted mental health days are also excluded from the 0.5% payment reduction. The payment reductions apply to all components except MERC.

RATEABLE INCREASE

The 2003 legislature enacted legislation to increase payments by 2% effective January 1, 2004. Local trade area hospitals are excluded from the payment increase. Hospitals with contracted mental health services have the increase included as part of the negotiated rates.

Attachment B

STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW ESTIMATE OF SFY 2006 FOR LEGISLATIVE REPORT

MEDICARE AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$6,555	$5,737	$7,033	Operating and Capital Payment
242	238	245	Outlier Adjustment
547	1,311	323	Indirect Medical Education
248	583	131	Direct Medical Education
478	1,031	283	Disproportionate Share / Low Income Patients
20	5	25	Organ Acquisition Cost Payment
$8,090	$8,905	$8,040	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$5,535	$5,539	$5,548	Operating and Property Payment
330	20	440	NICU Adjustment
260	192	289	Outlier Adjustment
339	415	312	Medical Education (MERC)
20	10	24	Frozen Outstate 16-DRG Payment Increase
72	56	78	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase (Aug 05 – Jun 06)
$6,556	$6,232	$6,691	Total Estimated Average Payment

DIFFERENCE:

Total	Non-State Gov't	Privately Owned	
$1,534	$2,673	$1,349	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are $42,566,346 ($1,349 X 31,554 admissions) below the limit.

2. Payments to government hospitals not owned or operated by the State of Minnesota are $29,683,665 ($2,673 X 11,105 admissions) below the limit.

Attachment C

STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW ESTIMATE OF SFY 2007 FOR LEGISLATIVE REPORT

MEDICARE AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$6,730	$5,878	$7,289	Operating and Capital Payment
248	242	250	Outlier Adjustment
559	1,341	345	Indirect Medical Education
252	589	134	Direct Medical Education
486	1,036	292	Disproportionate Share / Low Income Patients
20	5	25	Organ Acquisition Cost Payment
$8,295	$9,091	$8,335	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$5,727	$5,731	$5,739	Operating and Property Payment
342	21	454	NICU Adjustment
269	198	299	Outlier Adjustment
339	415	312	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
82	63	88	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
$6,779	$6,437	$6,916	Total Estimated Average Payment

DIFFERENCE:

Total	Non-State Gov't	Privately Owned	
$1,516	$2,654	$1,419	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are $44,775,126 ($1,419 X 31,554 admissions) below the limit.

2. Payments to government hospitals not owned or operated by the State of Minnesota are $29,472,670 ($2,654 X 11,105 admissions) below the limit.

Attachment D

STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW ESTIMATE OF FFY 2006 FOR LEGISLATIVE REPORT

MEDICARE AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$6,626	$5,787	$7,176	Operating and Capital Payment
244	238	246	Outlier Adjustment
550	1,320	340	Indirect Medical Education
248	580	132	Direct Medical Education
478	1,020	287	Disproportionate Share / Low Income Patients
20	5	25	Organ Acquisition Cost Payment
$8,166	$8,950	$8,206	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$5,512	$5,516	$5,524	Operating and Property Payment
329	20	437	NICU Adjustment
259	191	288	Outlier Adjustment
339	415	312	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
79	61	85	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
$6,538	$6,212	$6,670	Total Estimated Average Payment

DIFFERENCE:

Total	Non-State Gov't	Privately Owned	
$1,628	$2,738	$1,536	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are $48,466,944 ($1,536 X 31,554 admissions) below the limit.

2. Payments to government hospitals not owned or operated by the State of Minnesota are $30,405,490 ($2,738 X 11,105 admissions) below the limit.

Attachment E

STATE OF MINNESOTA DEPARTMENT OF HUMAN SERVICES
INPATIENT HOSPITAL MEDICARE UPPER PAYMENT LIMIT REVIEW
ESTIMATE OF FFY 2007 FOR LEGISLATIVE REPORT

MEDICARE AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$6,834	$5,969	$7,401	Operating and Capital Payment
252	245	254	Outlier Adjustment
567	1,361	351	Indirect Medical Education
256	598	136	Direct Medical Education
493	1,052	296	Disproportionate Share / Low Income Patients
21	5	26	Organ Acquisition Cost Payment
$8,423	$9,230	$8,464	Total Estimated Average Payment

MEDICAID AVERAGE RATE PER ADMISSION:

Total	Non-State Gov't	Privately Owned	
$5,834	$5,839	$5,847	Operating and Property Payment
348	21	463	NICU Adjustment
274	202	305	Outlier Adjustment
339	415	312	Medical Education (MERC)
20	9	24	Frozen Outstate 16-DRG Payment Increase
84	65	90	Difference Between 90% of Metro Avg and Frozen Outstate 16-DRG Pmt Increase
$6,899	$6,551	$7,041	Total Estimated Average Payment

DIFFERENCE:

Total	Non-State Gov't	Privately Owned	
$1,524	$2,679	$1,423	Medicaid Below/(Above) Medicare Per Admission

NOTES:

1. Payments to privately owned and operated hospitals are $44,901,342 ($1,423 X 31,554 admissions) below the limit.

2. Payments to government hospitals not owned or operated by the State of Minnesota are $29,750,295 ($2,679 X 11,105 admissions) below the limit.