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S.F. No. 2413

(SENATE AUTHORS: MANN)

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03/13/2025	747	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; imposing an assessment on hospitals; requiring directed payments to hospitals in the medical assistance program; requiring reports; amending Minnesota Statutes 2024, sections 256.9657, by adding a subdivision; 256B.1973, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. Minnesota Statutes 2024, section 256.9657, is amended by adding a subdivision to read:

Subd. 2b. **Hospital assessment.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "eligible hospital" means a hospital that participates in Minnesota's medical assistance program;

(2) "net inpatient revenue" means the value stated on line ... on worksheet ..., part ..., of the hospital's most recent Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS) as of October 1 of each year; and

(3) "net outpatient revenue" means the value stated on line ... on worksheet ..., part ..., of the hospital's most recent Medicare cost report filed and showing in HCRIS as of October 1 of each year.

(b) Subject to paragraph (k), each eligible hospital must pay to the hospital directed payment program account established under section 256B.1975 an assessment equal to the sum of the following:

(1) ... percent of the hospital's net inpatient revenue; and

(2) ... percent of the hospital's net outpatient revenue.

(c) Assessments are due on January 1, April 1, July 1, and October 1 each year. Assessments must be paid quarterly in the form and manner specified by the commissioner.

(d) Invoices for the assessments are due December 1, March 1, June 1, and September 1 each year.

(e) If any of the dates for assessments or invoices in paragraphs (c) and (d) falls on a holiday, the applicable date is the next business day.

(f) The commissioner must notify each eligible hospital of its estimated assessment amount for the subsequent year by October 15 each year.

(g) A hospital is not required to pay the assessment until the start of the first full fiscal year the hospital is an eligible hospital. A hospital that has merged with another hospital must have the hospital's assessment revised at the start of the first full fiscal year after the merger is complete. A closed hospital is retroactively responsible for assessments owed for services provided through the final date of operations.

(h) If the commissioner determines that a hospital has underpaid or overpaid assessments, the commissioner must notify the hospital of the unpaid assessments or of any refund due. A hospital that disputes the amount of an assessment by the commissioner may dispute the assessment utilizing any remedy available in law related to provider payments in medical assistance.

(i) Revenue from the assessment must only be used by the commissioner to pay the nonfederal share of the directed payment program under section 256B.1974.

(j) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when:

(1) federal financial participation is unavailable or disallowed; or

(2) a directed payment under section 256B.1974 is not approved by the Centers for Medicare and Medicaid Services.

(k) The commissioner must make the following discounts or exemptions from the assessment under this subdivision, or as necessary, to achieve federal approval of the assessment in this section:

(1) a long-term care hospital, as defined in Code of Federal Regulations, title 42, section 412.23, paragraph (e);

(2) each critical access hospital or independent hospital in rural Minnesota paid under the Medicare prospective payment system to the maximum extent necessary to meet the federal law requirements for this assessment;

(3) any hospital in Minnesota designated as a children's hospital under Code of Federal Regulation, title 42, section 412.23, paragraph (d), to the maximum extent necessary to meet the federal law requirements for this assessment;

(4) federal Indian Health Service facilities;

(5) state-owned or state-operated regional treatment centers and all state-operated services;

(6) a discount assessment for a hospital that is a nonstate government teaching hospital with high medical assistance utilization and a level 1 trauma center to the maximum extent necessary to meet the federal law requirements for this assessment; and

(7) a discount assessment at the level necessary to ensure that no single hospital system is responsible for greater than ... percent of the total assessments collected statewide on an annual basis.

(l) The commissioner must reduce the assessment on a uniform percentage basis across eligible hospitals on which the assessment is imposed, such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed for the annual nonfederal share of the directed payments authorized by section 256B.1974.

(m) Hospitals subject to the assessment under this subdivision must submit to the commissioner, in the form and manner specified by the commissioner and annually agreed to in writing by the Minnesota Hospital Association, all documentation necessary to determine the assessment amounts under this subdivision.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 2. Minnesota Statutes 2024, section 256B.1973, is amended by adding a subdivision to read:

Subd. 9. **Interaction with other directed payments.** Nothing in this section precludes an eligible provider under subdivision 3 from participating in the hospital directed payment program under section 256B.1974. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of their intention to participate in the hospital directed payment program under section 256B.1974.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of all of the following:

(1) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. **[256B.1974] HOSPITAL DIRECTED PAYMENT PROGRAM.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Health plan" means a managed care or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(c) "Hospital" means a hospital licensed under section 144.50.

Subd. 2. **Federal approval required.** The hospital directed payment program is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement the commissioner must determine a quarterly payment amount to be submitted by an eligible provider to a health plan. The commissioner must determine the quarterly payment amount using the average commercial payer rate, or using another method

acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy assessment liabilities under sections 256.9657 and 297I.05 attributable to the directed payment program. The commissioner must ensure that the application of the quarterly payment amounts maximizes the allowable directed payments and does not result in payments exceeding federal limits. The commissioner may use an annual settle-up process. The directed payment program must be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment program that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment. If federal approval of a directed payment under this subdivision is retroactive, the commissioner must make a onetime pro rata increase to the quarterly payment amount and the initial payments to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

(c) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each hospital as required by section 256.969.

(d) The commissioner must require managed care organizations to make quarterly supplemental directed payments according to this section. Each calendar year, the commissioner must require managed care organizations to pay the maximum amount out of these funds as directed payments. The commissioner must require managed care organizations to make quarterly supplemental directed payments using electronic funds transfers, if the hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner, within five business days of the date the funds are paid to the managed care organizations, as calculated by the date that the commissioner issued sufficient payments to the managed care organization to make the directed payments according to this section. If funds are not paid to the managed care organizations by the commissioner by electronic funds transfer, any directed payment must be made within seven business days of the date the money was actually received by the managed care organization. The managed care organization must be considered to have paid the directed payments when the payment remittance number is generated, or on the date the managed care organization sends the check to the hospital if electronic money

transfer information is not supplied. If a managed care organization is late in paying a directed payment as required under this section, including any extensions granted by the commissioner, the managed care organization must pay a penalty, unless waived by the commissioner for reasonable cause, to the commissioner equal to five percent of the amount of the directed payment not paid on or before the due date plus five percent of the portion remaining unpaid on the last day of each thirty day period thereafter. Payments to managed care organizations that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a consequence of payments made under this section. The commissioner must publish and maintain on its website for a period of no less than eight calendar quarters the total quarterly calculation of directed payments owed to each hospital from each managed care organization. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(e) By December 1 each year, the commissioner must notify each hospital of any changes to the payment methodologies in this section, including but not limited to changes in the fixed rate directed payment rates, the aggregate directed payment amount for all hospitals, and the hospital's directed payment amount for the upcoming calendar year.

(f) The commissioner must distribute payments required under this section within 30 days of the assessment being received and must pay the directed payments to managed care organizations under contract no later than January 1, April 1, July 1, and October 1 each year.

(g) A hospital is not entitled to payments under this section until the start of the first full fiscal year it is an eligible hospital. A hospital that has merged with another hospital must have its payments under this section revised at the start of the first full fiscal year after the merger is complete. A closed hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee. Health plans must allow each hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the hospital's internal records. To support the validation process for the directed payment program, managed care organizations must permit the commissioner to share inpatient and outpatient claims-level details with hospitals identifying only those claims where the prepaid

medical assistance program under section 256B.69 is the payer source. Hospitals must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner as a quarterly payment amount and on the same basis and calendar year timing for all health plans.

(b) Managed care organizations are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to a hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) A hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

(b) A hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the rate year. This subdivision does not prohibit a hospital from negotiating with a payer for a rate increase.

(c) Any hospital receiving a directed payment under this section must meet the commissioner's standards for directed payments as described in subdivision 7.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members may not include any current employee or paid consultant of any hospital.

EFFECTIVE DATE. This section is effective the later of January 1, 2026, or federal approval for all of the following:

(1) the amendments in this act to add Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to this section.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. **[256B.1975] HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.**

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner for the purposes specified in section 256B.1974.

(c) Transfers from this account to the general fund are prohibited.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of the amendments in this act to add section 256.9657, subdivision 2b.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 5. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) By October 1, 2025, the commissioner of human services must begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 60 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, draft directed payment details, and an estimate of each nonexempt hospital's assessment amount.

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any nonexempt hospitals that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide no less than 30 days for public posting and review of the federally approved terms and conditions for the assessment and the directed payment program.

EFFECTIVE DATE. This section is effective the day following final enactment.