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BILL SUMMARY

S.F. No. 2413 – Hospital assessment requirement provision and hospitals in the medical assistance program directed payments requirement provision

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Bill Overview

S.F. 2413 creates an assessment on hospitals (subject to certain exceptions as necessary to comply with federal law) as well as a directed payment to hospitals in the medical assistance managed care program. The hospital assessment is set at an annual amount based on a percentage of the hospital's net revenues, and this annual amount will be paid by the hospitals across four equal payments throughout the calendar year. The directed payment program requires health plans in the MA program to provide claims-level data to the commissioner of human services, who will establish the payment amount for hospitals. The program must align with the state's broader policy goals for medical assistance enrollees. This bill further directs the commissioner to seek federal approval of the assessment and directed payment program.

Section Summaries

Section 1 (adds Minn. Stat. § 256.9657, subd. 2b; Hospital Assessment) This section imposes a new assessment on hospitals that participate in Minnesota's medical assistance program. The assessment is based on a percentage of each hospital's net inpatient revenue and net outpatient revenue, as reported on the hospital's Medicare cost report. The commissioner of human services must annually notify hospitals of their estimated assessment amounts by October 15. The commissioner must provide a quarterly invoice to hospitals of their assessment amount, and apply a uniform percentage reduction if collections exceed the amount needed for the nonfederal share of directed payments under section 256B.1974 (a new section of law created in the bill establishing the hospital directed payment program).

The section provides for various exemptions and reductions from the hospital assessment (e.g., long-term care hospitals, critical access hospitals, and children's hospitals), as necessary to ensure federal funding for the assessment and new directed payment program and imposes a limit on total assessment liability for any single hospital system. The assessment is effective on the later of January 1, 2026, or upon federal approval of both this provision and the changes in sections 256B.1973 and 256B.1974.

Section 2 (adds Minn. Stat. § 256B.1973, subd. 9; Interaction with Other Directed Payments) This section clarifies that a hospital participating in the existing directed payment program under section 256B.1973 is also eligible to participate in the new hospital directed payment program under section 256B.1974. However, a provider participating in the new hospital directed payment program must not receive a directed payment under section 256B.1973 for the same classes of services also covered by section 256B.1974. A provider eligible for both programs must notify the commissioner of human services of its election to participate within 30 days of the enactment of this new subdivision.

Section 3 (adds Minn. Stat. § 256B.1974; Hospital Directed Payment Program)

Subd. 1. Definitions. This subdivision defines terms used throughout this section, including "health plan" and "hospital."

Subd. 2. Federal approval required. This subdivision makes implementation of the new hospital directed payment program contingent on federal approval. It requires the new program to conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subd. 5

Subd. 3. Commissioner's duties; state-directed fee schedule requirement. This subdivision requires the commissioner of human services to set quarterly payment amounts for each participating hospital, using an average commercial payer rate or another federally approved method. The commissioner must adjust these amounts to account for the costs of certain assessments (including those in sections 256.9657 and 297I.05) and must ensure that the directed payments supplement, rather than supplant, existing medical assistance rates. The commissioner must direct managed care organizations to pay these amounts on a timely, quarterly basis.

Subd. 4. Health plan duties; submission of claims. This subdivision requires health plans to submit paid claims data for hospital services to the commissioner in accordance with the health plan's medical assistance managed care contract. The subdivision further expressly allows hospitals to validate the health plans' claims-level details for accuracy.

Subd. 5. Health plan duties; directed payment add-on. This subdivision mandates that health plans pass through the directed payment funds it receives from the commissioner to the hospital, in an amount equal to the payment amounts the plan received from the commissioner. It further prohibits health plans from recouping or offsetting such a directed payment, and from adjusting a hospital's reimbursement rate in any manner to account for the directed payments.

Subd. 6. Hospital duties; quarterly supplemental directed payment add-on. This subdivision prohibits hospitals from (1) negotiating or setting rates in a way that factors in the new directed payment; or (2) passing assessment costs on to patients or non-MA payers. A hospital violating these restrictions is ineligible for further directed payments for the remainder of the rate year.

Subd. 7. State minimum policy goals established. This subdivision requires that the new directed payment program aligns with the state's broader policy goals for medical assistance enrollees. It specifically directs the commissioner, in consultation with the Minnesota Hospital Association, to submit a methodology to measure access and achievement of these goals to CMS.

Subd. 8. Administrative review. This subdivision directs the commissioner to consult annually with a permanent select committee established by the Minnesota Hospital Association to review and provide feedback on the program's payment amounts.

Effective Date. This section is effective on the later of January 1, 2026, or upon federal approval of both this section and the changes in section 256.9657, subdivision 2b.

Section 4 (adds Minn. Stat. § 256B.1975; Hospital Directed Payment Program Account)

Subd. 1. Account established; appropriation. This subdivision establishes the hospital directed payment program account in the special revenue fund. All revenues from the new hospital assessment are deposited in this account and annually appropriated to the commissioner of human services for making the nonfederal share of payments under section 256B.1974. This subdivision also prohibits any transfers from this account to the general fund.

Subd. 2. Reports to the legislature. This subdivision requires the commissioner to annually report, beginning January 15, 2027, on the uses of money in the new hospital directed payment program account. The report must also include metrics and outcomes of the state's medical assistance policy goals in section 256B.1674, subd. 7. This section is effective the later of January 1, 2026, or upon federal approval of the new assessment in section 256.9657, subdivision 2b.

Section 5 (uncodified; Implementation of Hospital Assessment and Directed Payment Program)
This section requires the commissioner, by October 1, 2025, to begin the necessary claims analysis to calculate the hospital assessment and make the new directed payments to hospitals. The commissioner must consult with the Minnesota Hospital Association to submit a request for federal approval to implement the new hospital assessment and directed payment program. The commissioner must make materials related to such federal approval available for public review both before and after federal approval. This section is effective the day following final enactment.

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