256B.1974 HOSPITAL DIRECTED PAYMENT PROGRAM.

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

(b) "Eligible hospital" has the meaning given in section 256.9657, subdivision 2b, paragraph (a), clause (1).

(c) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69 or 256B.692.

Subd. 2. **Required conditions for program.** The hospital directed payment program 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 that includes a quarterly payment amount to be submitted by each health plan to each eligible hospital, the commissioner must determine the quarterly payment amount using the statewide average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the statewide average commercial payer rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process to determine the accuracy of the amounts paid by the commissioner to health plans for directed payments to hospitals under this section. The commissioner's settle-up determination must occur within one year of the payment of the applicable amounts to health plans. If the commissioner determines the amount paid to a health plan exceeds or is less than the amount required under this section, the commissioner must pay an additional amount to the health plan for directed payments to hospitals or require a refund from the health plan for an overpayment. Any additional amount required to be paid by the commissioner to a health plan, or any refund to the commissioner from a health plan, must be paid by the immediately following April 1. Additional amounts received by a health plan under this paragraph must be paid to the eligible hospital in accordance with this section. Any refund amount the commissioner determines is owed by a health plan under this paragraph must be paid back by the eligible hospital in accordance with this section.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, and applicable to this section remain effective, the hospital directed payment program may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program under this section 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 eligible hospitals receive the entire permissible value of the federally approved directed payment.

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

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the eligible hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

(h) The commissioner of human services must publish on the Department of Human Services website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(i) Payments to health plans 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 result of this section.

(j) The commissioner must publish all directed payments resulting from this section owed to each eligible hospital from each health plan on the Department of Human Services website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

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

(l) The commissioner must pay the amounts to be used for the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

(m) A hospital is not entitled to payments under this section unless it is an eligible hospital. An eligible hospital that has merged with another hospital must have the surviving hospital's payments under this section revised at the start of the hospital's first full fiscal year after the merger is complete. A closed eligible 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 hospital for services provided to a medical assistance enrollee. Health plans must allow each eligible 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 eligible hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with eligible hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 or 256B.692 is the payer source. Eligible hospitals may request claims-level detail once annually and 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 each eligible hospital. The amount of the directed payment to the eligible hospital must be equal to the payment amounts the plan received from the commissioner for the hospital under this section.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with an eligible 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 an eligible 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) An eligible 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 an eligible 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) An eligible hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the calendar year. This subdivision does not prohibit an eligible hospital from negotiating with a payer for a rate increase.

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, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

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

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

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.

History: *1Sp2025 c 3 art 8 s 22*

NOTE: This section, as added by Laws 2025, First Special Session chapter 3, article 8, section 22, is effective upon federal approval of the following: (1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and (2) the hospital directed payment program under this section and any conforming changes to the directed payment program under Minnesota Statutes, section 256B.1973. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2025, First Special Session chapter 3, article 8, section 22, the effective date.