SENATE
STATE OF MINNESOTA
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S.F. No. 2073

(SENATE AUTHORS: MANN)

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

A bill for an act

relating to human services; modifying hospital payment rates; amending Minnesota Statutes 2024, section 256.969, subdivision 2b.

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

Section 1. Minnesota Statutes 2024, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November 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 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) For the period beginning January 1, 2011, through October 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 rate setting periods after November 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.

(c) Effective for discharges occurring on and after November 1, 2014, payment rates for hospital inpatient services provided by hospitals located in Minnesota or the local trade area, except for the hospitals paid under the methodologies described in paragraph (a), clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a manner similar to Medicare. The base year or years for the rates effective November 1, 2014, shall be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring that the total aggregate payments under the rebased system are equal to the total aggregate payments that were 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. Only the rate increases or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during the entire base period shall be incorporated into the budget neutrality calculation.

(d) For discharges occurring on or after November 1, 2014, through the next rebasing that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph (a), clause (4), shall include 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. Any adjustments to the rates made by the commissioner under this paragraph and paragraph (e) shall maintain budget neutrality as described in paragraph (c).

(e) For discharges occurring on or after November 1, 2014, the commissioner may make additional adjustments to the rebased rates, and when evaluating whether additional adjustments should be made, the commissioner shall consider the impact of the rates on the following:

(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.

(f) Hospital payment rates established under paragraph (c) must incorporate the following:

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

(2) for critical access hospitals, payment rates for discharges between November 1, 2014, and June 30, 2015, shall be set to the same rate of payment that applied for discharges on October 31, 2014;

(3) the cost and charge data used to establish hospital payment rates must only reflect inpatient services covered by medical assistance; 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 shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years. In determining hospital payment rates for discharges in subsequent base years, the per discharge rates shall be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

(g) The commissioner shall validate the rates effective November 1, 2014, by applying the rates established under paragraph (c), and any adjustments made to the rates under paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the total aggregate payments for the same number and types of services under the rebased rates are equal to the total aggregate payments made during calendar year 2013.

(h) Effective for discharges occurring on or after July 1, ~~2017~~ 2025, and ~~every two years~~ annually thereafter, payment rates under this section ~~shall~~ must be rebased to reflect only those changes in hospital costs between the existing base year or years and the next base year or years. In any year that inpatient claims volume falls below the threshold required to ensure a statistically valid sample of claims, the commissioner may combine claims data from two consecutive years to serve as the base year. Years in which inpatient claims volume is reduced or altered due to a pandemic or other public health emergency ~~shall~~ must not be used as a base year or part of a base year if the base year includes more than one year. Changes in costs between base years ~~shall~~ must be measured using ~~the lower of~~ the hospital cost index defined in subdivision 1, paragraph (a)~~, or the percentage change in the case mix adjusted cost per claim~~. The commissioner shall establish the base year for each rebasing period considering the most recent year or years for which filed Medicare cost reports are

available~~, except that the base years for the rebasing effective July 1, 2023, are calendar years 2018 and 2019~~. The estimated change in the average payment per hospital discharge resulting from a scheduled rebasing must be calculated and made available to the legislature by January 15 of each year in which rebasing is scheduled to occur, and must include by hospital the differential in payment rates compared to the individual hospital's costs.

(i) Effective for discharges occurring on or after July 1, ~~2015~~ 2025, inpatient payment rates for critical access hospitals located in Minnesota or the local trade area ~~shall be determined using a new cost-based methodology. The commissioner shall establish within the methodology tiers of payment designed to promote efficiency and cost-effectiveness. Payment rates for hospitals under this paragraph shall be set at a level that does not exceed the total cost for critical access hospitals as reflected in base year cost reports. Until the next rebasing that occurs, the new methodology shall result in no greater than a five percent decrease from the base year payments for any hospital, except a hospital that had payments that were greater than 100 percent of the hospital's costs in the base year shall have their rate set~~ must equal ~~to~~ 100 percent of costs in the base year~~. The rates paid for discharges on and after July 1, 2016, covered under this paragraph shall be increased by the inflation factor~~ inflated to the rate year using the hospital cost index defined in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not be settled to actual incurred costs. ~~Hospitals shall be assigned a payment tier based on the following criteria:~~

~~(1) hospitals that had payments at or below 80 percent of their costs in the base year shall have a rate set that equals 85 percent of their base year costs;~~

~~(2) hospitals that had payments that were above 80 percent, up to and including 90 percent of their costs in the base year shall have a rate set that equals 95 percent of their base year costs; and~~

~~(3) hospitals that had payments that were above 90 percent of their costs in the base year shall have a rate set that equals 100 percent of their base year costs.~~

~~(j) The commissioner may refine the payment tiers and criteria for critical access hospitals to coincide with the next rebasing under paragraph (h). The factors used to develop the new methodology may include, but are not limited to:~~

~~(1) the ratio between the hospital's costs for treating medical assistance patients and the hospital's charges to the medical assistance program;~~

~~(2) the ratio between the hospital's costs for treating medical assistance patients and the hospital's payments received from the medical assistance program for the care of medical assistance patients;~~

~~(3) the ratio between the hospital's charges to the medical assistance program and the hospital's payments received from the medical assistance program for the care of medical assistance patients;~~

~~(4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);~~

~~(5) the proportion of that hospital's costs that are administrative and trends in administrative costs; and~~

~~(6) geographic location.~~

~~(k)~~ (j) Subject to subdivision 2g, effective for discharges occurring on or after January 1, 2024, the rates paid to hospitals described in paragraph (a), clauses (2) to (4), must include a rate factor specific to each hospital that qualifies for a medical education and research cost distribution under section 62J.692, subdivision 4, paragraph (a).