Hospital Stabilization Program

Form and Manner of Reporting for Qualifying Hospitals

External Draft for Hospital Use | Minnesota Department of Health

Purpose. In response to concerns about the financial health of certain hospitals, the 2026 Minnesota Legislature appropriated funding to be distributed to eligible hospitals in two payment rounds based on their relative provision of qualifying uncompensated episodes of care. Under the legislation, the Minnesota Department of Health (MDH) must collect data from eligible hospitals to calculate the respective payments. This document explains the form and manner in which qualifying hospitals must submit data to MDH for the Hospital Stabilization Program.

Important. This document describes the reporting process for qualifying hospitals seeking payment based on qualifying uncompensated episodes of care. It does not apply to the separate one-time Critical Access Hospital/Rural Emergency Hospital payment process or to separate Hennepin Healthcare reporting requirements.

1. Statutory Basis and Reporting Timeline

A qualifying hospital seeking payment must submit documentation identifying qualifying uncompensated episodes of care within each reporting period in the form and manner specified by the commissioner. Hospitals must provide supporting documentation as requested by MDH.

Reporting period	Services/episodes included	Submission deadline	Payment deadline	Fiscal year
Round 1: First reporting period	January 1 through June 30, 2026	September 15, 2026	November 15, 2026	FY 2027
Round 2: Second reporting period	July 1 through December 31, 2026	March 15, 2027	May 15, 2027	FY 2027

2. Qualifying Uncompensated Episode of Care

Definition. A qualifying uncompensated episode of care is a single patient encounter or episode of care submitted by a qualifying hospital for consideration under the Hospital Stabilization Program. To qualify, the episode must involve hospital services that would be covered under Medical Assistance if the patient were enrolled. However, the patient must not have been enrolled in Medical Assistance (or been retroactively eligible), MinnesotaCare, Medicare, or other health coverage for the date of service. The patient also must have been determined to be ineligible for Medical Assistance and MinnesotaCare for the date of service following any retroactive eligibility determination. MDH will determine whether the submitted episode meets the required $2,000 to $50,000 calculated value threshold using the methodology specified by MDH.

Hospitals should submit only episodes they believe meet the statutory criteria for which they are seeking consideration for payment. Hospitals should not submit all uncompensated care episodes or episodes with pending, unknown, or unresolved coverage status.

3. Required Submission Workbook

Each qualifying hospital seeking payment must complete the MDH-provided Excel workbook for each reporting period. Hospitals must use the workbook made available by MDH and must not change worksheet names, column headings, formulas, locked cells, or validation fields.

Workbook section	Purpose	Completed by
Hospital Cover Sheet	Identifies the hospital, reporting period, primary submission contact, authorized certifying official, and basic submission totals.	Hospital
Episode Data	Lists each episode the hospital believes meets the qualifying uncompensated episode criteria and seeks to have considered for payment.	Hospital

Summary Totals	Provides summary counts and totals based on submitted data and MDH calculations, where applicable.	Workbook/MDH
Attestation	Allows the authorized official to certify the submission and acknowledge reporting responsibilities.	Hospital
Data Dictionary	Defines terms, fields, formats, and dropdown values. This tab is included in the workbook for reference; hospitals do not need to create a separate data dictionary.	MDH

4. Who May Submit

MDH will identify hospitals that may be eligible to submit qualifying uncompensated episode data based on available program information. A hospital's ability to submit data does not guarantee payment. Final payment determinations depend on statutory eligibility, timely submission, completeness of the submission, validation of submitted episodes, and application of the payment methodology.

5. Hospital Cover Sheet

Hospitals must complete the Hospital Cover Sheet tab in the MDH workbook. The cover sheet is used to identify the submitting hospital and route follow-up questions.

Field	**Instructions**
Hospital legal name	Enter the legal name of the hospital.
Doing business as name, if applicable	Enter the facility or DBA name if different from the legal name.
MDH license number	Enter the hospital's license number, if available.
Medicare ID / CCN	Enter the Medicare Certification Number.

HCCIS ID	Enter the HCCIS identifier.
Reporting period	Select the applicable reporting period from the dropdown.
Primary submission contact	Provide name, title, email, and phone number for the person MDH should contact about the workbook submission.
Authorized certifying official	Provide the name and title of the person completing the attestation.
Finance/revenue cycle contact	Provide the name, title, email, and phone number for the person MDH should contact about charge, billing, or revenue cycle questions.
Total number of episodes submitted	Enter the total number of episode records included in the Episode Data tab.
Total submitted charges	Enter the total charges for all episodes included in the Episode Data tab, if the workbook does not calculate this automatically.

6. Episode Data Reporting

Hospitals must report one row for each submitted episode. Each row should represent a single encounter or episode the hospital believes is eligible for consideration. Hospitals must use hospital-generated de-identified episode and patient identifiers and should not include direct patient identifiers unless specifically instructed by MDH through a secure submission process.

Field category	Required information
Episode identifiers	Facility name; hospital-generated unique de-identified episode ID; de-identified patient ID.
Episode type	Inpatient, outpatient, or observation, selected from the workbook dropdown.

Service category	Select the best category from the dropdown, such as emergency department, behavioral health, OB/maternal care, medical/surgical, primary care, imaging/lab, or other.
Charges and payments	Total episode charges; third-party payments received; patient payments received; charity care charges, if applicable; bad debt charges, if applicable.
Date fields	Enter the date needed to assign the episode to the correct reporting period, as described below.
Coverage and eligibility	Complete the coverage and retroactive eligibility fields described in Section 8.
Duplicate check	Confirm the episode has not been submitted in a prior reporting period and is not duplicated within the current submission.

Do not combine unrelated encounters to meet the statutory threshold. Hospitals should not combine separate, unrelated outpatient encounters, unrelated ED visits, or unrelated admissions to reach the $2,000 minimum.

7. Episode Type and Reporting Period Assignment

Episode type	**How to report**	**Reporting period assignment**
Inpatient admission	Report one record per inpatient stay. Include all hospital facility charges associated with the inpatient stay. If the patient was seen in the emergency department and then admitted, include the ED and observation-related facility charges as part of the inpatient stay when they are part of the same admission/account.	Assign to the reporting period based on discharge date. Do not split a single inpatient stay across reporting periods.

Outpatient encounter	Report one record per outpatient encounter. Include all hospital facility charges associated with that encounter. Do not combine unrelated outpatient encounters.	Assign to the reporting period based on service date. If the encounter spans more than one date, use the service end date.
Observation encounter	Report observation as a separate episode only when the patient was not converted to inpatient status. If the patient was converted to inpatient status, include observation-related facility charges in the inpatient episode and do not submit a separate observation record.	Assign to the reporting period based on observation end date or discharge date.

Observation encounter. For purposes of this reporting process, an observation encounter means hospital observation services provided to a patient who is not admitted as an inpatient. Observation should be reported separately only when the encounter does not convert to an inpatient admission.

Ambulance-related charges: Ambulance charges may be included if the service is part of the qualifying hospital's submitted episode of care, is the type of service that would be covered under Medical Assistance if the patient were enrolled and the service otherwise met Medical Assistance coverage requirements, is not separately reimbursed to or billed by another provider and otherwise meets all HSP requirements.

8. Coverage Status and Retroactive Eligibility

A submitted episode must involve a patient who had no coverage for the date of service. The patient must not have been enrolled in Medical Assistance, MinnesotaCare, or Medicare and must not have had other health coverage for the date of service. The patient also must have been determined ineligible for Medical Assistance and MinnesotaCare for the date of service following any retroactive eligibility determination.

Pending, unknown, or unresolved coverage status is not permissible for submitted episodes. Hospitals should not submit an episode if coverage or retroactive eligibility is pending, unknown, or unresolved at the time of submission. If coverage or eligibility is resolved after the first reporting period but before a later submission deadline, the hospital should follow MDH instructions for the applicable reporting period and should not submit duplicate records.

Coverage/eligibility field	Instructions
Coverage status at time of service	Select the appropriate status from the workbook dropdown. Episodes submitted for payment consideration should have no coverage for the date of service.
Not enrolled in Medical Assistance	Confirm the patient was not enrolled in Medical Assistance for the date of service.
Not enrolled in MinnesotaCare	Confirm the patient was not enrolled in MinnesotaCare for the date of service.
Not enrolled in Medicare	Confirm the patient was not enrolled in Medicare for the date of service.
No other health coverage	Confirm the patient had no other health coverage for the date of service.
Coverage verification date	Enter the date the hospital verified coverage status.
Retroactive eligibility review completed, if applicable	Confirm whether retroactive eligibility review was completed or was not applicable.
Final eligibility determination	Indicate whether the patient was determined ineligible for Medical Assistance and MinnesotaCare for the date of service, or whether the review was not applicable.
Final determination date	Enter the date of the final eligibility determination, if applicable.

Limited-benefit Medicaid coverage: If a patient had limited-benefit Medicaid coverage, such as Emergency Medical Assistance or Minnesota Family Planning Program coverage, the hospital must determine whether the submitted episode was covered under that limited benefit category for the date of service. Episodes covered or paid by MA, MinnesotaCare, Medicare, FP, EH/EMA, or any other coverage must not be submitted as qualifying uncompensated episodes. An episode that was outside the patient's limited benefit coverage may be submitted only if the hospital documents that the service was not covered, the patient had no other coverage for the service, any required retroactive eligibility review was completed, and all other program requirements are met. Episodes involving limited-benefit coverage may be flagged for MDH review.

9. Duplicate Records, Errors, and Limited Correction Process

Hospitals are responsible for removing duplicate, ineligible, and unsupported episodes before submission. Because payment amounts are based on each hospital's eligible episode value relative to statewide eligible episode value, corrections and resubmissions may affect payment calculations for all participating hospitals.

MDH may allow limited correction of technical deficiencies before the final validation cutoff if the correction is needed to complete review and can be made within payment timelines. Examples may include missing required fields, formatting errors, obvious duplicate records, or incorrect reporting-period assignment. MDH is not obligated to accept new episodes, replacement submissions, or substantive changes after the submission deadline unless MDH determines that a correction process is necessary and feasible.

Hospitals should not submit episodes with pending eligibility determinations in anticipation of correcting them later. Only validated episode values will be used in the proportional payment calculation.

10. Attestation

The workbook includes an attestation to be completed by an authorized hospital official. By completing the attestation fields, the authorized official certifies that the submission is accurate and complete to the best of the official's knowledge and acknowledges the conditions listed in the workbook.

- The hospital has submitted only episodes it believes meets the statutory criteria for consideration.
- The submitted episodes occurred within the applicable reporting period.
- Each submitted episode involves services that would be covered under Medical Assistance if the patient were enrolled.
- Each submitted patient was not enrolled in Medical Assistance, MinnesotaCare, or Medicare and had no other health coverage for the date of service.
- Each submitted patient was determined ineligible for Medical Assistance and MinnesotaCare for the date of service following any applicable retroactive eligibility determination.
- The hospital removed duplicate, ineligible, or unsupported episodes before submission.
- The hospital retained supporting documentation and will provide documentation to MDH upon request.

- The hospital understands that MDH may exclude, adjust, or reconcile episodes if errors, duplicate submissions, unsupported episodes, late submissions, or corrected claims are identified.

11. Supporting Documentation

Hospitals do not need to submit complete backup documentation for every episode with the initial workbook unless instructed by MDH. Hospitals must retain documentation supporting each submitted episode and make that documentation available to MDH upon request. Hospitals should retain documentation consistent with applicable hospital, payer, audit, and state record-retention requirements. MDH may provide additional retention guidance if needed.

Documentation type	Examples
Patient account or encounter record	Documentation identifying the submitted episode and supporting the reported service dates and episode type.
Billing summary or itemized charges	Documentation supporting total episode charges and hospital facility charges included in the submission.
Coverage screening documentation	Eligibility verification, payer screening, clearinghouse results, or other documentation showing lack of coverage.
Retroactive eligibility documentation	Records showing the patient was determined ineligible for Medical Assistance and MinnesotaCare for the date of service, if applicable.
Charity care or bad debt documentation	Documentation supporting uncompensated classification, if relevant.
Duplicate removal or reconciliation support	Internal reconciliation or audit trail showing how duplicate records were removed before submission.

MDH may request supporting documentation for selected episodes, outliers, high-dollar episodes, random samples, corrected claims, late submissions, or any episode where eligibility is unclear.

12. Submission Format and Secure Upload Process

- Hospitals must submit the completed MDH Excel workbook through the secure file transfer process designated by MDH.
- Hospitals must not email patient-level, encounter-level, billing, eligibility, or other sensitive data unless MDH specifically authorizes a secure email process.
- Hospitals must use the MDH-provided workbook and must not alter worksheet names, required fields, validation lists, locked formulas, or workbook structure.
- Hospitals must follow the file naming convention below.

If MDH requests supporting documentation for a specific episode, MDH will provide instructions for naming and uploading those materials.

How to Submit Data to an MDH S3 Bucket

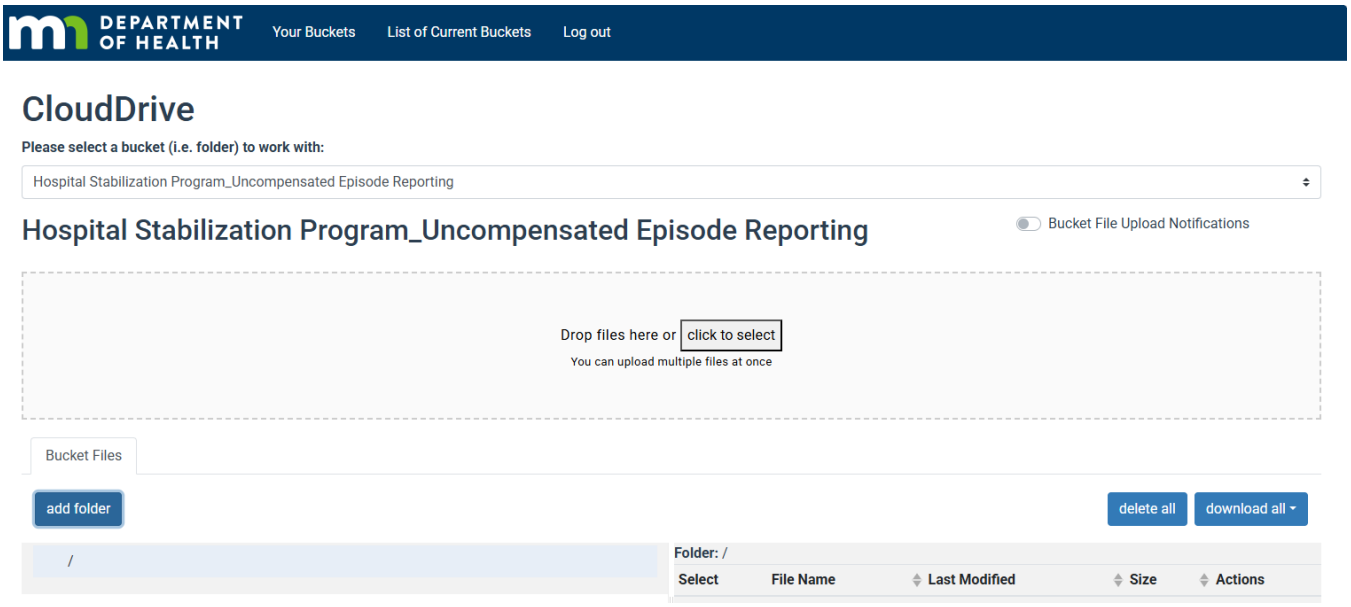
The Minnesota Department of Health CloudDrive is located here: https://clouddrive.web.health.state.mn.us/

A login has been established for the individual who was identified as the person who was identified as submitting reports on behalf of the hospital.

First time external users can set a personal password by clicking the “Forgot Password” link in the lower right of the login screen. The user will get an email prompting them to set a unique user password that does not have an expiration. If the user does not see the email check the spam folder.

Once logged in, please select the following bucket: **Hospital Stabilization Program_Uncompensated Episode Reporting.**

The bucket interface is a simple drag and drop use, with the addition of a folder button. Troubleshooting Tips: MNIT Clouddrive does not require VPN to access. Clouddrive needs Chrome or Firefox to operate.



Naming Convention - please label the reporting template for your hospital as follows:

HospitalStabilizationProgram_[HCCISID]_[HospitalName]_[ReportingPeriod]_[SubmissionDate].xlsx

Example: HospitalStabilizationProgram_1234_ExampleHospital_JanJun2026_20260915.xlsx

After uploading the file reporting template for your hospital, select "Log Out" located on the top right side of the screen.

If you have any questions or concerns please reach out to the hospitalstabilizationprogram_mdh@state.mn.us email.

13. MDH Review and Payment Calculation

MDH will review submitted workbooks for completeness and will calculate the value of submitted episodes using the methodology specified by MDH. Hospitals should submit total episode charges and required supporting fields; MDH will calculate or validate the cost-to-charge adjusted episode value used for payment calculation.

1. MDH will review the submission for completeness, required fields, valid dates, duplicate episode identifiers, and consistency with submission instructions.

2. MDH will compute the hospital-specific cost-to-charge ratio using the 2025 Hospital Annual Report submitted data.
3. MDH will apply the cost-to-charge ratio to submitted total allowable episode charges to calculate the cost-to-charge adjusted episode value.
4. MDH will compare each calculated episode value with the statutory threshold of at least $2,000 and not more than $50,000.
5. MDH will exclude or flag episodes that fall outside the range, are duplicated, have coverage concerns, are incomplete, or otherwise do not meet reporting requirements.
6. MDH will sum accepted episode values for each hospital and calculate each hospital's relative share of the statewide accepted value for the reporting period.
7. MDH will apply statutory payment limits, including any applicable cap and redistribution process.

After review, MDH will provide each hospital with payment-related information for its own submission, which may include accepted episode value, relative percentage, payment share, exclusion categories, and next steps. MDH will determine what statewide summary information may be shared after payment calculations are finalized.

14. Questions

Questions about the Hospital Stabilization Program reporting process should be directed to:
hospitalstabilizationprogram.mdh@state.mn.us

MDH may issue additional technical instructions, FAQs, template updates, or submission guidance as needed.

Appendix A. Submission Checklist

- Use the MDH-provided Excel workbook.
- Complete the Hospital Cover Sheet.
- Enter only episodes the hospital believes meet the qualifying uncompensated episode criteria.
- Do not include direct patient identifiers unless specifically instructed by MDH through a secure process.
- Confirm no Medical Assistance, MinnesotaCare, Medicare, or other coverage for the date of service.
- Do not submit episodes with pending, unknown, or unresolved coverage or eligibility status.
- Remove duplicate, ineligible, and unsupported episodes before submission.

- Complete the attestation through an authorized hospital official.
- Retain supporting documentation and provide it to MDH upon request.
- Submit the workbook through the secure MDH-designated upload process by the applicable deadline.