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Senate

State of Minnesota

S.F. No. 1372 – Nonstate Government-Owned Teaching Hospitals with High Medicaid Utilization Direct Payment Arrangements Authorization - as amended by the A-1 Delete-Everything Amendment

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SF 1372 establishes requirements for a new federally permissible directed managed care organization expenditure program for Hennepin County Medical Center (HCMC) and modifies existing supplemental payments to HCMC.

Section 1 **(section 256.969, subdivision 2f)** requires the commissioner of human services to reduce the existing disproportionate share hospital (DSH) payments to HCMC for serving a disproportionately high number of medical assistance enrollees and to replace the reduced DSH payments with an alternative fee-for-service payment rate.

Section 2 **(section 256B.196, subdivision 2)** effective July 1, 2021, eliminates HCMC's existing intergovernmental transfer (IGT) funded managed care pass-through, which is in the process of being phased out.

Section 3 **[256B.1973]** authorizes the creation of federally permissible directed managed care organization expenditures for eligible providers.

> **Subdivision 1** defines "billing professionals" for the purposes of determining which medical assistance billing claims must be included in a directed payment arrangement; defines "high medical assistance utilization" for the purposes of identifying eligible providers; and defines "health plan" for the purposes of identifying which insurance providers must participate in the directed payment arrangements.
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> **Subdivision 2** requires each directed payment arrangement to receive federal approval before being implemented.
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> **Subdivision 3** specifies which providers are eligible for a directed payment arrangement. Only HCMC is eligible under these specifications.

Subdivision 4 permits intergovernmental transfers for the purposes of funding the state share of a directed payment arrangement.

Subdivision 5 specifies the commissioner's duty with respect to a particular type of directed payment arrangement known as a state-directed fee schedule. For a state-directed fee schedule, the commissioner must determine a factor (e.g. a percent increase on each claim) to be applied to each medical assistance claim submitted to a health plan in order to maximize federally permissible state-directed fee schedule, including during the first year of implementation.

Subdivision 6 requires health plans to submit to the commissioner information required by the commissioner to determine the directed payment factor and apply it to capitation payments.

Subdivision 7 requires health plans, in accordance with their contracts with the commissioner, to pass through to the eligible provider (HCMC in this case) the entire value of the increased capitation rates resulting from the application of the state-directed fee schedule factor, less applicable taxes.

Subdivision 8 requires a directed payment arrangement to comply with federal requirements that such arrangements advance the state's quality goals.

Section 4 **(256B.6928, subdivision 5)** makes a clarifying addition to the state statute related to federally permissible state-directed managed care organization expenditures.

Section **5 (section 295.53, subdivision 1)** excludes from the health care provider tax the additional revenue received under a directed payment arrangement. Under current law, the value of revenue currently being received via IGT-funded managed care pass-throughs are excluded from the health care provider tax. Under this proposal, for HCMC, the IGT-funded managed care pass-throughs would cease and be replaced by IGT-funded directed payments.