Bill Summary

H.F. 1609

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Subject	Directed Payment Arrangements
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Overview

Federal Medicaid law allows local governments and providers owned or operated by local governments to transfer funds to the state to finance the nonfederal share of Medicaid payments. This bill eliminates an existing intergovernmental transfer from Hennepin County, and establishes a new Hennepin County intergovernmental transfer that involves the use of directed payments for managed care plans serving MA enrollees. Directed payments require managed care plans to pay providers for MA services at specified rates or using specified methods; directed payments are a state option under the 2016 federal Medicaid managed care rule.

Under the directed payment arrangement, Hennepin County makes voluntary intergovernmental transfers to DHS. DHS uses this money, and the resulting federal MA match, to increase capitation rates to managed care plans, and managed care plans are required to reimburse health care providers affiliated with Hennepin County based on a state-directed fee schedule that includes an adjustment factor.

Summary

Section	Description
1	**Alternate inpatient payment rate.** Amends § 256.969, by adding subd. 2f. Requires the commissioner, effective July 1, 2021, to reduce the disproportionate share hospital (DSH) payment by … percent for a hospital with an MA utilization rate at least two and one-half standard deviations above the statewide mean, and compute an alternative inpatient payment rate for that hospital. The alternative payment rate must target total aggregate reimbursement equal to what the hospital would have received for fee-for-service inpatient services had the hospital received the full DSH payment. Specifies a July 1, 2021, effective date.

Section	Description

2 **Commissioner's duties.**

Amends § 256B.196, subd. 2. Removes Hennepin County from an existing voluntary intergovernmental transfer, under which Hennepin County would transfer to the commissioner $12 million per year. Specifies a July 1, 2021, effective date.

3 **Directed payment arrangements.**

Adds § 256B.1973.

Subd. 1. Definitions. Defines the following terms: billing professionals, health plan, and high medical assistance utilization.

Subd. 2. Federal approval required. States that each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures.

Subd. 3. Eligible providers. States that eligible providers under this section are nonstate government teaching hospitals with high MA utilization and a level I trauma center, and the hospital's affiliated billing professionals, ambulance services, and clinics.

Subd. 4. Voluntary intergovernmental transfers. Allows a nonstate governmental entity eligible to perform intergovernmental transfers to make voluntary intergovernmental transfers to the commissioner. Requires the commissioner to inform the entity of the transfers necessary to maximize the allowable directed payments.

Subd. 5. Commissioner's duties; state-directed fee schedule requirement. (a) Requires the commissioner, for each federally approved directed payment arrangement that is a state-directed fee schedule requirement, to determine a uniform adjustment factor for each claim submitted to a health plan and to apply this to each claim. Directs the commissioner to ensure that the adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and allows the commissioner to use a settle-up process to adjust health plan payments to comply with this requirement.

(b) Requires the commissioner to ensure that the total annual amount of payments equals at least the sum of the annual value of voluntary intergovernmental transfers under subdivision 4 and federal financial participation.

(c) Requires the commissioner to develop a plan for initial implementation of the state-directed fee schedule requirement to ensure that eligible providers receive the entire permissible value under each arrangement. If federal approval is

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retroactive, requires the commissioner to make a onetime pro rata increase in the adjustment factor and initial payments.

Subd. 6. Health plan duties; submission of claims. Requires each health plan to submit to the commissioner payment information for each claim paid to an eligible provider for MA services.

Subd. 7. Health plan duties; directed payments. Requires each health plan to make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

Subd. 8. State quality goals. Requires the directed payment arrangement and the state-directed fee schedule requirement to advance state quality goals for Hennepin Healthcare MA patients. Specifies related requirements and quality measure domains.

States that this section is effective July 1, 2021, or upon federal approval, whichever is later, and allows for retroactive implementation.

4 **Direction of managed care organization expenditures.**

Amends § 256B.6928, subd. 5. Allows the commissioner to direct managed care organization expenditures as permitted under the federal rule governing Medicaid directed payments (42 CFR 438.6(c)).

5 **Exclusions and exemptions.**

Amends § 295.53, subd. 1. Excludes from the MinnesotaCare provider tax directed payments authorized under § 256B.1973. States that this section is effective for taxable years beginning after December 31, 2020.