256.9631 DIRECT PAYMENT SYSTEM FOR MEDICAL ASSISTANCE AND MINNESOTACARE.

Subdivision 1. **Direction to the commissioner.** (a) The commissioner shall develop an implementation plan for a direct payment system to deliver services to eligible individuals in order to achieve better health outcomes and reduce the cost of health care for the state. Under this system, eligible individuals must receive services through the medical assistance fee-for-service system, county-based purchasing plans, or county-owned health maintenance organizations. The commissioner shall present an implementation plan for the direct payment system to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy by January 15, 2026. The commissioner may contract for technical assistance in developing the implementation plan and conducting related studies and analyses.

(b) For the purposes of the direct payment system, the commissioner shall make the following assumptions:

(1) health care providers are reimbursed directly for all medical assistance covered services provided to eligible individuals, using the fee-for-service payment methods specified in chapters 256, 256B, 256R, and 256S;

(2) payments to a qualified hospital provider are equivalent to the payments that would have been received based on managed care direct payment arrangements. If necessary, a qualified hospital provider may use a county-owned health maintenance organization to receive direct payments as described in section 256B.1973; and

(3) county-based purchasing plans and county-owned health maintenance organizations must be reimbursed at the capitation rate determined under sections 256B.69 and 256B.692.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Eligible individuals" means qualified medical assistance enrollees, defined as persons eligible for medical assistance as families and children and adults without children.

(c) "Qualified hospital provider" means a nonstate government teaching hospital with high medical assistance utilization and a level 1 trauma center, and all of the hospital's owned or affiliated health care professionals, ambulance services, sites, and clinics.

Subd. 3. **Implementation plan.** (a) The implementation plan must include:

(1) a timeline for the development and recommended implementation date of the direct payment system. In recommending a timeline, the commissioner must consider:

(i) timelines required by the existing contracts with managed care plans and county-based purchasing plans to sunset existing delivery models;

(ii) in counties that choose to operate a county-based purchasing plan under section 256B.692, timelines for any new procurements required for those counties to establish a new county-based purchasing plan or participate in an existing county-based purchasing plan;

(iii) in counties that choose to operate a county-owned health maintenance organization under section 256B.69, timelines for any new procurements required for those counties to establish a new county-owned health maintenance organization or to continue serving enrollees through an existing county-owned health maintenance organization; and

(iv) a recommendation on whether the commissioner should contract with a third-party administrator to administer the direct payment system and the timeline needed for procuring an administrator;

(2) the procedures to be used to ensure continuity of care for enrollees who transition from managed care to fee-for-service and any administrative resources needed to carry out these procedures;

(3) recommended quality measures for health care service delivery;

(4) any changes to fee-for-service payment rates that the commissioner determines are necessary to ensure provider access and high-quality care and to reduce health disparities;

(5) recommendations on ensuring effective care coordination under the direct payment system, especially for enrollees who have complex medical conditions, who face socioeconomic barriers to receiving care, or who are from underserved populations that experience health disparities;

(6) recommendations on whether the direct payment system should provide supplemental payments for care coordination, including:

(i) the provider types eligible for supplemental payments;

(ii) procedures to coordinate supplemental payments with existing supplemental or cost-based payment methods or to replace these existing methods; and

(iii) procedures to align care coordination initiatives funded through supplemental payments under this section with existing care coordination initiatives;

(7) recommendations on whether the direct payment system should include funding to providers for outreach initiatives to patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care and treatment;

(8) recommendations for a supplemental payment to qualified hospital providers to offset any potential revenue losses resulting from the shift from managed care payments;

(9) recommendations on whether and how the direct payment system should be expanded to deliver services and care coordination to medical assistance enrollees who are age 65 or older, are blind, or have a disability and to persons enrolled in MinnesotaCare; and

(10) recommendations for statutory changes necessary to implement the direct payment system.

(b) In developing the implementation plan, the commissioner shall:

(1) calculate the projected cost of a direct payment system relative to the cost of the current system;

(2) assess gaps in care coordination under the current medical assistance and MinnesotaCare programs;

(3) evaluate the effectiveness of approaches other states have taken to coordinate care under a fee-for-service system, including the coordination of care provided to persons who are blind or have disabilities;

(4) estimate the loss of revenue and cost savings from other payment enhancements based on managed care plan directed payments and pass-throughs;

(5) estimate cost trends under a direct payment system for managed care payments to county-based purchasing plans and county-owned health maintenance organizations;

(6) estimate the impact of a direct payment system on other revenue, including taxes, surcharges, or other federally approved in lieu of services and on other arrangements allowed under managed care;

(7) consider allowing eligible individuals to opt out of managed care as an alternative approach;

(8) assess the feasibility of a medical assistance outpatient prescription drug benefit carve-out under section 256B.69, subdivision 6d, and in consultation with the commissioners of commerce and health, assess the feasibility of including MinnesotaCare enrollees and private sector enrollees of health plan companies in the drug benefit carve-out. The assessment of feasibility must address and include recommendations related to the process and terms by which the commissioner would contract with health plan companies to administer prescription drug benefits and develop and manage a drug formulary, and the impact of the drug-benefit carve-out on health care providers, including small pharmacies;

(9) consult with the commissioners of health and commerce and the contractor or contractors analyzing the Minnesota Health Plan under section 19 and other health reform models on plan design and assumptions; and

(10) conduct other analyses necessary to develop the implementation plan.

History: *2023 c 70 art 16 s 9*