State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 1609

02/25/2021 Authored by Liebling, Davnie, Acomb, Gruenhagen, Frazier and others
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to human services; establishing directed payment arrangements for nonstate government-owned teaching hospitals with high Medicaid utilization and level 1 trauma centers and their affiliated physicians; modifying inpatient hospital rates for certain hospitals; exempting certain health plan revenue from the insurance premium taxes and surcharges; exempting certain hospital revenue from the provider tax; amending Minnesota Statutes 2020, sections 256.9657, subdivision 3; 256.969, by adding a subdivision; 256B.196, subdivision 2; 256B.6928, subdivision 5; 295.53, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. Minnesota Statutes 2020, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wraparound subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary, minus the portion of medical assistance revenue attributable to an approved directed payment arrangement under section 256B.1973.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

(c) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(d) Effective June 15 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

(e) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge

imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

(f) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

(g) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

Sec. 2. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision to read:

Subd. 2f. **Alternate inpatient payment rate.** Effective July 1, 2021, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9 by ... percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 3. Minnesota Statutes 2020, section 256B.196, subdivision 2, is amended to read:

Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital services upper payment limit for nonstate government hospitals. The commissioner shall then determine the amount of a supplemental payment to Hennepin County Medical Center and Regions Hospital for these services that would increase medical assistance spending in this category to the aggregate upper payment limit for all nonstate government hospitals in Minnesota. In making this determination, the commissioner shall allot the available increases between Hennepin County Medical Center and Regions Hospital based on the ratio of medical assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner shall adjust this allotment as necessary based on federal approvals, the amount of intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,

in order to maximize the additional total payments. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match federal Medicaid payments available under this subdivision in order to make supplementary medical assistance payments to Hennepin County Medical Center and Regions Hospital equal to an amount that when combined with existing medical assistance payments to nonstate governmental hospitals would increase total payments to hospitals in this category for outpatient services to the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center and Regions Hospital.

(b) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians and other billing professionals affiliated with Hennepin County Medical Center and with Regions Hospital. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County and Ramsey County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and to make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group equal to the difference between the established medical assistance payment for physician and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians and other billing professionals affiliated with Hennepin County Medical Center and shall make supplementary payments to physicians and other billing professionals affiliated with Regions Hospital through HealthPartners Medical Group.

(c) Beginning January 1, 2010, ~~Hennepin County and~~ Ramsey County may make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed ~~$12,000,000 per year from Hennepin County and~~ $6,000,000 per year ~~from Ramsey County~~. The commissioner shall increase the medical assistance capitation payments to any licensed health plan under contract with the medical assistance program that agrees to make enhanced payments to ~~Hennepin County Medical Center or~~ Regions Hospital. The increase shall be in an amount equal to the annual value of the monthly transfers plus federal financial participation, with each health plan receiving its pro rata share of the increase based on the pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~ Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"

means the total annual value of increased medical assistance capitation payments, including the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce the total annual value of increased medical assistance capitation payments under this paragraph by an amount equal to ten percent of the base amount, and by an additional ten percent of the base amount for each subsequent contract year until December 31, 2025. Upon the request of the commissioner, health plans shall submit individual-level cost data for verification purposes. The commissioner may ratably reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed health plan that receives increased medical assistance capitation payments under the intergovernmental transfer described in this paragraph shall increase its medical assistance payments to ~~Hennepin County Medical Center and~~ Regions Hospital by the same amount as the increased payments received in the capitation payment described in this paragraph. This paragraph expires January 1, 2026.

(d) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul, and ambulance services owned and operated by another governmental entity that chooses to participate by requesting the commissioner to determine an upper payment limit. The upper payment limit shall be based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform Hennepin County, the city of St. Paul, and other participating governmental entities of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to Hennepin County Medical Center, the city of St. Paul, and other participating governmental entities. A tribal government that owns and operates an ambulance service is not eligible to participate under this subdivision.

(e) For the purposes of this subdivision and subdivision 3, the commissioner shall determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. The upper payment limit shall be based on the average commercial rate or be determined using

another method acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall inform the University of Minnesota Medical School and University of Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available under this subdivision in order to make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians equal to the difference between the established medical assistance payment for physician, dentist, and other billing professional services and the upper payment limit. Upon receipt of these periodic transfers, the commissioner shall make supplementary payments to physicians, dentists, and other billing professionals affiliated with the University of Minnesota and the University of Minnesota Physicians.

(f) The commissioner shall inform the transferring governmental entities on an ongoing basis of the need for any changes needed in the intergovernmental transfers in order to continue the payments under paragraphs (a) to (e), at their maximum level, including increases in upper payment limits, changes in the federal Medicaid match, and other factors.

(g) The payments in paragraphs (a) to (e) shall be implemented independently of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

(h) All of the data and funding transactions related to the payments in paragraphs (a) to (e) shall be between the commissioner and the governmental entities.

(i) For purposes of this subdivision, billing professionals are limited to physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and dental therapists.

EFFECTIVE DATE. This section is effective July 1, 2021.

Sec. 4. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given them.

(b) "Billing professionals" means physicians, nurse practitioners, nurse midwives, clinical nurse specialists, physician assistants, anesthesiologists, and certified registered anesthetists, and may include dentists, dental hygienists, and dental therapists.

(c) "Health plan" means a licensed health plan under contract with the medical assistance program.

(d) "High medical assistance utilization" means a medical assistance utilization rate equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause (6).

Subd. 2. **Federal approval required.** 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 under section 256B.6928, subdivision 5.

Subd. 3. **Eligible providers.** Eligible providers under this section are nonstate government teaching hospitals with high medical assistance utilization and a level 1 trauma center and the hospital's affiliated billing professionals, ambulance services, hospitals, and non-hospital-based clinics.

Subd. 4. **Voluntary intergovernmental transfers.** A nonstate governmental entity that is eligible to perform intergovernmental transfers may make voluntary intergovernmental transfers to the commissioner. The commissioner shall inform the nonstate governmental entity of the intergovernmental transfers necessary to maximize the allowable directed payments.

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits. The commissioner shall apply the uniform adjustment to each submitted claim.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner must ensure that the total annual amount of payments equals at least the sum of the annual value of the voluntary intergovernmental transfers to the commissioner under subdivision 4 and federal financial participation.

(c) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform

adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Subd. 6. **Health plan duties; submission of claims.** In accordance with its contract, each health plan shall submit to the commissioner payment information for each claim paid to an eligible provider for services provided to a medical assistance enrollee.

Subd. 7. **Health plan duties; directed payments.** In accordance with its contract, each health plan shall make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.

EFFECTIVE DATE. This section is effective July 1, 2021, or upon federal approval, whichever is later, unless the federal approval provides for an effective date after July 1, 2021, but before the date of federal approval, in which case the federally approved effective date applies.

Sec. 5. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

Subd. 5. **Direction of managed care organization expenditures.** (a) The commissioner shall not direct managed care organizations expenditures under the managed care contract, except ~~in~~ as permitted under Code of Federal Regulations, part 42, section 438.6(c). The exception under this paragraph includes the following situations:

(1) implementation of a value-based purchasing model for provider reimbursement, including pay-for-performance arrangements, bundled payments, or other service payments intended to recognize value or outcomes over volume of services;

(2) participation in a multipayer or medical assistance-specific delivery system reform or performance improvement initiative; or

(3) implementation of a minimum or maximum fee schedule, or a uniform dollar or percentage increase for network providers that provide a particular service. The maximum fee schedule must allow the managed care organization the ability to reasonably manage risk and provide discretion in accomplishing the goals of the contract.

(b) Any managed care contract that directs managed care organization expenditures as permitted under paragraph (a), clauses (1) to (3), must be developed in accordance with Code of Federal Regulations, part 42, sections 438.4 and 438.5; comply with actuarial soundness and generally accepted actuarial principles and practices; and have written approval from the Centers for Medicare and Medicaid Services before implementation. To obtain approval, the commissioner shall demonstrate in writing that the contract arrangement:

(1) is based on the utilization and delivery of services;

(2) directs expenditures equally, using the same terms of performance for a class of providers providing service under the contract;

(3) is intended to advance at least one of the goals and objectives in the commissioner's quality strategy;

(4) has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals in the commissioner's quality strategy;

(5) does not condition network provider participation on the network provider entering into or adhering to an intergovernmental transfer agreement; and

(6) is not renewed automatically.

(c) For contract arrangements identified in paragraph (a), clauses (1) and (2), the commissioner shall:

(1) make participation in the value-based purchasing model, special delivery system reform, or performance improvement initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the model, reform, or initiative; and

(2) use a common set of performance measures across all payers and providers.

(d) The commissioner shall not set the amount or frequency of the expenditures or recoup from the managed care organization any unspent funds allocated for these arrangements.

Sec. 6. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

Subdivision 1. **Exclusions and exemptions.** (a) The following payments are excluded from the gross revenues subject to the hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received by a health care provider or the wholly owned subsidiary of a health care provider for care provided outside Minnesota;

(2) government payments received by the commissioner of human services for state-operated services;

(3) payments received by a health care provider for hearing aids and related equipment or prescription eyewear delivered outside of Minnesota; and

(4) payments received by an educational institution from student tuition, student activity fees, health care service fees, government appropriations, donations, or grants, and for

services identified in and provided under an individualized education program as defined in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee for service payments and payments for extended coverage are taxable.

(b) The following payments are exempted from the gross revenues subject to hospital, surgical center, or health care provider taxes under sections 295.50 to 295.59:

(1) payments received for services provided under the Medicare program, including payments received from the government and organizations governed by sections 1833, 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid by the Medicare enrollee, by Medicare supplemental coverage as described in section 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal Social Security Act. Payments for services not covered by Medicare are taxable;

(2) payments received for home health care services;

(3) payments received from hospitals or surgical centers for goods and services on which liability for tax is imposed under section 295.52 or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(4) payments received from the health care providers for goods and services on which liability for tax is imposed under this chapter or the source of funds for the payment is exempt under clause (1), (6), (9), (10), or (11);

(5) amounts paid for legend drugs to a wholesale drug distributor who is subject to tax under section 295.52, subdivision 3, reduced by reimbursement received for legend drugs otherwise exempt under this chapter;

(6) payments received from the chemical dependency fund under chapter 254B;

(7) payments received in the nature of charitable donations that are not designated for providing patient services to a specific individual or group;

(8) payments received for providing patient services incurred through a formal program of health care research conducted in conformity with federal regulations governing research on human subjects. Payments received from patients or from other persons paying on behalf of the patients are subject to tax;

(9) payments received from any governmental agency for services benefiting the public, not including payments made by the government in its capacity as an employer or insurer or payments made by the government for services provided under the MinnesotaCare

program or the medical assistance program governed by title XIX of the federal Social Security Act, United States Code, title 42, sections 1396 to 1396v;

(10) payments received under the federal Employees Health Benefits Act, United States Code, title 5, section 8909(f), as amended by the Omnibus Reconciliation Act of 1990. Enrollee deductibles, co-insurance, and co-payments are subject to tax;

(11) payments received under the federal Tricare program, Code of Federal Regulations, title 32, section 199.17(a)(7). Enrollee deductibles, co-insurance, and co-payments are subject to tax; and

(12) supplemental ~~or,~~ enhanced, or directed payments authorized under section 256B.196 ~~or,~~ 256B.197, or 256B.1973.

(c) Payments received by wholesale drug distributors for legend drugs sold directly to veterinarians or veterinary bulk purchasing organizations are excluded from the gross revenues subject to the wholesale drug distributor tax under sections 295.50 to 295.59.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2020.

Sec. 7. **DIRECTION TO COMMISSIONER; DIRECTED PAYMENT ARRANGEMENTS.**

The commissioner of human services, in consultation with Hennepin Healthcare System, shall submit Section 438.6(c) Preprint to Centers for Medicare and Medicaid Services as soon as practicable, but no later than ... calendar days following the effective date of this section. The commissioner shall request from the Centers for Medicare and Medicaid Services an effective date of July 1, 2021.

EFFECTIVE DATE. This section is effective the day following final enactment.