

1.1 moves to amend H.F. No. 1609 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. Minnesota Statutes 2020, section 256.969, is amended by adding a subdivision
1.4 to read:

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

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

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

1.15 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
1.16 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
1.17 payment limit for nonstate government hospitals. The commissioner shall then determine
1.18 the amount of a supplemental payment to Hennepin County Medical Center and Regions
1.19 Hospital for these services that would increase medical assistance spending in this category
1.20 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
1.21 In making this determination, the commissioner shall allot the available increases between
1.22 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
1.23 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
1.24 shall adjust this allotment as necessary based on federal approvals, the amount of

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

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

2.27 (c) Beginning January 1, 2010, ~~Hennepin County and Ramsey County~~ may make monthly
2.28 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
2.29 ~~\$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.~~
2.30 The commissioner shall increase the medical assistance capitation payments to any licensed
2.31 health plan under contract with the medical assistance program that agrees to make enhanced
2.32 payments to ~~Hennepin County Medical Center or Regions Hospital~~. The increase shall be
2.33 in an amount equal to the annual value of the monthly transfers plus federal financial
2.34 participation, with each health plan receiving its pro rata share of the increase based on the
2.35 pro rata share of medical assistance admissions to ~~Hennepin County Medical Center and~~

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

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

3.33 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
3.34 determine an upper payment limit for physicians, dentists, and other billing professionals
3.35 affiliated with the University of Minnesota and University of Minnesota Physicians. The

4.1 upper payment limit shall be based on the average commercial rate or be determined using
4.2 another method acceptable to the Centers for Medicare and Medicaid Services. The
4.3 commissioner shall inform the University of Minnesota Medical School and University of
4.4 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
4.5 match the federal Medicaid payments available under this subdivision in order to make
4.6 supplementary payments to physicians, dentists, and other billing professionals affiliated
4.7 with the University of Minnesota and the University of Minnesota Physicians equal to the
4.8 difference between the established medical assistance payment for physician, dentist, and
4.9 other billing professional services and the upper payment limit. Upon receipt of these periodic
4.10 transfers, the commissioner shall make supplementary payments to physicians, dentists,
4.11 and other billing professionals affiliated with the University of Minnesota and the University
4.12 of Minnesota Physicians.

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

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

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

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

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

4.26 Sec. 3. **[256B.1973] DIRECTED PAYMENT ARRANGEMENTS.**

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

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

5.1 (c) "Health plan" means a managed care or county-based purchasing plan that is under
5.2 contract with the commissioner to deliver services to medical assistance enrollees under
5.3 section 256B.69.

5.4 (d) "High medical assistance utilization" means a medical assistance utilization rate
5.5 equal to the standard established in section 256.969, subdivision 9, paragraph (d), clause
5.6 (6).

5.7 Subd. 2. **Federal approval required.** Each directed payment arrangement under this
5.8 section is contingent on federal approval and must conform with the requirements for
5.9 permissible directed managed care organization expenditures under section 256B.6928,
5.10 subdivision 5.

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

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

5.19 Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For
5.20 each federally approved directed payment arrangement that is a state-directed fee schedule
5.21 requirement, the commissioner shall determine a uniform adjustment factor to be applied
5.22 to each claim submitted by an eligible provider to a health plan. The commissioner shall
5.23 ensure that the application of the uniform adjustment factor maximizes the allowable directed
5.24 payments and does not result in payments exceeding federal limits, and may use a settle-up
5.25 process to adjust health plan payments to comply with this requirement. The commissioner
5.26 shall apply the uniform adjustment to each submitted claim.

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

5.31 (c) For each federally approved directed payment arrangement that is a state-directed
5.32 fee schedule requirement, the commissioner shall develop a plan for the initial
5.33 implementation of the state-directed fee schedule requirement to ensure that the eligible
5.34 provider receives the entire permissible value of the federally approved directed payment

6.1 arrangement. If federal approval of a directed payment arrangement under this subdivision
6.2 is retroactive, the commissioner shall make a onetime pro rata increase to the uniform
6.3 adjustment factor and the initial payments in order to include claims submitted between the
6.4 retroactive federal approval date and the period captured by the initial payments.

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

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

6.11 Subd. 8. **State quality goals.** The directed payment arrangement and state-directed fee
6.12 schedule requirement must advance state quality goals for Hennepin Healthcare medical
6.13 assistance patients, as assessed through the integrated health partnership quality reporting
6.14 structure established under section 256B.0755. Measured domains may include:

- 6.15 (1) prevention and screening;
6.16 (2) care for at-risk populations;
6.17 (3) behavioral health;
6.18 (4) access to care;
6.19 (5) quality of outpatient care; and
6.20 (6) equity attachment measures.

6.21 **EFFECTIVE DATE.** This section is effective July 1, 2021, or upon federal approval,
6.22 whichever is later, unless the federal approval provides for an effective date after July 1,
6.23 2021, but before the date of federal approval, in which case the federally approved effective
6.24 date applies.

6.25 Sec. 4. Minnesota Statutes 2020, section 256B.6928, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

7.25 (6) is not renewed automatically.

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

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

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

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

8.3 Sec. 5. Minnesota Statutes 2020, section 295.53, subdivision 1, is amended to read:

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

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

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

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

8.13 (4) payments received by an educational institution from student tuition, student activity
8.14 fees, health care service fees, government appropriations, donations, or grants, and for
8.15 services identified in and provided under an individualized education program as defined
8.16 in section 256B.0625 or Code of Federal Regulations, chapter 34, section 300.340(a). Fee
8.17 for service payments and payments for extended coverage are taxable.

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

8.20 (1) payments received for services provided under the Medicare program, including
8.21 payments received from the government and organizations governed by sections 1833,
8.22 1853, and 1876 of title XVIII of the federal Social Security Act, United States Code, title
8.23 42, section 1395; and enrollee deductibles, co-insurance, and co-payments, whether paid
8.24 by the Medicare enrollee, by Medicare supplemental coverage as described in section
8.25 62A.011, subdivision 3, clause (10), or by Medicaid payments under title XIX of the federal
8.26 Social Security Act. Payments for services not covered by Medicare are taxable;

8.27 (2) payments received for home health care services;

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

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

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

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

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

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

9.14 (9) payments received from any governmental agency for services benefiting the public,
9.15 not including payments made by the government in its capacity as an employer or insurer
9.16 or payments made by the government for services provided under the MinnesotaCare
9.17 program or the medical assistance program governed by title XIX of the federal Social
9.18 Security Act, United States Code, title 42, sections 1396 to 1396v;

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

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

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

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

9.30 **EFFECTIVE DATE.** This section is effective for taxable years beginning after December
9.31 31, 2020."

9.32 Amend the title accordingly