SENATE
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A bill for an act

relating to health care; establishing a Patient-Centered Care program; authorizing direct state payments to health care providers; appropriating money; amending Minnesota Statutes 2024, section 256B.0753; proposing coding for new law in Minnesota Statutes, chapter 256; repealing Minnesota Statutes 2024, section 256B.0755.

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

Section 1. **[256.9632] PATIENT-CENTERED CARE AND DIRECT PAYMENT FOR MEDICAL ASSISTANCE AND MINNESOTACARE.**

Subdivision 1. **Program established.** (a) The Patient-Centered Care program is established to achieve better health outcomes and reduce the cost of health care for the state. The commissioner shall pay health care providers directly to provide services for all medical assistance enrollees who are eligible under section 256B.055 and MinnesotaCare enrollees eligible under section 256L.05.

(b) In counties that choose to use a county-based purchasing (CBP) system under section 256B.692, the commissioner shall permit those counties to form a new CBP or participate in an existing CBP. The commissioner shall have the CBP administer the program and pay providers unless a county requests that the commissioner take over the responsibility.

Subd. 2. **Payment to providers.** (a) The commissioner of human services shall pay licensed health care providers directly for all services provided to medical assistance enrollees under section 256B.0625 and MinnesotaCare enrollees under section 256L.03. Payments for services shall be made to individual providers and clinics for the services they provide, not to hospital systems or networks of providers. In addition to payments to licensed health

care providers for services, the commissioner shall pay providers separately for drugs, immunizations, and vaccines provided to medical assistance and MinnesotaCare enrollees.

(b) Providers shall bill the state or the county-based purchaser directly for the services they provide. The state and county-based purchasers may not shift risk to providers or any other entity.

(c) The commissioner shall not renew the state's contracts with managed care plans under sections 256B.69 and 256L.12 and with integrated health partnerships under section 256B.0755 for providing services to enrollees in the medical assistance and MinnesotaCare programs.

Subd. 3. **Care coordination.** (a) In addition to paying providers under subdivision 2, the commissioner shall pay primary care providers for coordinating care for medical assistance and MinnesotaCare enrollees.

Under the program, patients may choose a primary care provider to act as the enrollee's care coordinator. Primary care physicians, nurses, and other qualified licensed or certified case management professionals may provide care coordination.

Each individual clinic of care providers that provide care coordination services, or counties that provide such coordination, shall receive a monthly fee for performing the services according to subdivision 2, paragraph (a), for each medical assistance or MinnesotaCare patient who receives primary care from the clinic. The commissioner shall set higher care coordination fees for clinics that serve a higher population of people with socioeconomic factors that lead to health disparities.

(b) The primary care provider shall provide overall oversight of the enrollee's health and coordinate with any case manager of the enrollee.

(c) The commissioner shall pay community health workers in federally qualified health centers and other medical clinics for care coordination provided for medical assistance and MinnesotaCare enrollees.

Subd. 4. **Community outreach.** (a) The commissioner shall provide funding through grants to community health clinics and CBPs to hire community health workers, nurses, or social workers who shall, in coordination with social service agencies, do outreach in the community and deliver medical care and care coordination services in the community for patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care and treatment. In addition to helping people obtain care, the clinics shall assist patients to enroll in medical assistance.

(b) The commissioner shall provide funding through grants to community health clinics and CBPs or county social service providers to collaborate with medical providers to reduce hospital readmissions by providing discharge planning and services, including medical respite and transitional care for patients leaving medical facilities and mental health and chemical dependency treatment programs.

Subd. 5. **Duties.** (a) For enrollees, the commissioner shall:

(1) maintain a hotline and website to assist enrollees in locating providers;

(2) provide a nurse consultation helpline 24 hours per day, seven days a week; and

(3) contact enrollees based on claims data who have not had preventive visits and help them select a primary care provider.

(b) Counties that elect a CBP system may choose to provide the services in paragraph (a) with reimbursement through the Department of Human Services.

(c) For providers, the commissioner shall:

(1) ensure provider reimbursement rates are reasonable and fair, meet the requirements of the Centers for Medicare and Medicaid Services, and address and prevent shortages of providers for services such as mental health and dental services;

(2) ensure that providers are reimbursed on a timely basis; and

(3) collaborate with individual frontline providers to explore means of improving health care quality and reducing costs.

EFFECTIVE DATE. This section is effective the day following final enactment. Direct payments to providers under the Patient-Centered Care program shall be effective when the current contracts with managed care plans under Minnesota Statutes, sections 256B.69 and 256L.12, for medical assistance and MinnesotaCare services expire on January 1, 2026.

Sec. 2. Minnesota Statutes 2024, section 256B.0753, is amended to read:

256B.0753 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

Subdivision 1. ~~**Development**~~ **Payment system.** The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides per-person care coordination payments to licensed health care ~~homes certified under section 62U.03~~ providers and community health workers for providing care coordination services and directly managing on-site or employing care coordinators. ~~The~~

~~care coordination payments under this section are in addition to the quality incentive payments in section 256B.0754, subdivision 1. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination.~~ In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may determine a schedule for phasing in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions.

Subd. 2. **Implementation.** The commissioner of human services shall implement care coordination payments as specified under this section by July 1, ~~2010, or upon federal approval, whichever is later~~ 2026. For enrollees served under the fee-for-service system, the care coordination payment shall be determined by the commissioner in contracts with ~~certified health care homes~~ licensed health care providers. For enrollees served by ~~managed care or~~ county-based purchasing plans, the commissioner's contracts with these plans shall require the payment of care coordination fees ~~to certified health care homes~~ under current county-based purchasing plans or new county-based purchasing plans.

~~Subd. 3. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner may make recommendations to the legislature on reallocating costs within the health care system.~~

Sec. 3. **APPROPRIATIONS.**

(a) $..... in fiscal year .... is appropriated from the general fund to the commissioner of human services for grants to community health clinics and to CBPs to do outreach and deliver medical care and care coordination services to people who are unlikely to obtain needed care and treatment under Minnesota Statutes, section 256.9632, subdivision 4, paragraph (a).

(b) $..... in fiscal year .... is appropriated from the general fund to the commissioner of human services for grants to community health clinics and CBPs or other social service providers to reduce hospitalization and readmissions by providing discharge planning and services under Minnesota Statutes, section 256.9632, subdivision 4, paragraph (b).

Sec. 4. **REPEALER.**

Minnesota Statutes 2024, section 256B.0755, is repealed.

256B.0755 INTEGRATED HEALTH PARTNERSHIP DEMONSTRATION PROJECT.

Subdivision 1. **Implementation.** (a) The commissioner shall continue a demonstration project established under this section to test alternative and innovative integrated health partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a request for proposals for participation in the demonstration project in consultation with hospitals, primary care providers, health plans, and other key stakeholders.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the appropriate Minnesota public program populations, to be used by the commissioner for the integrated health partnership projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become integrated health partnerships, and may be customized for the special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors;

(4) encourage and authorize different levels and types of financial risk;

(5) encourage and authorize projects representing a wide variety of geographic locations, patient populations, provider relationships, and care coordination models;

(6) encourage projects that involve close partnerships between the integrated health partnership and counties and nonprofit agencies that provide services to patients enrolled with the integrated health partnership, including social services, public health, mental health, community-based services, and continuing care;

(7) encourage projects established by community hospitals, clinics, and other providers in rural communities;

(8) identify required covered services for a total cost of care model or services considered in whole or partially in an analysis of utilization for a risk/gain sharing model;

(9) establish a mechanism to monitor enrollment;

(10) establish quality standards for the integrated health partnerships that are appropriate for the particular patient population to be served; and

(11) encourage participation of privately insured population so as to create sufficient alignment in the integrated health partnership.

(c) To be eligible to participate in the demonstration project an integrated health partnership must:

(1) provide required covered services and care coordination to recipients enrolled in the integrated health partnership;

(2) establish a process to monitor enrollment and ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telehealth, patient educators, care coordinators, and community health workers.

(d) An integrated health partnership may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

An integrated health partnership may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods established by the commissioner for integrated health partnerships.

(e) The commissioner may require an integrated health partnership to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare shall be eligible for enrollment in an integrated health partnership.

(b) Eligible applicants and recipients may enroll in an integrated health partnership if the integrated health partnership serves the county in which the applicant or recipient resides. If more than one integrated health partnership serves a county, the applicant or recipient shall be allowed to choose among the integrated health partnerships. The commissioner may assign an applicant or recipient to an integrated health partnership if an integrated health partnership is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Integrated health partnerships must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability standards must be appropriate to the particular population served.

(b) An integrated health partnership may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, county agencies, and rural clinics to the extent practicable.

(c) An integrated health partnership must indicate how it will coordinate with other services affecting its patients' health, quality of care, and cost of care that are provided by other providers, county agencies, and other organizations in the local service area. The integrated health partnership must indicate how it will engage other providers, counties, and organizations, including county-based purchasing plans, that provide services to patients of the integrated health partnership on issues related to local population health, including applicable local needs, priorities, and public health goals. The integrated health partnership must describe how local providers, counties, organizations, including county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project.

Subd. 4. **Payment system.** (a) In developing a payment system for integrated health partnerships, the commissioner shall establish a total cost of care benchmark or a risk/gain sharing payment model to be paid for services provided to the recipients enrolled in an integrated health partnership.

(b) The payment system may include incentive payments to integrated health partnerships that meet or exceed annual quality and performance targets realized through the coordination of care.

(c) An amount equal to the savings realized to the general fund as a result of the demonstration project shall be transferred each fiscal year to the health care access fund.

(d) The payment system shall include a population-based payment that supports care coordination services for all enrollees served by the integrated health partnerships, and is risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with chronic conditions, limited English skills, cultural differences, who are homeless, or who experience health disparities or other barriers to health care. The population-based payment shall be a per member, per month payment paid at least on a quarterly basis. Integrated health partnerships receiving this payment must continue to meet cost and quality metrics under the program to maintain eligibility for the population-based payment. An integrated health partnership is eligible to receive a payment under this paragraph even if the partnership is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served by the integrated health partnership. Any integrated health partnership participant certified as a health care home under section 62U.03 that agrees to a payment method that includes population-based payments for care coordination is not

eligible to receive health care home payment or care coordination fee authorized under section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled or attributed to the integrated health partnership under this demonstration.

Subd. 5. **Outpatient prescription drug coverage.** Outpatient prescription drug coverage may be provided through accountable care organizations only if the delivery method qualifies for federal prescription drug rebates.

Subd. 6. **Federal approval.** The commissioner shall apply for any federal waivers or other federal approval required to implement this section. The commissioner shall also apply for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the establishment of accountable care organizations.

Subd. 7. **Expansion.** The commissioner shall expand the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the integrated health partnership demonstration. As part of the demonstration expansion, the commissioner may procure the services of the integrated health partnerships authorized under this section by geographic area, to supplement or replace the services provided by managed care plans operating under section 256B.69.

Subd. 8. **Patient incentives.** The commissioner may authorize an integrated health partnership to provide incentives for patients to:

(1) see a primary care provider for an initial health assessment;

(2) maintain a continuous relationship with the primary care provider; and

(3) participate in ongoing health improvement and coordination of care activities.