SENATE COUNSEL, RESEARCH, & FISCAL ANALYSIS

BILL SUMMARY

S.F. No. 1059 – Patient-Centered Care program establishment

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Bill Overview

S.F. 1059 establishes a Patient-Centered Care program to provide direct state payments to health care providers for services furnished to Medical Assistance (MA) and MinnesotaCare enrollees. The bill prohibits the renewal of current contracts with managed care plans for these programs and shifts to a fee-for-service system in which the state pays licensed health care providers and clinics directly. Counties that choose a county-based purchasing model retain flexibility in administration. The legislation also authorizes payments for care coordination, grants for community outreach and discharge planning, and directs the commissioner of human services to ensure reasonable and timely provider reimbursement. Finally, it repeals the statute governing integrated health partnerships, as that program is made obsolete by the new Patient-Centered Care program.

Section Summaries

Section 1 (adds Minn. Stat. § 256.9632; Patient-Centered Care and Direct Payment for Medical Assistance and MinnesotaCare)

Subdivision 1. Program established. This subdivision creates the Patient-Centered Care program to provide direct payments to health care providers, rather than contracting with managed care plans, for all MA and MinnesotaCare enrollees. Allows counties that use a county-based purchasing (CBP) system to continue or establish a new CBP.

Subdivision 2. Payment to providers. This subdivision requires the commissioner to pay licensed health care providers and clinics directly for services provided to MA and MinnesotaCare enrollees. Providers must bill the state or CBP directly, and insurance risk for services provided cannot be shifted to providers or other entities. This subdivision further prohibits managed care and integrated health partnership contract renewals in MA and MinnesotaCare after January 1, 2026.

Subdivision 3. Care coordination. This subdivision directs the commissioner to pay primary care providers a monthly care coordination fee for enrollees who designate that provider as their care coordinator. Higher fees must be paid for clinics serving a higher population of people with socioeconomic factors that lead to health disparities. This subdivision further

authorizes payment for community health workers in FQHCs and other medical clinics for the provision of care coordination services.

Subdivision 4. Community outreach. This subdivision requires the commissioner to award grants to community health clinics and CBPs to hire community health workers, nurses, or social workers to do outreach for patients who are unlikely to seek or maintain care without assistance. This subdivision also authorizes grants to reduce hospital readmissions by providing discharge planning, transitional care, and medical respite.

Subdivision 5. Duties. This subdivision requires the commissioner of human services to maintain a patient hotline and website for provider referrals, provide a 24/7 nurse consultation line, and perform outreach to enrollees who are not completing preventive visits. The commissioner must also, for providers, ensure timely and fair reimbursement rates that address provider shortages and engage with frontline providers to improve quality and reduce costs.

Section 2 (amends Minn. Stat. § 256B.0753; Payment Restructuring; Care Coordination Payments)

Subdivision 1. Development—Payment system. This subdivision modifies the existing care coordination payment system to provide for per-person payments to licensed health care providers and community health workers.

Subdivision 2. Implementation. This subdivision sets a 2026 start date for implementing care coordination payments for enrollees served by fee-for-service and county-based purchasing under the new direct-payment model.

Subdivision 3. Cost neutrality. Removes obsolete language.

Section 3 (Appropriations) This section appropriates unspecified amounts from the general fund to the commissioner of human services for:

1. Grants to community health clinics and CBPs for outreach and care delivery to individuals unlikely to seek care on their own; and
2. Grants to community health clinics, CBPs, or other social service providers to reduce hospitalization and readmissions through discharge planning and related services.

Section 4 (Repealer) This section repeals Minnesota Statutes 2024, section 256B.0755, which established integrated health partnerships. This repeal aligns with the shift to direct payments under the new Patient-Centered Care program.