SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 3149

(SENATE AUTHORS: HOFFMAN, Utke, Mann, Abeler and Kupec)

DATE	D-PG	OFFICIAL STATUS
04/01/2025	1250	Introduction and first reading Referred to Health and Human Services
04/07/2025		Authors added Abeler; Kupec

A bill for an act

relating to human services; establishing a county-administered rural medical assistance program; establishing payment, coverage, and eligibility requirements for the CARMA program; directing the commissioner of human services to seek federal waivers; amending Minnesota Statutes 2024, section 256B.69, subdivision 3a; 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 2024, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 142F and 145A and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board may recommend a maximum number of participating health plans after considering

the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance benefit set. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance program in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment. This paragraph expires upon the effective date of paragraph (d).

(d) Effective January 1, 2027, for counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision.

~~(d)~~ (e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of

participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

~~(e)~~ (f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

~~(f)~~ (g) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

~~(g)~~ (h) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

~~(h)~~ (i) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 2. **[256B.695] COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM.**

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

(b) "CARMA" means the county-administered rural medical assistance program established under this section.

(c) "Commissioner" means the commissioner of human services.

(d) "Eligible individual" means an individual who is:

(1) residing in a county administering CARMA; and

(2) eligible for medical assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC).

(e) "Enrollee" means an individual enrolled in CARMA.

(f) "PMAP" means the prepaid medical assistance program under section 256B.69.

(g) "Rural county" has the meaning given to "rural area" in Code of Federal Regulations, title 42, section 438.52.

Subd. 2. **Program established.** A county-administered rural medical assistance program is established to:

(1) provide a county-owned and county-administered alternative to PMAP;

(2) facilitate integration of health care, public health, and social services to address health-related social needs in rural communities;

(3) account for the fewer enrollees and local providers of health care and community services in rural communities; and

(4) promote accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

Subd. 3. **County participation.** Each county or group of counties authorized under section 256B.692 may administer CARMA for any or all eligible individuals as an alternative to PMAP, MinnesotaCare, MSHO, MSC+, or SNBC programs. Counties choosing and authorized to administer CARMA are exempt from the procurement process as required under section 256B.69.

Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and 256B.692, unless otherwise provided for under this section. The commissioner must develop and implement a procurement process requiring applications from county-based purchasing plans interested in offering CARMA. The procurement process must require county-based purchasing plans to demonstrate compliance with federal and state regulatory requirements

and the ability to meet the goals of the program set forth in subdivision 2. The commissioner must review and approve or disapprove applications.

Subd. 5. **CARMA enrollment.** (a) Subject to paragraphs (d) and (e), eligible individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible individuals may enroll in fee-for-service medical assistance. Eligible individuals may change their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may offer a second health plan other than, and in addition to, CARMA to eligible individuals when another health plan is required by federal law or rule. The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

(e) The commissioner may, on a county-by-county basis, offer a health plan other than, and in addition to, CARMA to individuals who are eligible for both Medicare and medical assistance due to age or disability if the commissioner deems it necessary for enrollees to have another choice of health plan. Factors the commissioner must consider when determining if the other health plan is necessary include the number of available Medicare Advantage Plan options that are not special needs plans in the county, the size of the enrolling population, the additional administrative burden placed on providers and counties by multiple health plan options in a county, the need to ensure the viability and success of the CARMA program, and the impact to the medical assistance program.

(f) In counties where the commissioner is required by federal law or elects to offer a second health plan other than CARMA pursuant to paragraphs (d) and (e), eligible enrollees who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(g) This subdivision supersedes section 256B.694.

Subd. 6. **Benefits and services.** (a) County entities administering CARMA must cover all benefits and services required to be covered by medical assistance under section 256B.0625.

(b) County entities administering CARMA may include health-related social needs (HRSN) benefits as covered services under medical assistance as of January 1, 2030. Coverage for HRSN must be based on the assessed needs of housing, food, transportation, utilities, and interpersonal safety.

(c) County entities administering CARMA may reimburse enrollees directly for out-of-pocket costs incurred obtaining assessed HRSN services provided by nontraditional providers who are unable to accept payment via traditional health insurance methods. Enrollees must not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.

Subd. 7. **Payment.** (a) The commissioner, in consultation with counties administering CARMA, must develop a mechanism for the payment of county entities administering CARMA. The payment mechanism must:

(1) be governed by contracts with terms, including but not limited to payment rates, amended on an as-needed basis;

(2) pay a full-risk monthly capitation payment for services included in CARMA, including the cost for administering CARMA benefits and services;

(3) include risk corridors based on minimum loss ratio, total cost of care, or other metrics;

(4) include a settle-up process tied to the risk corridor arrangement allowing a county entity administering CARMA to retain savings for reinvestment in health care activities and operations to protect against significant losses that a county entity administering CARMA or the state might realize, beginning no sooner than after the county-entity's third year of CARMA operations;

(5) include a collaborative rate-setting process accounting for CARMA experience, regional experience, and the Department of Human Services fee-for-service experience; and

(6) be exempt from section 256B.69, subdivisions 5a, paragraphs (c) and (f), and 5d, and payment for Medicaid services provided under section 256B.69, subdivision 28, paragraph (b), no sooner than three years after CARMA implementation.

(b) Payments for benefits and services under subdivision 6, paragraph (a), must not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region. Payments for HRSN benefits under subdivision 6,

paragraph (b), must be in addition to payments for benefits and services under subdivision 6, paragraph (a).

Subd. 8. **Quality measures.** (a) The commissioner and county entities administering CARMA must collaborate to establish quality measures for CARMA not to exceed the extent of quality measures required under sections 256B.69 and 256B.692. The measures must include:

(1) enrollee experience and outcomes;

(2) population health;

(3) health equity; and

(4) the value of health care spending.

(b) The commissioner and county entities administering CARMA must collaborate to define a quality improvement model for CARMA. The model must include a focus on locally specified measures based on the counties' unique needs. The locally specified measures for the county entity administering CARMA must be determined before the commissioner enters into any contract with the county entity.

Subd. 9. **Data and systems integration.** The commissioner and county entities administering CARMA must collaborate to:

(1) identify and address barriers that prevent county entities administering CARMA from reviewing individual enrollee eligibility information to identify eligibility and to help enrollees apply for other appropriate programs and resources;

(2) identify and address barriers preventing county entities administering CARMA from more readily communicating with and educating potential and current enrollees regarding other program opportunities, including helping enrollees apply for those programs and navigate transitions between programs;

(3) develop and test, in counties participating in CARMA, a universal public assistance application form to reduce the administrative barriers associated with applying for and participating in various public programs;

(4) identify and address regulatory and system barriers that may prohibit county entities administering CARMA, agencies, and other partners from working together to identify and address an individual's needs;

(5) facilitate greater interoperability between county entities administering CARMA, agencies, and other partners to send and receive the data necessary to support CARMA,

counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations;

(6) support efforts of county entities administering CARMA to incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged; and

(7) support the creation and maintenance by county entities administering CARMA of an updated electronic inventory of community resources available to assist the enrollee in the enrollee's HRSN, including an electronic closed-loop referral system.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 3. **REQUEST FOR FEDERAL WAIVER.**

The commissioner of human services must seek all federal waivers and authority necessary to implement CARMA. Any part of the CARMA program that does not require federal approval shall have an effective date as specified in state law. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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