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		Referred to Human Services

A bill for an act

relating to human services; implementing the Program of All-Inclusive Care for the Elderly service delivery system; amending Minnesota Statutes 2024, sections 256B.69, subdivision 23; 256L.12, subdivision 9; 256S.02, subdivision 17; 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 23, is amended to read:

Subd. 23. **Alternative services; elderly persons and persons with a disability.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs

plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly persons with a disability, or persons with a disability only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

~~(b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]~~

~~(c)~~ (b) Before implementation of a demonstration project for persons with a disability, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

~~(d)~~ (c) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

~~(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older~~

~~who have been screened by the county and found to be eligible for services under the elderly waiver or community access for disability inclusion or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.~~

~~(f)~~ (d) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract year 2010 for services provided under the community access for disability inclusion waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance prior to implementation.

~~(g)~~ (e) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 2. **[256B.6902] PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY SERVICE DELIVERY SYSTEM.**

Subdivision 1. **Establishment.** The Program of All-Inclusive Care for the Elderly (PACE) is established as authorized under sections 1894, 1905(a), and 1934 of the Social Security Act.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

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

(c) "Eligible person" means a person who meets the eligibility requirements to enroll in PACE as defined in Code of Federal Regulations, title 42, section 460.150. Eligibility for medical assistance of a person receiving PACE services is controlled by sections 256B.055, 256B.056, 256B.059, and 256B.06.

(d) "PACE organization" means an entity as defined in Code of Federal Regulations, title 42, section 460.6, that is a not-for-profit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986.

Subd. 3. **Services for eligible persons.** The commissioner may include any or all of the services offered in medical assistance long-term services and supports in PACE coverage. The commissioner must provide all services and programs through PACE in accordance with Code of Federal Regulations, title 42, sections 460.90 to 460.106.

Subd. 4. **Enrollment.** (a) An eligible person may enroll in PACE.

(b) If an eligible person enrolls in PACE, the eligible person is not eligible for payment through other Medicare, medical assistance, or MinnesotaCare programs.

Subd. 5. **Disenrollment.** An eligible person may disenroll from PACE at any time.

Subd. 6. **Requirements.** (a) The commissioner must coordinate an extensive array of medical and nonmedical services to meet the needs of a PACE enrollee primarily in outpatient environments, including but not limited to an adult day center, the enrollee's home, or an institutional setting.

(b) The commissioner must administer PACE to:

(1) enhance the quality of life for enrollees;

(2) offer the potential to reduce the costs of the medical needs of enrollees, including costs of hospital and nursing home admissions;

(3) maintain enrollees in the community as an alternative to long-term institutionalization;

(4) provide optimum accessibility to various social and health resources to assist enrollees in maintaining independent living;

(5) coordinate, integrate, and link social and health services by removing obstacles that impede or limit improvements in delivery of those services;

(6) provide the most efficient and effective use of capitated money for the delivery of social and health services; and

(7) ensure that capitation payments comply with Code of Federal Regulations title 42, section 460.182.

Subd. 7. **Contracts with PACE organizations.** (a) The commissioner must only enter into PACE contracts with approved PACE organizations. A state readiness review must be performed before the commissioner enters into a contract with a PACE organization. The commissioner must only contract with PACE organizations that the commissioner determines have the ability and resources to effectively operate a PACE organization in accordance with Code of Federal Regulations, title 42, section 460.12.

(b) A PACE organization must have an agreement with the Centers for Medicare and Medicaid Services (CMS) and with the commissioner to operate. PACE contracts must include but are not limited to:

(1) a designation of the PACE organization's service area;

(2) a statement of commitment by the PACE organization to meet all applicable federal, state, and local requirements;

(3) the effective date and terms of the agreement;

(4) a description of the PACE organization's organizational structure;

(5) a copy of the participant bill of rights;

(6) a description of grievance and appeal processes;

(7) the policies on eligibility, enrollment, and disenrollment;

(8) a description of the services offered;

(9) a description of the PACE organization's quality improvement program;

(10) a statement of levels of performance required on standard quality measures;

(11) CMS and department data requirements;

(12) the Medicaid capitation rate or Medicaid payment rate methodology and the methodology used to calculate the medical assistance capitation rate;

(13) the procedures for program termination; and

(14) a statement by the PACE organization to hold CMS, the state, and PACE enrollees harmless if the PACE organization fails to pay for services performed by a provider in accordance with the contract.

(c) The commissioner must establish a competitive bidding process to solicit proposals from PACE organizations by December 31, 2025, or upon federal approval, whichever is later.

(d) PACE organizations awarded contracts by the commissioner must establish operations by June 30, 2026, and begin providing services on January 1, 2027.

(e) Contracted PACE organizations must use a risk-based financing model, assume responsibility for all costs generated by PACE enrollees, and create and maintain solvency according to federal regulations to cover any cost overages for any enrollee.

(f) Contracted PACE organizations must assume responsibility for all services listed under subdivision 3 as determined necessary for an enrollee by an interdisciplinary team, including but not limited to hospital and nursing home care.

Subd. 8. **Implementation.** By October 1, 2025, the commissioner must prepare and submit a state plan amendment to CMS to establish PACE and provide community-based, risk-based, and capitated long-term care services as optional services under the state plan; under contracts entered into between CMS, the commissioner, and PACE organizations meeting the requirements of Code of Federal Regulations title 42, sections 460.30 to 460.34; and under any other applicable law or regulation.

Subd. 9. **Payment rates.** (a) The commissioner must develop and implement a methodology for establishing payment rates for costs of benefits provided by PACE organizations to medical assistance-eligible PACE enrollees beginning July 1, 2025. The commissioner must implement the methodology by January 1, 2027.

(b) The methodology and rates must comply with applicable federal requirements and CMS rate setting rules and guidance. If required by federal law, the rate methodology for

PACE organizations must result in a payment amount no greater than the amount that would have been paid for comparable services provided by other programs under the state plan if the enrollee was not enrolled in PACE.

Subd. 10. **Commissioner's duties.** The commissioner must:

(1) establish a reimbursement system for services under PACE;

(2) develop and implement contracts with and set contractual obligations for PACE organizations, including but not limited to reporting and monitoring utilization costs of PACE organizations; and

(3) collect data from PACE organizations, including but not limited to encounter data for oversight, quality management, rate setting, and other similar purposes.

Sec. 3. Minnesota Statutes 2024, section 256L.12, subdivision 9, is amended to read:

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no

sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in ~~section~~ sections 256B.69, subdivisions 23 and 28, and 256B.6902, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the

health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in ~~section~~ sections 256B.69, subdivisions 23 and 28, and 256B.6902, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare

enrollees, excluding enrollees in programs described in ~~section~~ sections 256B.69, subdivisions 23 and 28, and 256B.6902, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Sec. 4. Minnesota Statutes 2024, section 256S.02, subdivision 17, is amended to read:

Subd. 17. **Managed care organization.** "Managed care organization" means a prepaid health plan or county-based purchasing plan with liability for elderly waiver services under sections 256B.69, subdivisions 6b and 23, 256B.6902, and 256B.692.