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S.F. No. 3612

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02/17/2026	6319	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health care; establishing a Patient-Centered Care program; authorizing direct state payments to health care providers; authorizing contracting with administrative services organizations; appropriating money; making conforming changes; amending Minnesota Statutes 2024, sections 62Q.1841, subdivision 1; 62U.03, subdivisions 1, 10; 62U.06, subdivision 2; 62W.14; 256B.021, subdivision 4; 256B.0625, subdivisions 56a, 58; 256B.072, subdivisions 1, 2; 256B.0757, subdivision 6; 256B.198; 256L.01, subdivision 7; Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 56; proposing coding for new law in Minnesota Statutes, chapter 256; repealing Minnesota Statutes 2024, sections 256B.0753; 256B.0755.

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

ARTICLE 1
PATIENT-CENTERED CARE

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, reduce the cost of health care for the state, and increase transparency and accountability for public health care programs. 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) The commissioner may contract with one or more administrative services organizations (ASOs) under section 256.9633 to process claims, pay bills, and perform other administrative functions. The ASO may not bear any risk and shall be paid only for the administrative functions specified in section 256.9633.

(c) 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 serve as the ASO for the county, unless a county requests that the commissioner take over the responsibility.

(d) In addition to the care coordination under subdivision 3, paragraph (b), the department may contract with CBPs, counties, FQHCs, and community-based programs with interdisciplinary teams to provide care coordination services. The teams shall collaborate with medical providers to provide services that include but are not limited to: (1) patient navigation; (2) assisting patients in maintaining eligibility in the program; (3) transportation services for health care; (4) interdisciplinary care planning; (5) chronic disease management; (6) specialist consultations to primary care; (7) case management services for patients with specialized care needs, including for those with serious mental illness and substance abuse disorders; (8) discharge planning and services, including medical respite and transitional care for patients leaving medical facilities and mental health and chemical dependency treatment programs; (9) behavioral health integration; and (10) culturally competent outreach. Budgets for these care coordination programs shall be based on cost of operations and community needs and not risk-based financial arrangements.

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

Subd. 2. **Definitions.** (a) "Administrative services organization" or "ASO" means an entity contracted by the Department of Human Services to perform administrative functions related to medical assistance and MinnesotaCare, including but not limited to claims processing, customer service and grievance resolution. An ASO shall not assume financial risk for the cost of medical assistance and MinnesotaCare services.

(b) "Care coordination" means a set of services provided by physicians, nurses, community health workers, behavioral health professionals, and other licensed health providers to ensure that patients receive appropriate, timely, and culturally responsive care.

Subd. 3. **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 shall be made on a fee-for-service basis.

(b) The commissioner shall provide flat care coordination payments to any primary care practice designated by a medical assistance or MinnesotaCare enrollee as the enrollee's primary care provider. The primary care provider shall provide general oversight of the enrollee's health and coordinate with any case manager of the enrollee. The commissioner shall encourage primary care practices to collaborate with community-based care coordination teams to ensure flexibility, cost-effectiveness, and responsiveness to patient needs.

(c) 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.

Subd. 4. **Community outreach.** The commissioner may provide funding through grants to community health clinics, FQHCs, 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 and CBPs shall assist patients to enroll in medical assistance or MinnesotaCare.

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

(1) ensure that medically necessary services are provided in a timely and equitable manner;

(2) recruit providers to ensure sufficient culturally competent and geographically distributed providers to meet patients' needs;

(3) provide data analytics and utilization monitoring to evaluate patterns and identify gaps in care;

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

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

(6) 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) make recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance to ensure provider reimbursement rates are reasonable and fair;

(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.

Subd. 6. **ASO data transparency.** (a) All contracts entered into by the department with administrative services organizations shall include provisions requiring full compliance with Minnesota applicable laws governing public access to government records and data. No private entity shall assert proprietary rights over data generated through publicly funded programs.

(b) The department shall develop and maintain a publicly accessible data dashboard that includes de-identified medical assistance and MinnesotaCare data for research, oversight, and community engagement. The dashboard shall be updated quarterly and shall include metrics related to usage, trends, and disparities. The department shall also publish an annual report summarizing these trends.

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, 2027.

Sec. 2. **[256.9633] CONTRACTING WITH ADMINISTRATIVE SERVICES ORGANIZATIONS.**

Subdivision 1. **Contracting for administrative functions.** (a) The Department of Human Services may contract with one or more administrative services organizations (ASOs) as defined in section 256.9632, subdivision 2, to perform administrative functions necessary for operation of the medical assistance and MinnesotaCare programs. These functions may include but are not limited to:

(1) processing claims to ensure accurate and timely reimbursement for covered services;

(2) providing customer service and grievance resolution to assist enrollees in navigating benefits, resolving disputes, and accessing care; and

(3) providing administrative support for care coordination programs, including scheduling assistance, documentation infrastructure, and technical support for interdisciplinary teams engaged in patient-centered care.

(b) Administrative services organizations shall not establish or maintain separate provider networks and shall include any qualified provider. All medical assistance and MinnesotaCare enrollees shall access care through a statewide provider network that is publicly managed. The Department of Human Services shall accept any qualified licensed health care provider who agrees to meet the requirements of the Patient-Centered Care program, medical assistance, and MinnesotaCare.

Subd. 2. **Fraud prevention.** (a) Notwithstanding the classification of data under chapter 13 as not public, the Department of Human Services Office of Inspector General shall have full access to records and data of the ASOs to audit procedures of the patient-centered care program in order to investigate and prevent fraud. The legislative auditor may coordinate reviews and investigations with the inspector general if coordination conserves resources and does not impede the progress of reviews and investigations.

(b) The inspector general shall annually report to the legislative auditor on the inspector general's audit of procedures.

Sec. 3. **APPROPRIATIONS.**

(a) $..... in fiscal year .... is appropriated from the general fund to the commissioner of human services for:

(1) transitioning of infrastructure and administrative systems from PMAP to patient-centered care systems and contracting with ASOs;

(2) establishing and maintaining the care coordination fund including provider outreach, enrollment, and performance monitoring;

(3) expanding provider recruitment, training, and retention programs with the emphasis on culturally competent care and services to underserved populations; and

(4) other objectives necessary to implement the patient-centered care program as determined by the commissioner.

(b) $..... in fiscal year .... is appropriated from the general fund to the commissioner of human services for care coordination services under Minnesota Statutes, section 256.9632, subdivision 1, paragraph (d).

(c) $..... in fiscal year .... is appropriated from the general fund to the commissioner of human services for grants to community health clinics and 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.

ARTICLE 2
CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 62Q.1841, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan" has the meaning given in section 62Q.01, subdivision 3. Health plan includes health coverage provided by a county-based purchasing plan participating in a public program under chapter 256B or 256L ~~or an integrated health partnership under section 256B.0755~~.

(c) "Stage four advanced metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other parts of the body.

(d) "Step therapy protocol" has the meaning given in section 62Q.184, subdivision 1.

Sec. 2. Minnesota Statutes 2024, section 62U.03, subdivision 1, is amended to read:

Subdivision 1. **Payment restructuring and care coordination payments.** (a) ~~By January 1, 2010,~~ Health plan companies shall include health care homes in their provider networks and ~~by July 1, 2010,~~ shall pay a care coordination fee for their members who choose to enroll in health care homes certified by the commissioner under this section. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under Minnesota Statutes 2024, section 256B.0753. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes. Health plan companies may reduce or reallocate payments to other providers to ensure that implementation of care coordination payments is cost neutral.

(b) ~~By July 1, 2010,~~ The commissioner of management and budget shall implement the care coordination payments for participants in the state employee group insurance program.

The commissioner of management and budget may reallocate payments within the health care system in order to ensure that the implementation of this section is cost neutral.

Sec. 3. Minnesota Statutes 2024, section 62U.03, subdivision 10, is amended to read:

Subd. 10. **Pediatric care coordination.** The commissioner of human services shall implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services. Care coordination services must be targeted to children not already receiving care coordination through another service and may include but are not limited to the provision of health care home services to children admitted to hospitals that do not currently provide care coordination. Care coordination services must be provided by care coordinators who are directly linked to provider teams in the care delivery setting, but who may be part of a community care team shared by multiple primary care providers or practices. For purposes of this subdivision, the commissioner of human services shall, to the extent possible, use the existing health care home certification and payment structure established under this section and Minnesota Statutes 2024, section 256B.0753.

Sec. 4. Minnesota Statutes 2024, section 62U.06, subdivision 2, is amended to read:

Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance periodic progress reports on the implementation of this chapter ~~and sections 62U.03 and 256B.0753 to 256B.0754~~.

Sec. 5. Minnesota Statutes 2024, section 62W.14, is amended to read:

62W.14 PROMPT FILLING FOR SPECIALTY DRUGS.

(a) A health carrier or pharmacy benefit manager that requires or provides financial incentives for enrollees to use a mail order pharmacy to fill a prescription for a specialty drug must ensure through contract and other means that the mail order pharmacy dispenses the prescription drug to the enrollee in a timely manner, such that the enrollee receives the filled prescription within seven business days of the date of transmittal to the mail order pharmacy. The health carrier or pharmacy benefit manager may grant to a mail order pharmacy an exemption from this requirement if the mail order pharmacy can document that the specialty drug was out of stock due to a delay in shipment by the specialty drug manufacturer or wholesaler. If an exemption is granted, the health carrier or pharmacy

benefit manager must notify the enrollee within 24 hours of granting the exemption and, if medically necessary, must provide the enrollee with an emergency supply of the specialty drug.

(b) For purposes of this section, "health carrier" includes managed care plans and county-based purchasing plans participating in a public health care program under chapter 256B or 256L~~, and integrated health partnerships established under section 256B.0755~~.

Sec. 6. Minnesota Statutes 2024, section 256B.021, subdivision 4, is amended to read:

Subd. 4. **Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with ~~sections 256B.0755 and~~ section 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit, and to impose a 180-day durational residency requirement in

MinnesotaCare, consistent with section 256L.09, subdivision 4, for adults without children, regardless of income.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka-Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services

provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

Sec. 7. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 56, is amended to read:

Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department as an eligible procedure under a state health care program for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(2) Medical assistance covers in-reach community-based service coordination that is performed through a hospital emergency department or inpatient psychiatric unit for a child or young adult up to age 21 with a serious mental illness who has frequented the hospital emergency room two or more times in the previous consecutive three months or been admitted to an inpatient psychiatric unit two or more times in the previous consecutive four months, or is being discharged to a shelter.

(b) Reimbursement must be made in 15-minute increments and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. For children and young adults with a serious mental illness, in-reach community-based service coordination includes navigating and arranging for

community-based services prior to discharge to address a client's mental health, chemical health, social, educational, family support and housing needs, or any other activity targeted at reducing multiple incidents of emergency room use, inpatient readmissions, and other nonmedically necessary health care utilization. In-reach services shall seek to connect them with existing covered services, including targeted case management, waiver case management, care coordination in a health care home, children's therapeutic services and supports, crisis services, and respite care. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c)(1) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, education, and peer support services, by working with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

(2) Hospitals utilizing in-reach service coordinators shall report annually to the commissioner on the number of adults, children, and adolescents served; the postdischarge services which they accessed; and emergency department/psychiatric hospitalization readmissions. The commissioner shall ensure that services and payments provided under in-reach care coordination do not duplicate services or payments provided under subdivision 20 ~~or section 256B.0753 or 256B.0755~~.

Sec. 8. Minnesota Statutes 2024, section 256B.0625, subdivision 56a, is amended to read:

Subd. 56a. **Officer-involved community-based care coordination.** (a) Medical assistance covers officer-involved community-based care coordination for an individual who:

(1) has screened positive for benefiting from treatment for a mental illness or substance use disorder using a tool approved by the commissioner;

(2) does not require the security of a public detention facility and is not considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(3) meets the eligibility requirements in section 256B.056; and

(4) has agreed to participate in officer-involved community-based care coordination.

(b) Officer-involved community-based care coordination means navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of jail utilization and connecting individuals with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination.

(c) Officer-involved community-based care coordination must be provided by an individual who is an employee of or is under contract with a county, or is an employee of or under contract with an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under Public Law 93-638 as a 638 facility to provide officer-involved community-based care coordination and is qualified under one of the following criteria:

(1) a mental health professional;

(2) a clinical trainee qualified according to section 245I.04, subdivision 6, working under the treatment supervision of a mental health professional according to section 245I.06;

(3) a mental health practitioner qualified according to section 245I.04, subdivision 4, working under the treatment supervision of a mental health professional according to section 245I.06;

(4) a mental health certified peer specialist qualified according to section 245I.04, subdivision 10, working under the treatment supervision of a mental health professional according to section 245I.06;

(5) an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5; or

(6) a recovery peer qualified under section 245G.11, subdivision 8, working under the supervision of an individual qualified as an alcohol and drug counselor under section 245G.11, subdivision 5.

(d) Reimbursement is allowed for up to 60 days following the initial determination of eligibility.

(e) Providers of officer-involved community-based care coordination shall annually report to the commissioner on the number of individuals served, and number of the community-based services that were accessed by recipients. The commissioner shall ensure

that services and payments provided under officer-involved community-based care coordination do not duplicate services or payments provided under section 256B.0625, subdivision 20, ~~256B.0753, 256B.0755,~~ or 256B.0757.

Sec. 9. Minnesota Statutes 2024, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** (a) Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). In administering the EPSDT program, the commissioner shall, at a minimum:

(1) provide information to children and families, using the most effective mode identified, regarding:

(i) the benefits of preventative health care visits;

(ii) the services available as part of the EPSDT program; and

(iii) assistance finding a provider, transportation, or interpreter services;

(2) maintain an up-to-date periodicity schedule published in the department policy manual, taking into consideration the most up-to-date community standard of care; and

(3) maintain up-to-date policies for providers on the delivery of EPSDT services that are in the provider manual on the department website.

(b) The commissioner may contract for the administration of the outreach services as required within the EPSDT program.

~~(c) The commissioner may contract for the required EPSDT outreach services, including but not limited to children enrolled or attributed to an integrated health partnership demonstration project described in section 256B.0755. Integrated health partnerships that choose to include the EPSDT outreach services within the integrated health partnership's contracted responsibilities must receive compensation from the commissioner on a per-member per-month basis for each included child. Integrated health partnerships must accept responsibility for the effectiveness of outreach services it delivers. For children who are not a part of the demonstration project, the commissioner may contract for the administration of the outreach services.~~

~~(d)~~ (c) The payment amount for a complete EPSDT screening shall not include charges for health care services and products that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 10. Minnesota Statutes 2024, section 256B.072, subdivision 1, is amended to read:

Subdivision 1. **Performance measures.** (a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with section 62U.02, subdivision 1, paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public website the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a website suitable for this purpose.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph (c), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

(f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve

socioeconomically complex patient populations and request to be scored on additional measures in this subdivision. This applies to all Minnesota health care programs, including for patient populations enrolled in health plans, county-based purchasing plans, or managed care organizations and for value-based purchasing arrangements, including, but not limited to, initiatives operating under sections 62U.03, ~~256B.0753, 256B.0755,~~ 256B.0756, and 256B.0757.

(g) Assessment of patient satisfaction with chronic pain management for the purpose of determining compensation or quality incentive payments is prohibited. The commissioner shall require managed care plans, county-based purchasing plans, and integrated health partnerships to comply with this requirement as a condition of contract. This prohibition does not apply to:

(1) assessing patient satisfaction with chronic pain management for the purpose of quality improvement; and

(2) pain management as a part of a palliative care treatment plan to treat patients with cancer or patients receiving hospice care.

Sec. 11. Minnesota Statutes 2024, section 256B.072, subdivision 2, is amended to read:

Subd. 2. **Adjustment of quality metrics for special populations.** Notwithstanding subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socioeconomically complex patient populations and request to be scored on additional measures in this subdivision. This requirement applies to all medical assistance and MinnesotaCare programs and enrollees, including persons enrolled in managed care and county-based purchasing plans or other managed care organizations, persons receiving care under fee-for-service, and persons receiving care under value-based purchasing arrangements, including but not limited to initiatives operating under sections 62U.03, ~~256B.0753,~~ ~~256B.0755,~~ 256B.0756, and 256B.0757.

Sec. 12. Minnesota Statutes 2024, section 256B.0757, subdivision 6, is amended to read:

Subd. 6. **Coordination.** The commissioner, to the extent feasible, shall ensure that the requirements and payment methods for designated providers developed under this section are consistent with the requirements and payment methods for health care homes established under ~~sections~~ section 62U.03 ~~and 256B.0753~~. The commissioner may modify requirements and payment methods under ~~sections~~ section 62U.03 ~~and 256B.0753~~ in order to be consistent with federal health home requirements and payment methods.

Sec. 13. Minnesota Statutes 2024, section 256B.198, is amended to read:

256B.198 PAYMENTS FOR NON-HOSPITAL-BASED GOVERNMENTAL HEALTH CENTERS.

(a) The commissioner may make payments to non-hospital-based health centers operated by a governmental entity for the difference between the expenditures incurred by the health center for patients eligible for medical assistance, and the payments to the health center for medical assistance permitted elsewhere under this chapter.

(b) The nonfederal share of payments authorized under paragraph (a) shall be provided through certified public expenditures authorized under section 256B.199, paragraph (b).

(c) Effective July 1, 2013, or no earlier than 12 months after implementation of a total cost of care demonstration project, Hennepin County may receive federal matching funds for certified public expenditures under paragraph (a), if the county participates in a total cost of care demonstration project under ~~sections 256B.0755 and~~ section 256B.0756, or another total cost of care demonstration project approved by the commissioner, and the county exceeds the minimum performance threshold established by the commissioner for the demonstration project. The value of the federal matching funds for the certified public expenditures allocated to Hennepin County shall be equal to the value of savings achieved above the minimum performance threshold. The same proportion of federal matching funds for certified public expenditure allocated to Hennepin County based on savings achieved under the demonstration project shall continue after the demonstration project and must continue to be paid to Hennepin County each year thereafter.

(d) Beginning July 1, 2014, or no earlier than 12 months after the initial allocation under paragraph (c) if a portion of the federal matching funds for certified public expenditure remains with the state, the commissioner shall annually determine if the savings from county's total cost of care demonstration project exceeded the savings from the previous year and allocate federal matching funds for certified public expenditures to Hennepin County equal to the amount of savings achieved above the amount achieved in the previous year. The proportion of federal matching funds for certified public expenditure allocated to Hennepin County shall be paid to Hennepin County each year thereafter, until no federal matching funds for certified public expenditures under paragraph (a) remain with the state.

~~(e) Nothing under this section precludes Hennepin County from receiving an additional gain-sharing payment or relieves the county from paying a downside risk-sharing payment to the state under the demonstration project under section 256B.0755.~~

Sec. 14. Minnesota Statutes 2024, section 256L.01, subdivision 7, is amended to read:

Subd. 7. **Participating entity.** "Participating entity" means a health carrier as defined in section

62A.01, subdivision 2; a county-based purchasing plan established under section 256B.692; ~~an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755;~~ an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

Sec. 15. **REPEALER.**

Minnesota Statutes 2024, sections 256B.0753; and 256B.0755, are repealed.

APPENDIX
Article locations for 26-06923

256B.0753 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

Subdivision 1. **Development.** 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 health care homes certified under section 62U.03 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. 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. 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.

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.

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.