DEPARTMENT OF HUMAN SERVICES

Legislative Report

County Administered Rural Medical Assistance (CARMA) Model Implementation

Minnesota Department of Human Services, Healthcare Administration

May 2025

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Contents

Executive summary

This report was created to provide recommendations and an implementation plan for a potential County Administered Rural Medical Assistance Program (CARMA) as required by statute. The report includes a summary of how the CARMA model was developed, as well as legislative requirements. Information appears in the report about the Steering Committee and each subgroup, including the members in each subgroup, and the subgroup recommendations. Finally, the report includes a section noting the implementation plan and a summary of future considerations.

Legislation

See Laws of Minnesota 2024, Chapter 127, Article 54, Sec. 10.

COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE MODEL.

Subdivision 1. **Model development.**

(a) The commissioner of human services, in collaboration with the Association of Minnesota Counties and county-based purchasing plans, shall develop a county-administered rural medical assistance (CARMA) model and a detailed plan for implementing the CARMA model.

(b) The CARMA model must be designed to achieve the following objectives:

(1) provide a distinct county owned and administered alternative to the prepaid medical assistance program;

(2) facilitate greater integration of health care and social services to address social determinants of health in rural communities, with the degree of integration of social services varying with each county's needs and resources;

(3) account for the smaller number of medical assistance enrollees and locally available providers of behavioral health, oral health, specialty and tertiary care, nonemergency medical transportation, and other health care services in rural communities; and

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

Subd. 2. **County participation.** The CARMA model must give each rural county the option of applying to participate in the CARMA model as an alternative to participation in the prepaid medical assistance program. The CARMA model must include a process for the commissioner to determine whether and how a rural county can participate.

Subd. 3. **Report to the legislature.** (a) The commissioner shall report recommendations and an implementation plan for the CARMA model to the chairs and ranking minority members of the legislative committees with

jurisdiction over health care policy and finance by January 15, 2025. The CARMA model and implementation plan must address the issues and consider the recommendations identified in the document titled "Recommendations Not Contingent on Outcome(s) of Current Litigation," attached to the September 13, 2022, e-filing to the Second Judicial District Court (Correspondence for Judicial Approval Index #102), that relates to the final contract decisions of the commissioner of human services regarding *South Country Health Alliance v. Minnesota Department of Human Services*, No. 62-CV-22-907 (Ramsey Cnty. Dist. Ct. 2022).

(b) The report must also identify the clarifications, approvals, and waivers that are needed from the Centers for Medicare and Medicaid Services and include any draft legislation necessary to implement the CARMA model.

Introduction

In 1997, the Minnesota Legislature passed bipartisan legislation allowing counties to select County-Based Purchasing (CBP) for delivery of Minnesota Health Care Programs (MHCP) as an alternative to a Health Maintenance Organization (HMO) administered MHCP. Thirty-two rural Minnesota counties currently conduct CBP through three county entities, individually and collectively called CBP plans. South Country Health Alliance was the first CBP plan operational under the new designation, which began in 2001. Itasca Medical Care (IMCare), though operational as a managed care plan since 1985, was designated a CBP plan in 2002, and PrimeWest Health began conducting CBP in 2003.

Despite the successful and long-running operation of CBP plans, counties have expressed frustration that the full vision of CBP has not been realized. Counties have filed legal action against the Department of Human Services (DHS) over county authority in procurement under the state's CBP laws. The most recent managed care procurement impacting CBP counties resulted in decisions about the selection of health plans to which counties objected. As a result, CBP counties requested mediation as provided for in Minnesota Statutes, section 256B.69, subdivision 3a(d). In 2022, the three mediators in that procurement cycle first proposed the County Administered Rural Medical Assistance (CARMA) model among their recommendations to the Commissioner. (See Appendix A for the Mediation Panel Report.) CARMA establishes a path forward for counties and DHS to work together to implement an enhanced CBP model. The aim is a new and innovative, county-based approach to serving public program enrollees that builds on the current CBP model in Minnesota (§ 256B.692) and other county-based models from around the country.

In early 2023, the Association of Minnesota Counties (AMC), the CBP plans, and DHS convened a collaborative workgroup with additional partners and subject matter experts to discuss a new county-based model. DHS Commissioner, the executive director of AMC, the three mediators who first proposed CARMA and the CBP plan CEOs were directly engaged from the beginning. They established a CARMA Steering Committee representing close collaboration among Minnesota counties and DHS. The Steering Committee worked to develop a model that distinguishes between county-owned-and-operated health benefits administration and traditional managed care models in rural Minnesota. The CARMA model leverages local integration of county services, focusing on

improving the health and well-being of enrollees while addressing the unique health needs, disparities, and challenges of people living in rural Minnesota.

In 2024, legislation passed (Laws of Minnesota 2024, chapter 127, article 54, section 10) requiring the DHS commissioner to report recommendations and an implementation plan for the CARMA model. This report addresses the legislative requirements and the 2022 mediation panel recommendations.

Management Analysis and Development (MAD) at Minnesota Management and Budget assisted with the design, planning, structure, and facilitation of the CARMA Steering Committee and subgroup meetings starting in March 2024. MAD also assisted with writing this report.

Steering Committee

The twenty-member CARMA Steering Committee includes leadership from the Minnesota Association of County Health Plans (MACHP), the AMC, the state's three CBP plans, DHS, and the 2022 procurement mediators, all of whom have expertise in county-based purchasing, health insurance, and health plan financing. The Steering Committee began meeting in spring 2023 and established common goals and objectives for a new county-based purchasing model in the form of a set of workgroup agreements (see Appendix B). The Steering Committee determined the various subgroups that would work on developing the new model.

Subgroups

General structure and rationale

The CARMA Steering Committee established seven subgroups to address key elements needed to establish the CARMA model. Subgroup members were selected based on their areas of expertise and interest; subgroups included Steering Committee members as well as representatives from other counties and partner organizations. The Steering Committee created detailed outcomes descriptions and charges for each subgroup (see Appendix C). Subgroups met to develop recommendations based on their charges and sent their recommendations to the Steering Committee for consideration and approval.

CARMA subgroups met beginning in the spring of 2024. Most subgroups met weekly, while the Legislative Subgroup met monthly, and some subgroups held joint meetings to address overlapping elements and issues. Subgroups adjusted their meeting dates and times as appropriate. The subgroups included subject matter participants from Big Stone County, Chippewa County, Clearwater County, Horizon Public Health (Douglas, Grant, Pope, Stevens, and Traverse Counties), IMCare and Itasca County, Kandiyohi County, Meeker County, MACHP, PrimeWest Health, Renville County, South Country Health Alliance (Brown, Dodge, Goodhue, Sibley, Steele, Waseca, and Wabasha Counties), Southwest Health and Human Services (Lincoln, Lyon, Pipestone, and Redwood Counties), Steele County, Swift County, Yellow Medicine County, and DHS. The subgroups completed their initial recommendations in early October 2024.

Model development and summary

Laws of Minnesota 2024, chapter 127, article 54, section 10 states the commissioner of human services, in collaboration with AMC and CBP plans, shall develop a county-administered rural medical assistance model and a detailed plan for implementing the model. The model must be designed with the following objectives:

- Provide a distinct county-owned and administered alternative to the prepaid medical assistance program
- Facilitate greater integration of health care, public health, and social services to address Health Related Social Needs (HRSN) in rural communities, with the degree of integration of social services varying based on each county's unique needs and resources
- Account for the smaller number of medical assistance (MA) enrollees and locally available providers of behavioral health, oral health, specialty and tertiary care, nonemergency medical transportation, and other health care services in rural communities; and
- Promote greater accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

In addition to these objectives, subgroups established components of the model that would improve data sharing and availability, work to streamline applications and enrollment, address the financial uncertainty inherent in operating risk-based contracts with smaller numbers of enrollees, and establish a more collaborative method of working together through the contracting and rate setting process.

The model as designed by the subgroups with approval by the Steering Committee includes but is not limited to the following components (see Appendix C for a full list):

- CARMA will be a "managed care" program under the federal definition and will have a comprehensive risk contract with prospective rates paid on a per member per month basis.
- CARMA will include risk corridors to mitigate the risk associated with a new model serving a smaller, rural population.
- CARMA will be available for all populations currently covered under the Prepaid Medical Assistance Program (PMAP), and non-dually eligible Special Needs BasicCare (SNBC) enrollees, combined into one population. The Steering Committee will determine which contract(s) will include duals not enrolled in integrated products.
- CARMA will include the current benefits covered by managed care as well as Community First Services and Supports (CFSS) for the PMAP and SNBC population.
- CARMA will include an extended list of in-lieu-of services to more effectively address CARMA enrollees' needs.
- CARMA will be the only managed care option available for the PMAP and non-dual SNBC population. Enrollees can choose to opt out into fee-for-service MA once annually. People who have opted out of CARMA can also choose to opt in annually.
- CARMA will use the definition of "rural" included in the federal managed care regulation.

Implementation Plan

Pending legislative authorization, CARMA could be implemented for coverage beginning January 1, 2027. The following implementation plan includes the major items and estimated date of delivery, based on legislative enactment in the 2025 session.

CARMA Model Element	Description	Estimated date of delivery, modeled on legislative enactment in 2025
Technology project initiated	DHS to initiate IT projects to allow for CARMA voluntary enrollment, enrollee communications, and other activities for implementation.	Begins July 1, 2025, and completed by September 1, 2026
Request for Proposals (RFP)	DHS to issue an RFP for CARMA participation in the current CBP counties. RFP will include elements determined by the CARMA Steering Committee and DHS.	Fall 2025
RFP awards	Award letters sent to applicant CBP counties outlining the contracting process and timeline.	Spring 2026
Development of member notices and materials	Work to develop new enrollee notices and revise any existing member materials that require updating.	Begin spring 2026 and conclude by September 2026
Contract negotiations	Contract and rate development for 2027 contracts.	Late spring/early summer 2026
Contracts submitted to CMS	All managed care contracts are required to be submitted to CMS for approval.	Due by October 1, 2026

Enrollment begins	Enrollment into CARMA will begin during the annual health plan selection. DHS will work with counties, CBP plans, and HMOs to make member transitions smooth and accurate	October 2026

Future considerations

The CARMA model would be implemented in phases. CARMA subgroups have identified immediate, near, and long-term elements. The Steering Committee would reconvene and form new subgroups as needed to detail additional phases of the model.

- The second phase of CARMA implementation will incorporate a health-related social needs (HRSN) waiver that will help address housing insecurity, food insecurity, transportation, utilities, and interpersonal safety, to be based upon individual enrollee assessments.
- Future phases of CARMA will explore including disability waiver services. If included, CARMA plans can merge their Minnesota Senior Health Options (MSHO) and I-SNBC products to offer them under one contract.
- Future phases of CARMA will explore covering children with disabilities in the model.
- Work will continue to allow county staff working on CARMA programs to review individual eligibility information to assess eligibility and assist with applications for all county administered social services.
- Future phases of CARMA will support interoperability between CBP plans, agencies, and other partners to support the CARMA program, counties, and local health system efforts to improve the health and welfare of CARMA enrollees.
- Work will continue to implement a statewide community resource directory that will allow health care and human services providers to send electronic referrals that are confirmed by the organizations providing the services.
- Community engagement: In alignment with federal enrollee engagement language, there will be continued meaningful community engagement, specifically with representative populations currently served by CBP.

Appendices

Appendix A: Mediation panel recommendations

In August 2022, a mediation panel provided several recommendations for consideration. The contents below come from the panel's recommendation document.

Recommendations Not Contingent on Outcome(s) of Current Litigation

August 30, 2022

Commissioner Jodi Harpstead
c/o Alexandra McDonough
Minnesota Department of Human Services
Elmer L. Andersen Human Services Building
540 Cedar St.
St. Paul, MN 55101

Submitted via email to alexandra.mcdonough@state.mn.us

Dear Commissioner,

The undersigned constitute the three-person mediation panel (hereinafter "the Mediation Panel" or "the Panel") pursuant to Minn. Stat. § 256B.69, subd. 3a(d) and offer the following recommendations with respect to the 33 counties that requested mediation regarding the Minnesota Department of Human Services' procurement of Medical Assistance managed care grant contracts for the Seniors, Special Needs Basic Care (SNBC), and Families and Children programs. Throughout our discussion, when we refer to county-based purchasing (CBP) counties or to a particular CBP's counties (e.g., PrimeWest counties), we are referring to those counties that sought mediation with respect to the procurement process for particular programs in their county.

Context

While the following may be evident to you, the Panel believes it is important to articulate some of our perceptions and understandings for the record.

1. Issues and interpretations of counties' roles in Medicaid managed care have a long, contentious and, at times, confusing history in Minnesota. Many of the issues and disputes raised in the mediation process concern differences of opinion or interpretation of that history, and the significance of historical decisions, legal or regulatory changes, etc.

2. County-based purchasing (CBP) is a creature of state law. It has a long and proud history of innovation and service for people enrolled in Medical Assistance and MinnesotaCare. The CBP model has qualities that can have advantages over other models, especially when it comes to the integration of health care, social

services, housing, transportation, law enforcement, and other county functions, as well as greater understanding of and responsiveness to local needs and priorities.

3. The Minnesota Department of Human Services (DHS), the Association of Minnesota Counties, and the Minnesota Association of County Social Service Administrators, should be commended loudly and publicly for the time, effort, and commitment they devoted to exploring how to improve the procurement process and build stronger collaborations. The current disputes threaten to obscure the progress made, especially with respect to dramatically increasing all counties' contributions to identifying the objectives of managed care procurements, developing the questions to be included in the Requests for Proposals (RFPs), defining how responses would be scored, and perhaps most significantly, the ultimate weight that would be given to counties' scoring of the RFP responses relative to the weight of DHS' scoring.

4. Employees working for counties and for DHS are deeply committed public servants who dedicate themselves to achieving the best possible outcomes for Minnesotans and members of sovereign tribes, especially those people who are or will be enrolled in Medical Assistance or MinnesotaCare. They take their roles and responsibilities seriously and pursue them in good faith. The issues in dispute in no way reflect ill intent, willful disregard of laws or standards, or a lack of effort. Again, they should be loudly and publicly commended for their work and contributions to Minnesota's health coverage programs.

5. Minnesota's state elected officials, DHS, counties, and advocacy groups representing stakeholders in our health coverage programs, have left known disputes and ambiguities about our state law requirements, and their application to county-based purchasing in the larger context of federal laws and regulations, unaddressed for at least seven years. Neither the 1.5 million Minnesotans enrolled in our health coverage programs, the counties and their employees, DHS and its employees, private managed care organizations (MCOs), Minnesota's health care providers, nor Minnesota taxpayers have benefited from this inaction. Regardless of the outcome(s) of the current litigation and procurement, the Panel recommends state statutory changes.

Despite this lack of clarity and related challenges, county-based purchasing has led to many important innovations in managed care methods with health policy significance and excellent outcomes. As with any structure or system that has been in place for decades, and especially one that has resulted in strained relationships between counties and DHS and disruptions of efficient program administration, there are times when a significant reform or evolution is necessary to reimagine and reposition for the future.

Minnesota has a tradition of innovative and successful health reforms. Elected officials, DHS, counties, policy makers, and health care stakeholders should consider reforms and innovations that will build on and improve our current system, further integrate public health coverage programs with social services and community supports at the local level, and share risks and accountability in new ways designed to drive improved health outcomes for enrollees while enhancing stewardship for taxpayer dollars.

Recommendations Contingent on Outcome(s) of Current Litigation

The Panel understands that litigation on almost identical issues is underway. We recognize the limits of our authority to make recommendations vis-à-vis the binding authority of the district court's pending decision which

will carry the force of law. Since DHS must comply with the court's ultimate decision, below are two sets of recommendations depending on the outcome of the litigation. In addition, we have provided other recommendations for your consideration that do not depend on the outcome(s) of the court's decision regarding future legislation and policy matters.

If the district court rules that DHS is legally obligated to award single-plan contracts to CBPs, then the Panel recommends the following:

1. Proceed with negotiating and executing contracts under this procurement in accordance with the following recommendations. In other words, we recommend against cancelling the procurement process at this stage.

2. Award contracts to each CBP in its respective counties for PMAP and the Seniors Programs, and do not award contracts to any private MCOs in those counties for those programs.

3. Award contracts to each CBP in its respective counties and one other private MCO in those counties for the MinnesotaCare program, as required under federal law.

4. Award contracts in the PrimeWest counties and SCHA counties for SNBC, and do not award contracts to any private MCOs in those counties for this program.

5. Seek clarification from the Itasca County Board of Commissioners regarding its preferences for plans in SNBC and accord those preferences the appropriate weight in applying DHS' policy regarding single-plan contracts for SNBC.

   Although Itasca County did not respond to the RFP for SNBC, the county did seek mediation for SNBC and raised concerns about DHS' plan selections in its mediation statement. During mediation the Panel discovered what appears to be a simple miscommunication with respect to the County's preferences for this contract.

6. According to representatives participating in the mediation on behalf of the County, Itasca County preferred to have only one Medicaid plan serving SNBC in its county and believed that Medica's RFP response received the highest score. Accordingly, the County expressed its preference for DHS to contract exclusively with Medica.

   However, under DHS' policy regarding contracting with any Medicaid plan already serving the SNBC Programs in a county, DHS selected UCare for a contract because UCare already serves SNBC in Itasca County. DHS reasonably interpreted the County's preference on its form to mean that the County wanted DHS to add Medica as another MCO along with UCare for SNBC. Accordingly, DHS has proceeded with the selection of both UCare and Medica to serve Itasca County residents enrolled in SNBC.

   Itasca County representatives indicated that if they realized that UCare's proposal received the highest score, the County Board would have expressed its preference for DHS to contract with UCare exclusively. And, because UCare already serves the SNBC Programs in the county and its proposal received the highest

score, UCare might be eligible for a single-plan contract under DHS' policy for this procurement. In other words, it is more important to Itasca County for DHS to contract with a single plan to administer SNBC than whether DHS contracts with UCare or Medica.

In light of this, the Panel recommends that DHS seek clarification from the Itasca County Board regarding its preferences for the plan(s) in SNBC and accord those preferences the appropriate weight in applying DHS' policy regarding single-plan contracts in SNBC.

7. Inform CMS that the State is exercising its authority to enter single-plan contracts after conducting a competitive procurement in accordance with existing federal law exceptions allowing single-plan contracts in rural communities and counties operating a CBP before 1986 and pursuant to the district court's ruling.

If the district court rules that DHS is not legally obligated to award single-plan contracts to CBPs, then the Panel recommends the following:

DHS articulated reasonable policy interests for providing enrollees with a choice of at least two plans including enrollee empowerment, concerns about privacy and local government functions, language and cultural considerations, continuity of care when changing programs, and maintenance of unique Medicare benefits. The CBP counties also articulated reasonable policy interests including higher administrative costs for county agencies and financial impacts that could jeopardize their respective CBP plan's viability and/or capacity to sustain their distinct model and mission. With enhanced enrollee assistance to support choice of health plans as required by the recently updated federal Medicaid managed care regulations, enrollees should have the opportunity to exercise plan choice especially those for whom the factors highlighted by DHS are paramount, and the actual enrollment impact of the respective policy interests will be learned.

1. Proceed with DHS' plan selections for contracts in the Seniors and MinnesotaCare programs in each of the CBP counties.

2. Proceed with DHS' plan selections for contracts in SNBC in each of the PrimeWest counties and SCHA counties.

3. Seek clarification from the Itasca County Board regarding its preferences for plans in the SNBC eligibility category and accord those preferences the appropriate weight in applying DHS' policy regarding single-plan contracts in SNBC for the reasons stated in #5 above.

4. Award IMCare a single-plan contract for PMAP in Itasca County.

   As described above, DHS and Itasca County articulated reasonable policy interests and concerns, respectively, if two plans are offered. Because IMCare operates exclusively in Itasca County, selecting two plans to serve the small number of enrollees in this county seems likely to result in IMCare losing economic viability. In the recent past, even with single-plan status, the Minnesota Department of Health exercised its regulatory oversight responsibility to require IMCare to develop and adhere to a corrective action plan to ensure it had sufficient capital to cover its medical loss risks.

Therefore, awarding contracts to two plans in Itasca County seems likely to cause one plan to leave the market during the contract and ultimately result in the same situation DHS is trying to avoid: a single plan administering the PMAP program and two plans administering the MinnesotaCare program. Because that outcome seems likely (if not inevitable) if DHS proceeds with contracting with two plans, the Panel recommends entering a single-plan contract with the CBP that already serves this population, rather than putting some enrollees through the upheaval of losing their plan and ending up with a single private MCO that does not have IMCare's years of experience operating in the county.

5. Proceed with DHS' selections of plans for contracts in the PMAP program in the PrimeWest counties and in the SCHA counties.

6. Designate CBPs as the default plan in each program in the CBP counties, except for SNBC in Itasca County. No one can predict with certainty the market dynamics and outcomes of the change to contracting with multiple plans in many of the CBP counties. Granting CBPs the default plan status mitigates the likelihood that these arrangements will cause plans to leave counties during the contract period.

7. Reexamine processes regarding the Medical Assistance and MinnesotaCare managed care procurements to prevent actual or perceived conflicts of interest with respect to counties actively helping DHS develop and score RFPs and, at the same time, operating CBPs that respond to those same RFPs, and then seek necessary process or statutory changes to protect the integrity of the procurement process.

Recommendations Not Contingent on Outcome(s) of Current Litigation

As stated above, many of the issues disputed in this mediation process have been known and disputed for several years. The Panel recommends that DHS, ideally in collaboration with counties and other stakeholders, pursue the following:

1. Share DHS' decisions on procurement policy issues that are known to be of significant interest to the counties in advance of issuing RFPs so counties have an opportunity to explain their concerns or offer alternatives. While the Panel understands the reasons underlying DHS' decision to pursue contracts with more than one plan in every county for PMAP, and that DHS likely believed that counties knew about DHS' positions regarding plan choice, the value of the relationships between the agency and counties would benefit from allowing more time for counties to provide their feedback and suggestions.

2. While many counties may not have been confused by the group scoring methodology used in this procurement process, it was apparent that some counties were confused about whether plan selection decisions would be based on an individual county's scores for plans in its county or, as DHS intended, that plan selection decisions would be based on the aggregate scores of the respective group of counties. It is impossible to avoid every miscommunication or misunderstanding in a process that is so complex and involves so many components. Nevertheless, this area of confusion should be easy to avoid in future procurements.

3. Seek legislative changes to the mediation process described in Minn. Stat. § 256B.69, subd. 3a(a) to require future mediation panels to submit their recommendations to the Commissioner by a date certain to ensure that DHS has a meaningful opportunity to consider the recommendations, make any changes to its plan selections or contract terms, and meet CMS' deadlines for executed contracts to be delivered for federal approvals. Under the current statutory language, a mediation panel could fail to make recommendations before it is too late for them to be considered.

4. Seek legislation to replace the current CBP model with a clearer, more efficient, and more distinct and innovative model that would more closely embody the Legislature's original intent to create a county-administered alternative to the managed care PMAP program with private MCOs. The new program, referred to here as County Administered Rural Medical Assistance (CARMA), builds on the success of CBPs with the following objectives:
   a. Creating a more meaningful county-administered alternative to managed care as originally intended by the Legislature;

   b. Fostering greater integration of health and social services to better address social determinants of health in rural communities;

   c. Accounting for the smaller numbers of enrollees and of locally available providers, especially for specialty and tertiary care, in rural communities; and

   d. Promoting greater accountability for health outcomes, health equity, customer service, community outreach, and costs of care.

   Each rural county, as designated under federal law, would have authority to decide whether to participate in either the PMAP program or the CARMA program. A county that chooses the PMAP program would do so in the same or similar manner as counties without CBP plans do today.

   If a county chooses to participate in the CARMA program, DHS would not administer the PMAP program or contract with private MCOs in that county. Instead, DHS would contract with the county under a global budget model for all Medical Assistance covered services. Counties would accept financial risk within risk corridors for the total Medical Assistance expenditures for their county residents enrolled in Medical Assistance. Legislators, DHS, and counties should consider whether this calculation of Medical Assistance expenditures should be based on annual spending or whether at least some components of the calculation or other incentives should be based on spending over a longer time horizon, such as three or five years, to encourage counties and their health care providers to incur short-term spending that will produce longer-term savings. CARMA would be distinct from current Medicaid managed care by its use of a global budget that includes all Medicaid-covered benefits; a formal structure for ongoing DHS / county partnership for the development, evaluation and refinement of key outcome measures; and the inclusion of all Medicaid eligible populations, other than those enrollees who have a right to choose to receive services through the fee-for-service program.

As already authorized under state law, counties wishing to operate jointly under the CARMA program could do so through a joint powers agreement, thereby enabling them to benefit from economies of scale, reductions in duplication, etc.

Legislation should provide flexibility for counties participating in the CARMA program and DHS to develop metrics, incentives, risk corridors, accountability standards, and other components that might evolve to address community needs. In addition, the legislation and DHS policy should create oversight, auditing, and other appropriate controls to ensure stewardship of public resources, compliance with federal and state requirements, efficient and effective operations, etc. in the absence of the competitive procurement process and market forces.

Given the federal government's heightened interest in accountable care organization and global budget models, as well as rural health reforms with strong local buy-in and accountability, the Panel believes that CMS might be more receptive to a waiver request for a non-competitive, county-administered program framed in this manner than its predecessor was in 1999.

Depending on the degree of interest and cooperation from CMS, the Panel suggests exploring a § 1332 waiver to include allowing counties in the CARMA program to administer MinnesotaCare as well, thereby expanding the population under the global budget model, increasing efficiencies and economies of scale, reducing administrative burdens and costs of MinnesotaCare managed plan procurements, and simplifying public health programs and reducing churn for enrollees.

Thank you to the Association of Minnesota Counties for the opportunity to participate in this mediation process and contribute to Minnesota's health coverage programs. We hope our recommendations are helpful as you make these critically important decisions on behalf of the people of Minnesota.

Respectfully,

John D. Klein, Marie Dotseth, and Matthew L. Anderson

Appendix B: Areas of Agreement Document

The CARMA Steering Committee finalized this list of agreements in August of 2023.

AREAS OF AGREEMENT TOWARD A NEW COUNTY-BASED MODEL WITH CARMA AS OUR STARTING POINT:
This list is intended to capture areas of agreement about what we want a new county-based model to accomplish. While we have agreed the CARMA framework is a good place to start, we have also expressed willingness to depart from that framework if doing so will accomplish our shared objectives.

1. The CARMA model is a sound framework to start assessing a next iteration of a county-based public programs model. *(Agreed.)*
2. The goals and objectives of the CARMA model are valid and would address several issues raised with the current managed care and procurement approach. *(Agreed.)*
3. The final model will place top priority and focus on improving the health and well-being of enrollees. *(Agreed.)*
4. The final model will define "rural" or other mechanisms for determining which counties are eligible to participate for initial implementation. (We have not taken a position on whether or not expanding the model or a version of it to larger/urban counties has merit.) *(Agreed.)*
5. The final model will address the unique needs and challenges of people living in Minnesota's rural communities in a locally responsive and accountable manner. *(Agreed.)*
6. * The final model will address the needs of rural health care providers, including partnering with them in strengthening local capacity and access. *(Agreed, but with the caveat we "will incorporate" the needs of rural providers, and this objective involves "many stakeholders.")*
7. * The final model will allow counties and DHS to enter into more comprehensive arrangements in which other county services are included, leveraged, and/or accounted for to further address social drivers of health (SDOH) and support more integrated care and services delivery. *(Agreed, but with the caveat we will need to "explore" such arrangements before incorporating them.)*
8. The final model will incorporate best practices addressing health care disparities pertaining to race, ethnicity, disability status, sexual orientation, gender identity and geography. *(Agreed.)*
9. * The final model will include multi-year global budgeting, including clear definition of what "global budget" means, encompasses and what constitutes appropriate reimbursement. *(Agreed, but with the caveat we will need to "explore this" in greater detail, including examining "other models' and with the understanding this will need to be approached "incrementally".)*
10. * The final model will incorporate all MA services possible and desirable. We understand there are likely services that fall outside of managed care that counties might not want to include in a global budget and, conversely, services that DHS feels are better handled through fee for services (FFS) (such as organ transplants).

We expect this will require engagement with advocates, state and federal stakeholders. *(Agreed, but with the further caveat we will "need to explore" what is allowed or can be allowed, what makes sense, and with respect for "county-specific" flexibility.)*

11. The final model will address challenges arising from a multi-year global budget model, such as how to accommodate legislated benefits changes, new drugs or technologies, CMS regulatory developments, etc. *(Agreed.)*

12. The final model will include a mechanism for addressing failure to meet outcomes or budget targets, as well as other accountability or service expectations that DHS and counties would identify and agree to through the contracting process. *(Agreed.)*

13. The final model will distinguish between county-owned-and-operated health benefits administration and other models of fee-for-service and managed care. *(Agreed. We also agreed we "will not let old definitions restrict us" and we will focus on what makes this model "distinct and unique".)*

14. The final model will specify financial details including risk sharing or mitigation mechanisms, reserve requirements, and approaches to provider payments. *(Agreed.)*

15. The final model will specify how counties will exercise their choice between either private PMAP plans, or the county-based model. *(Agreed. We added this will include specifying how counties may exit the model.)*

16. The final model will define efficient mechanisms for ongoing collaboration and program administration between counties and DHS, as well as appropriate methods for program oversight that provide necessary accountability and transparency without undue administrative burdens. *(Agreed. We will need to further define "undue burdens" and noted "audits" as an area of opportunity.)*

17. In developing the final model, we will consider best practices from other states utilizing county-based, global budgeting, or other rural-relevant models. *(Agreed.)*

18. We will collaborate in passing enabling legislation to implement the final model. *(Agreed.)*

19. We anticipate needing and will work jointly and proactively to obtain any necessary CMS clarifications, approvals, or waivers for implementing the final model. *(Agreed.)*

The following were added based on our discussions 6-26-23:

20. The final model will incorporate a process of ongoing evaluation and adjustment of the model.

21. We will define populations to be served by this model, and under what circumstances enrollees could opt out of the model.

22. The final model will encourage enrollee empowerment, more clearly define "choice", and consider how "choice" ultimately benefits enrollees.

23. The final model will address effective enrollee education, communication and engagement so they understand what they are getting and have input to improving the model.

Appendix C: Subgroup descriptions, charges, and membership

The following table provides a brief description of each subgroup, its charges (as determined by the Steering Committee), and a list of subgroup members based on their affiliation with the CBPs, counties, other partners, or DHS, and the number of meetings each subgroup completed.

Subgroup	Description	Charges	Membership	Number of meetings
Benefits and Services	• Determine the benefits covered in the CARMA model. • Address whether all county entities administering CARMA will offer the same benefits and services or if variation is permitted. • If variation is permitted, recommend how that would function.	• Recommend benefits and services to be included in CARMA. • Benefits and services should incorporate all covered MA services, including those not currently covered under managed care as well as new benefits or services that would support the CARMA model. • Consider services to address health-related social needs. • Recommend state plan services to be included in CARMAs. • Identify other benefits and services that could be included in the CARMA program.	• CBP plans: 12 • Counties/Other partners: 5 • DHS: 4	• 13
Data and Systems Integration	• Determine IT systems and data-sharing optimization opportunities for future integration among counties administering CARMA, DHS, and other partners.	• Identify IT systems, data sharing, and integration improvements needed to optimize the integration potential of the CARMA model (including between counties administering CARMA, DHS, county agencies, and other service providers) and to efficiently support performance measurements and reporting. • Determine ways to efficiently support performance measurements and reporting.	• CBP plans: 9 • Counties/Other partners: 3 • DHS: 4	• 12

Subgroup	Description	Charges	Membership	Number of meetings
Finance	• Identify issues associated with the financial structure of CARMA, in the context of the overall state Medicaid Plan.	• Recommend structures and practices to budget accurately for covered services, local initiatives to improve long-term outcomes and efficiencies, and ensure the financial integrity of CARMA. • Determine financial regulation, reporting, and oversight appropriate for CARMA. • Recommend statutes and rules for regulating CARMA.	• CBP plans: 7 • Counties/Other partners: 2 • DHS: 5	• 19
Legislative	• Develop legislative language and strategy, through guidance from the Steering Committee and subgroups, to address the vision of CARMA	• Develop proposed legislative language for the initial implementation of CARMA.	• CBP plans: 8 • Counties/Other partners: 1 • DHS: 3	• 10
Oversight and Regulation	• Establish the framework for DHS oversight and ongoing maintenance of the CARMA model. • Determine how DHS and counties would work together effectively under the new CARMA model and build on the strengths of state and county governments.	• Recommend a framework for DHS and other state agency evaluation of the CARMA model and oversight of existing county entities administering CARMA, including plans for oversight, auditing, and other appropriate controls to ensure stewardship of public resources, compliance with federal and state requirements, and efficient and effective operations. • Recommend a structure for ongoing work between DHS and county entities administering CARMA to allow for program evaluation, changes, and improvements, strengthening the working relationships between DHS and counties to improve CARMA over time.	• CBPs: 9 • Counties/Other partners: 1 • DHS: 4	• 12

Subgroup	Description	Charges	Membership	Number of meetings
Performance Improvement and Measurement	• Identify issues associated with improving outcomes through the CARMA model. • Determine initial CARMA performance measures.	• Programs, structures, and practices for improving members' experience and outcomes, population health, health equity, and the value of health care spending compared to PMAP and/or fee-for-service • Develop performance measures with reasonable duration. • Focus on locally specific measures based on counties' unique needs.	• CBP plans: 7 • Counties/Other partners: 4 • DHS: 4	• 13
Population Expansion	• Determine the work necessary to expand CARMA to people dually eligible for Medicare and Medical Assistance and MinnesotaCare. • Make recommendations about the initial populations to be covered.	• Determine whether all county entities administering CARMA will serve the same MHCP populations or if variation is permitted. If variation is permitted, the subgroup should recommend how that would function. • The Steering Group has determined that initially CARMA will include Medical Assistance (MA) populations under age 65, and the MA-only SNBC population. • Determine the steps needed to include duals in the CARMA model.	• CBP plans: 9 • Counties/Other partners: 4 • DHS: 3	• 14

Appendix D: Subgroup Recommendations Approved by the Steering Committee

The following is a spreadsheet used to track all subgroup recommendations to the CARMA Steering Committee. Some of the recommendations considered and approved by the Steering Committee have not been included in the initial CARMA legislation and will be considered for future implementation as the CARMA model evolves or will be addressed in the contracting process. The Steering Committee views this phased approach as pragmatic and important to the overall success of the CARMA model.

Subgroup	Recommendation	Date Approved by Steering Committee
A. Benefits and Services	1. In the CARMA model, state plan benefits will be used first, then in-lieu-of services, then community services and resources, and then flexible funds to address HRSN (with a needs assessment)	8/15/24
A. Benefits and Services	2. For CARMA, keep RHCs the way they are for now	9/17/24
A. Benefits and Services	3. The CARMA model to have infrastructure that allows county entities administering CARMA to reimburse members directly for assessed health-related social needs provided by non-traditional providers who are unable to accept payment via traditional health insurance methods. Members will not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.	9/17/24: Conditionally approved with revisions 9/23 conditionally approved
A. Benefits and Services	4. Expand officer-involved care coordination to all CARMA counties	9/17/24: Approved with an acknowledgment that this will need more investigation and likely be considered in a later phase
A. Benefits and Services	5. An assessment of CARMA benefits and service needs should be completed with the current health risk assessment when a member enrolls in CARMA. This would include a reassessment when a change in life situation or condition occurs.	9/17/24
A. Benefits and Services	6. Health-related social needs assessment is offered to all members seeking enhanced health-related social needs benefits. Members must complete the assessment and be determined eligible to receive the enhanced benefits. Once the assessment is completed, members will be reassessed annually or when a life change occurs.	9/23/24
A. Benefits and Services	7. The enhanced health-related social needs benefits will be based on assessed needs in the following domains: Housing, Food, Transportation, Utilities, Interpersonal Safety, and provided and financed akin to home and community-based services under the Elderly Waiver program.	9/23/24
B. Data Integration	1. Allow county entities administering CARMA the ability to review individual eligibility information to identify program eligibility and help members apply for appropriate programs and resources.	9/17/24: Conditionally approved with some additions
B. Data Integration	2. Allow county entities administering CARMA to more readily communicate and educate potential and current members regarding other program opportunities, including helping members apply and navigate transitions between programs.	9/17/24
B. Data Integration	3. Creation of a universal application form to apply for public programs.	9/17/24
B. Data Integration	4. Identify and address regulatory and system barriers that would prohibit county entities administering CARMA, agencies, and other partners from working together to holistically identify and address an individual's needs. For example, eligibility workers.	9/17/24
B. Data Integration	5. Recognize county entities administering CARMA as counties	9/23/24
B. Data Integration	6. Require interoperability between county entities administering CARMA, agencies, and other partners to send/receive the data necessary to support CARMA, counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations.	9/23/24
B. Data Integration	7. Incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged.	9/23/24
C. Finance	1. CARMA contracts will be procured on a multi-year contract cycle with rates and contract terms amended at least annually or as needed.	9/23/24
C. Finance	2. The model will include an add-on payment for services to address health related social needs that operate like the elderly waiver payment does today.	9/23/24
C. Finance	3. The financial model includes two-sided risk corridors tied to MLR, total cost of care, or a similar metric to be assessed following the conclusion of the third year of the contract. Risk corridors may widen as the model matures.	9/23/24
C. Finance	4. A settle-up process will be implemented after the three-year results are calculated to allow county entities administering CARMA to retain savings for reinvestment in health care activities and CARMA entity operations or to protect against significant losses that a CARMA entity or the state might realize.	9/23/24
C. Finance	5. Quality initiatives tied to funding such as withholds, or quality bonus payments will be calculated after the 3-year contract term.	9/23/24
C. Finance	6. The rate-setting process will be collaborative and take into consideration the experience of county entities administering CARMA, regional experience, and DHS FFS experience.	9/23/24

Subgroup	Recommendation	Date Approved by Steering Committee
C. Finance	7. Remove the current quality-based withholds. Explore potential quality incentive programs after the initial contract period.	12/12/24
D. Legislative	1. Following definition of "rural" taken from 42 CFR 438.52: The definition of "rural county" using the 42 CFR 438.52 definition of "rural area" being any county designated as "micro, rural or County with Extreme Access Considerations (CEAC)" in the Medicare Advantage Health Services Delivery (HSD) Reference File for the applicable calendar year."	8/15/24
E. Oversight and Regulation	1. Develop CARMA under Minnesota's existing federal Medicaid managed care authority (42 CFR 438) and seek a waiver of any desired provision that cannot be implemented under the existing 438 authority.	8/15/24
E. Oversight and Regulation	2. The commissioner of human services, in collaboration with the Association of Minnesota Counties and county-based purchasing plans shall constitute a steering committee to provide guidance to the ongoing development of and implementation of the county-administered rural medical assistance (CARMA) model. The steering committee will meet at least twice annually. The steering committee may convene subgroups as needed. The commissioner in collaboration with the steering committee will ensure meaningful enrollee engagement.	12/12/24
F. Performance Improvement and Measurement	1. Each county entity administering CARMA shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of program evaluation and compliance with federal and state requirements. (Source: 256B.69) • The commissioner shall also develop methods of data reporting and collection to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance (Source: 256B.69). • The commissioner and county entities administering CARMA shall work in collaboration to define a quality improvement model for CARMA that shall include a focus on locally specified measures based on the counties' unique needs and shall be specified before the commissioner contracts with county entities seeking to administer CARMA.	9/23/24
G. Population Expansion	1. CARMA will be a voluntary managed care program (opt-out) covering those currently eligible for PMAP, and those currently eligible for Special Needs Basic Care (SNBC), ages 18-64, Medicaid only (excludes dual eligibles). Include in the model legislation language indicating intent to consider adding other populations.	8/15/24
G. Population Expansion	2. All CARMA populations are voluntary opt-out	8/15/24
G. Population Expansion	3. Coverage begins the first of the month following the eligibility determination. (Which would eliminate YY exclusion).	9/23/24
G. Population Expansion	4. For the initial population, all county entities administering CARMA would need to cover all populations, under one contract. Integrated products may have a different recommendation later.	9/23/24
G. Population Expansion	5. Follow the current managed care selection process and annual election period, new enrollees have 90 days to make a change, with allowances for special circumstances. Ongoing enrollees choose CARMA or fee-for-service at the annual health plan selection.	9/23/24
G. Population Expansion	6. Annual process to connect with individuals who have previously opted out to determine if they would like to enroll	9/23/24
G. Population Expansion	7. These populations, including, but not limited to MNCare, Duals, and Incarcerated individuals, would be included in a later phase of implementation pending federal approval	9/23/24