DEPARTMENT OF HUMAN SERVICES

Legislative Report

Minnesota Alternative Care Delivery Model Implementation Plans

November 2026

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I. Executive Summary

This report is submitted pursuant to Minn. Stat. § 256.9631, which directs the Minnesota Department of Human Services (DHS) to develop implementation plans for alternative care delivery models for Medical Assistance and MinnesotaCare that do not shift financial risk to non-governmental entities.

In response to this legislative direction, DHS, with support from Public Consulting Group (PCG), evaluated alternatives to commercial managed care arrangements and developed detailed implementation plans for selected models.

The report documents the process used to identify and assess alternative care delivery models, including analysis of Minnesota's current Medicaid delivery system, review of statutory and regulatory requirements, evaluation of operational and financial impacts, and extensive stakeholder engagement.

Five initial models were identified and presented to legislative leadership, as required by statute. Following that consultation, three models were selected for further development. The three models addressed in this report are: (1) Eliminating Non-Governmental Risk from the Status Quo, (2) Multiple or Regional Administrative Services Organizations (ASOs), and (3) Expansion of County-Based Purchasing Plans and County-Owned Health Maintenance Organizations.

Stakeholder feedback was collected from providers, counties, county-based purchasing plans, health plans, Tribal and Urban Indian health organizations, and member advocacy groups through surveys, focus groups, and ongoing consultation. This input informed model refinement and highlighted key considerations related to access, continuity of care, administrative burden, financial risk, and implementation feasibility.

This report presents implementation considerations, financial and operational implications, statutory and regulatory considerations, and indicative timelines for each model. It is intended to support legislative deliberation regarding next steps consistent with Minn. Stat. § 256.9631 and the State's goals of accountability, equity, and continuity of care.

II. Legislation

This report is submitted pursuant to Minn. Stat. § 256.9631.

256.9631 ALTERNATIVE CARE DELIVERY MODELS FOR MEDICAL ASSISTANCE AND MINNESOTACARE.

Subdivision 1. **Direction to the commissioner.**

(a) The commissioner, in order to deliver services to eligible individuals, achieve better health outcomes, and reduce the cost of health care for the state, shall develop implementation plans for at least three care delivery models that:

(1) are alternatives to the use of commercial managed care plans to deliver health care to Minnesota health care program enrollees; and

(2) do not shift financial risk to nongovernmental entities.

(b) One of the alternative models must be a direct payment system under which eligible individuals receive services through the fee-for-service system, county-based purchasing plans, and county-owned health maintenance organizations. At least one additional model must include county-based purchasing plans and county-owned health maintenance organizations in their design, and must allow these entities to deliver care in geographic areas on a single plan basis, if:

(1) these entities contract with all providers that agree to contract terms for network participation; and

(2) the commissioner of human services determines that an entity's provider network is adequate to ensure enrollee access and choice.

(c) Before determining the alternative models for which implementation plans will be developed, the commissioner shall consult with the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy.

(d) The commissioner shall present implementation plans for the selected models to the chairs and ranking minority members of the legislative committees with jurisdiction over health care finance and policy by January 15, 2026. The commissioner may contract for technical assistance in developing the implementation plans and conducting related studies and analyses.

Subd. 2.**Definitions.**

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

(b) "Eligible individuals" means all medical assistance and MinnesotaCare enrollees.

(c) "Minnesota health care programs" means the medical assistance and MinnesotaCare programs.

(d) "Qualified hospital provider" means a nonstate government teaching hospital with high medical assistance utilization and a level 1 trauma center, and all of the hospital's owned or affiliated health care professionals, ambulance services, sites, and clinics.

Subd. 3.**Implementation plans.**

(a) Each implementation plan must include:

(1) a timeline for the development and recommended implementation date of the alternative model. In recommending a timeline, the commissioner must consider:

(i) timelines required by the existing contracts with managed care plans and county-based purchasing plans to sunset existing delivery models;

(ii) in counties that choose to operate a county-based purchasing plan under section 256B.692, timelines for any new procurements required for those counties to establish a new county-based purchasing plan or participate in an existing county-based purchasing plan;

(iii) in counties that choose to operate a county-owned health maintenance organization under section 256B.69, timelines for any new procurements required for those counties to establish a new county-owned health maintenance organization or to continue serving enrollees through an existing county-owned health maintenance organization; and

(iv) a recommendation on whether the commissioner should contract with a third-party administrator to administer the alternative model, and the timeline needed for procuring an administrator;

(2) the procedures to be used to ensure continuity of care for enrollees who transition from managed care to fee-for-service and any administrative resources needed to carry out these procedures;

(3) recommended quality measures for health care service delivery;

(4) any changes to fee-for-service payment rates that the commissioner determines are necessary to ensure provider access and high-quality care and to reduce health disparities;

(5) recommendations on ensuring effective care coordination under the alternative model, especially for enrollees who:
   (i) are age 65 or older, blind, or have disabilities;
   (ii) have complex medical conditions;
   (iii) face socioeconomic barriers to receiving care; or
   (iv) are from underserved populations that experience health disparities;
(6) recommendations on payment arrangements for care coordination, including:
   (i) the provider types eligible for care coordination payments;
   (ii) procedures to coordinate care coordination payments with existing supplemental or cost-based payment methods or to replace these existing methods; and
   (iii) procedures to align care coordination initiatives funded under the alternative model with existing care coordination initiatives;
(7) recommendations on whether the alternative model should include funding to providers for outreach initiatives to patients who, because of mental illness, homelessness, or other circumstances, are unlikely to obtain needed care and treatment;
(8) recommendations for a supplemental payment to qualified hospital providers to offset any potential revenue losses resulting from the shift from managed care payments; and
(9) recommendations for statutory changes necessary to implement the alternative model.

(b) In developing each implementation plan, the commissioner shall:
(1) calculate the projected cost of the alternative model relative to the cost of the current system;
(2) assess gaps in care coordination under the current medical assistance and MinnesotaCare programs;
(3) evaluate the effectiveness of approaches other states have taken to coordinate care under a fee-for-service system, including the coordination of care provided to persons who are age 65 or older, are blind, or have disabilities;
(4) estimate the loss of revenue and cost savings from other payment enhancements based on managed care plan directed payments and pass-throughs;
(5) estimate cost trends under the alternative model for managed care payments to county-based purchasing plans and county-owned health maintenance organizations;
(6) estimate the impact of the alternative model on other revenue, including taxes, surcharges, or other federally approved in lieu of services and on other arrangements allowed under managed care;
(7) consider allowing eligible individuals to opt out of managed care as an alternative approach;
(8) consult with the commissioners of health and commerce and the contractor or contractors analyzing the Minnesota Health Plan and other health reform models on plan design and assumptions; and
(9) conduct other analyses necessary to develop the implementation plan.

III. Introduction

A. Brief Overview of the Initiative

This initiative responds to legislative direction under Minn. Stat. § 256.9631 to evaluate and develop alternative care delivery models that move away from commercial managed care arrangements and eliminate financial risk transfer to non-governmental entities. As a result of the legislation, the Minnesota Department of Human Services (DHS), through its Health Care Administration, is exploring a strategic shift in the delivery of health care services under the Minnesota Health Care Programs (MHCP). The MHCP currently serves over 1.3 million individuals through Medical Assistance (MA) and MinnesotaCare, with the majority enrolled in managed care

plans. PCG, in collaboration with DHS, has identified and formulated implementation plans for three distinct models which have been consolidated into a single report.

B. How the Report was Prepared

To choose three models for consideration, an initial draft summary was created outlining five alternative models. These five models were presented to the chairs and ranking members of the legislative committees, as mandated by statute. After this presentation, three models from the original five were selected for further development into detailed implementation plans. The next steps involved ongoing collaboration with Minnesota stakeholders and community partners, as well as working with DHS to refine and clarify the chosen model options.

To ensure the initial five models put forward were the best fit for Minnesota, PCG worked in collaboration with key stakeholder groups to identify what is working under the current Medicaid delivery system, and where there are areas for improvement. One method to collect this data was a survey, which was sent out to six main groups: Providers, Tribal and Urban Indian Health Care Providers, Counties, County-Based Purchasing Plans (CBPs), Health Maintenance Organizations (HMOs), and Member Advocacy Groups. Some key themes arose:

Providers, Counties, CBPs, and HMOs all like that Medical Assistance (MA) provides quality, accessible, and affordable care to populations that may otherwise be uninsured or underinsured. Member Advocacy Groups express a similar sentiment, further supporting the idea that MA has appropriate benefits and eligibility requirements.

Despite this widespread support for Medical Assistance as it currently operates, these stakeholder groups expressed varying challenges in the current system:

- Providers and Member Advocacy Groups expressed concern over provider reimbursement, highlighting how providers are not reimbursed enough to cover the cost of care.
- Counties and HMOs discuss gaps in coverage for certain services and providers, like dental.

Providers, Counties, CBPPs, and HMOs provided feedback on the five initial alternative care delivery models proposed and continued to provide feedback on the three models selected for further consideration which are described in more detail in this implementation plan. Stakeholder feedback has been incorporated into the model summaries, as well as closely considered in how full implementation proposals have been structured.

Figure 1 below outlines the initial five alternative care delivery models identified.

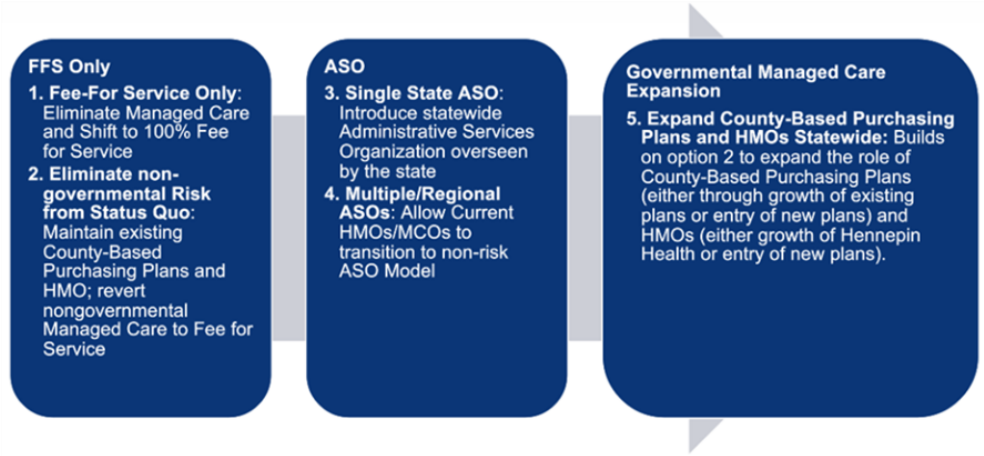


Figure 1. Initial Five Alternative Care Model Options Considered (Options 2, 4, & 5 selected)

PCG conducted a stakeholder engagement process which included feedback from:

- Allina Health and HealthPartners
- Allina Health EMS
- Allina Health IHP
- Altair ACO
- Anoka County
- ARRM
- Avera Marshall
- Benton County Human Services
- Blue Cross and Blue Shield of Minnesota
- Brown County
- Care Providers of Minnesota
- Catholic Charities Twin Cities
- Chippewa County Family Services
- DHS & Red Lake Nation
- DVHHS
- Essentia Health
- Family Tree Clinic
- Farmers Union
- Gillette Children's
- Goodhue County Health and Human Services
- Goodhue County HHS
- Health Care for All MN
- HealthPartners
- Hennepin Health
- Hennepin Healthcare
- Integrity Health Network
- ISAIAH
- Itasca Medical Care
- Lakewood Health System
- Le Sueur County Human Services
- MARRCH
- Medica
- Metro Meals on Wheels
- Mid-Minnesota Legal Aid
- Minnesota Ambulance Association
- MNPrairie County Alliance
- Neighborhood Health Care Network DBA "FUHN"
- Nicollet County
- One Arrow Group
- Perham Health
- PrimeWest Health
- Rice County
- SEIU
- South Country Health Alliance
- Stearns County Human Services
- Stevens County
- Trellis
- UCare
- Unidos

- Wabasha County Public Health
- Wabasha County Social Services
- Wilderness Health, Inc.
- Yellow Medicine County

IV. Statement of Objectives and Intended Outcomes

This section contains an overview of each of the three identified models: “Eliminating Non-Governmental Risk from Status Quo”, “Multiple/Regional Administrative Services Organization(s) (ASO)” and “Expand County-Based Purchasing Plans and County-Owned HMOs”. The primary objective of the detailed implementation plans developed for the three selected alternative care delivery models is to:

- Remove financial risk from nongovernmental entities with models such as fee-for-service (FFS), county-based purchasing plans, and county-owned health maintenance organizations.
- Improve access to care, especially for populations facing socioeconomic barriers, complex medical conditions, disabilities, or health disparities.
- Strengthen care coordination and continuity of care across counties and delivery systems.
- Provide actionable recommendations on quality measures, payment structures, statutory changes, and administrative support necessary for successful implementation.
- Deliver cost-effective solutions that align with federal and state requirements while preserving member choice and provider network adequacy.

These models are expected to support the State’s broader goals of improving health outcomes, reducing disparities, and ensuring equitable access to care for all MHCP enrollees leading to the selection of one of the models, or hybrid, to be moved into the next phase of implementation.

Overview of the Structure of the Report

All three models under review are projected to lead to an increase in Medicaid Fee-for-Service enrollment, accompanied by a corresponding reduction in Medicaid managed care enrollment. Each model also signifies a substantial departure from the current care delivery system in Minnesota. Accordingly, this report is structured by topic area, with general information relevant to all three models presented initially. For each topic area, details specific to individual models are subsequently outlined following the overarching information.

V. Description of Identified Models

Below are descriptions of three distinct alternative care delivery models:

- Eliminate Non-Governmental Risk from Status Quo
- Multiple/Regional Administrative Services Organizations (ASOs)

- Expand County-Based Purchasing Plans and County-Owned HMOs

A. Eliminate Non-Governmental Risk from Status Quo

This model entails the removal of all non-governmental (including non-county-based or non-county owned and operated) managed care arrangements. The primary goal of this option is to phase out non-county-based HMOs and transition eligible individuals to Medicaid FFS or CBP and county HMO managed care coverage. Unlike the "Fee for Service Only" model, this option would allow for the ongoing operation of Hennepin Health, as well as the three existing County Based Purchasing (CBP) plans. Collectively, Hennepin Health and the CBPs will be referred to as "CBPs and county HMOs".

CBPs and county HMOs currently constitute approximately 10% of all managed care enrollment in the State of Minnesota. Consequently, restricting managed care to only CBP and county HMOs will result in a significant shift for the remaining 90% of managed care enrollees. The largest likely impact of this transition will be on counties with no CBP or county HMOs. Managed care will be eliminated entirely in these counties. For counties with existing CBPs, there will be significantly lower impact, as County Administered Rural Medical Assistance (CARMA) will be implemented as of January 1, 2027. CARMA establishes the CBPs as the single MCO in their counties for all non-dual Medicaid managed care products, and nothing in this proposal would alter that implementation plan.

The landscape of CBPs and county HMOs may shift over time through locally initiated efforts. CBPs and county HMOs may experience increased enrollment based on the removal of non-governmental HMOs with overlapping service areas. However, this option is distinct from "County-Based Managed Care Expansion" because there will be no significant state-level initiative in expanding or altering the existing framework and coverage area of CBPs and county HMOs.

The expected proportion of current non-governmental HMO enrollees that may transition to a CBP or county HMO is unknown at this time. One major factor is the capacity of existing CBPs and county HMOs to accommodate increases in enrollment, especially in Hennepin County where Hennepin Health currently serves 10% of the managed care population in Hennepin County. It is unclear if Hennepin Health, the only government owned HMO in Hennepin County, could expand their enrollment to replace all non-governmental HMOs currently serving Hennepin County.

This model provides significant flexibility to the State, eliminating services provided by non-governmental entities, but preserving the existing CBPs and county HMOs, minimizing disruption and transitions for enrollees not receiving care through a non-governmental entity. This section outlines considerations which are unique to this model. Additional considerations relating to this model align with those outlined in the Fee-for-Service Only model as well as the Expansion of County Based Managed Care model, as applicable.

Level of Risk

Financial risk will vary by county, based on the existence and level of CBP and county HMO coverage. In counties with county-based coverage, financial risk would remain with the CBPs and county HMOs. For the remaining

counties that would operate under FFS (as their current managed care provider will no longer be eligible), financial risk will be absorbed entirely by the state.

Organization Responsible for Care Delivery

The organization will vary based on CBP and county HMO coverage. In counties with CBP or county HMO coverage, the county-based plan will be responsible for care delivery. In the FFS model, the state Medicaid agency will fill that role. The state may employ vendors to support the administration of the program, if it is determined that the current FFS system does not have the bandwidth to manage the influx of FFS enrollees.

Capitation

Capitation will also vary based on CBP and county HMO care coverage. Counties with CBP or county HMO will receive capitated payments directly from the state. All remaining counties operating under FFS will not receive capitated payments, as the enrollees will remain in the FFS model.

Model Opportunities

- **Preserve the role of counties in care management and purchasing**, while eliminating managed care risk from non-governmental entities. Through a coordinated effort between the state and participating counties, counties have played a key role in the growth of managed care in the State of Minnesota. This option allows for the benefits of CBP and county HMO arrangements to be retained.
- **Leverage community partnerships, which counties and public providers are uniquely well-positioned to do.** County involvement in managed care delivery creates unique opportunities to foster collaboration and coordination with local providers and community resources and support provider networks at the local level.
- **State-level control of reimbursement rates and methodologies** for the population shifting to a Fee for Service delivery system which can ensure greater consistency and fairness.
- **Preservation of participation in State Directed payment program** for the current State Directed Payment program for HCMC allows for Medicaid federal matching equal to Average Commercial Rate (ACR) payments for services rendered to Medicaid managed care enrollees including certain inpatient and outpatient hospital services, professional services at an academic medical center and ambulance services. Although the existing directed payment program could continue under this model, the proportion of total utilization paid under Medicaid managed care would decrease significantly and the total dollar value of existing directed payments would also decrease. For utilization that shifts from managed care to fee for service following the implementation of this delivery model, a fee for service Upper Payment Limit program is in place which would allow for the recoupment of additional federal payments for similar services; however, FFS UPL payments are significantly below ACR levels available under managed care. It is also important to note that the current directed payment landscape is set to shift based on H.R. 1 requirements which will scale-back certain directed payment programs by 10% annually beginning in 2028 until they reach Medicare levels.

Model Considerations

- **Disparity in coverage options based on county of residence.** The current managed care structure in the state allows for some continuity in service options regardless of where an individual is located because managed care is available statewide. Under this model, counties with no CBP or county HMO will shift to FFS. Figure 2 below highlights current CBP coverage.
- **Transition considerations for individuals currently enrolled with non-governmental HMOs** that reside in a county with a CBP or county HMO. Determining whether the existing CBPs and county HMO would expand enrollment, or individuals would be transitioned to an FFS delivery system would need to be addressed. There is potential that the solution identified may vary by county, which would create additional geographical disparities in care options and delivery. There are many contributing factors which would impact the next steps for counties with CBP or county HMO coverage, including whether each CBP or county HMO is willing and able to accommodate expanded enrollment as well as the additional startup cost and ramp-up-period needed to prepare for expanded enrollment.
- **Mandatory Managed Care:** Currently, most of Minnesota's Medicaid beneficiaries participate in mandatory managed care. One key underlying requirement of mandatory managed care is choice of coverage. Consistent with Section 1932 (a)(3), In order to maintain choice of coverage "a State must permit an individual to choose a managed care entity from not less than two such entities". There are exemptions for individuals residing in rural areas which allow for a single coverage option as long as certain minimum criteria are met to ensure beneficiaries have choice in providers. All CBP coverage areas are subject to the rural exemption; however, Hennepin County is not eligible for a rural exemption. Removing non-governmental HMOs from Hennepin County would impact the County's ability to maintain compliance with the choice of coverage requirement which enables mandatory managed care. Hennepin County currently serves approximately 32,000 enrollees compared to nearly 258,000 enrollees county-wide. In addition to meeting the requirement to maintain choice in coverage in Hennepin County, it may not be possible for Hennepin Health to significantly scale up enrollment sufficiently to maintain mandatory managed care. To address mandatory managed care requirements, it would be necessary to consider alternatives such as adding choice in coverage and scaling up Hennepin Health capacity, shifting the County to voluntary enrollment or obtaining a waiver related to mandatory managed care requirements. Additionally, the County Administered Rural Medical Assistance (CARMA) initiative that will go into effect on January 1, 2027, will establish CBPs as the single plan in the areas where they currently operate. This would remove the mandatory managed care requirement in those counties. Given their rural exemption, CBP coverage areas could maintain compliance with Section 1932 (a)(3) even in the absence of non-governmental HMOs. However, eliminating non-governmental HMOs in CBP coverage areas would reduce choice of coverage and may warrant further consideration of the impact of voluntary vs. mandatory managed care in those counties.

Figure 2 shows the current geographical coverage areas of the three CBPs operating in Minnesota.

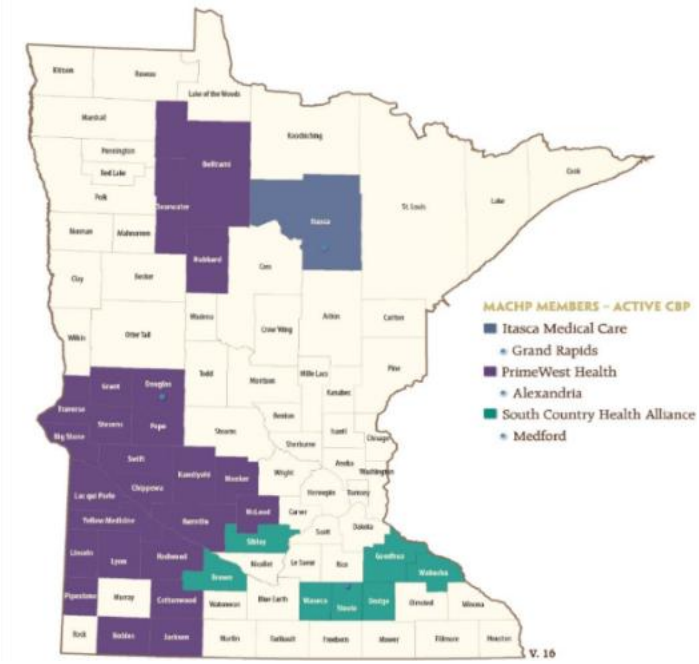


Figure 2. MN Distribution of CBP Coverage

B. Multiple/Regional Administrative Services Organization(s) (ASO)

An Administrative Services Organization (ASO) is an organization independent of the State, which is under agreement to provide administrative services to a state Medicaid program. This includes the administration of claims, benefits, and many other functions of a Managed Care Organization (MCO). ASOs do not assume medical or financial risk.

The administrative functions of an ASO typically include human resources management, regulatory compliance, development and management of information systems, provider credentialling and contract management, provider and member services, claims administration, and data reporting. An ASO may also perform other functions, beyond those of traditional managed care, such as physician billing and office staffing, physician recruitment, community services, health promotion campaigns and wellness and prevention services.

While ASOs do not assume any medical or financial risk themselves, they can perform certain risk management functions on behalf of the state. This includes the provision services such as case management, utilization management, and prospective or retrospective review of authorization for health care services.

Under this model, the state would contract with multiple ASOs to perform a range of administrative services/supports. ASOs can be contracted to cover geographic regions or based on services rendered. For example, Connecticut delivers managed Medicaid through four ASOs, divided based on the type of care delivered, namely: medical services, behavioral health, dental care, and non-emergency transportation. The ASOs are responsible for traditional services including beneficiary support, referrals to providers, utilization

management (e.g. prior authorization of services when required), and grievances and appeals, as well as provider support.

While there are no current examples of a multiple ASO model by geographic region, this model may be of interest to MN, as there is the potential to leverage existing managed care plans in the state to operate the ASOs, and preserve continuity for many of the functions that a managed care plan and an ASO both perform.

Level of Risk

The ASOs do not bear any financial or medical risk. All financial risk remains with the State.

Organization Responsible for Care Delivery

Typically, an insurance company or other independent organization serves in the role of an ASO. Under this model, the state would procure multiple ASOs by region, or by service group. The ASOs are selected from the respondents to a request for proposal. The state may need to do some coordination with the applicants to ensure full coverage of all counties, and no overlapping service areas.

Capitation

ASOs are not paid under a capitated model. The State reimburses the ASOs with a fixed administrative fee for their role as the ASO and pays a fee-for-service rate for medical services.

Model Opportunities

- **State retains more control over service delivery and risk management**, through prior authorization (PA)/utilization management.
- **Efficiency can be leveraged where ASOs have regional or population-specific experience**, as compared to a single ASO, or program administrator.
- **Eliminates government managed care risk** while maintaining many services and supports currently provided by MCOs/HMOs.
- **Cost efficiency** can be achieved through outsourcing administrative services.
- **Regional autonomy** in determining the most effective way to manage the Medicaid population, if using the regional ASO model.

Model Considerations

- There is **no built-in financial incentive to promote quality of care**, as there is no financial risk to the ASOs for managing the volume or value of services. Other mechanisms to incentivize quality of care that do not transfer risk to the ASOs will need to be developed. Given that there is no financial risk to the ASOs in managing the volume or value of services, costs will need to be managed by the State.
- **The state will be responsible for oversight and reporting to CMS.** Therefore, data collection and reporting requirements by the ASOs should be built into the ASO contracts, similar to under a Medicaid

Managed Care model. Administrative costs to manage and oversee the ASOs will be incurred by the state.

- **High variability in cost**, owing to variability in service delegation to ASOs. The state will need to carefully consider which functions are more effectively delivered by a third party, and which are better managed within the agency, taking impacts on cost, quality and member experience into account.
- **Multiple ASOs can introduce variability in outcomes and member experience across geographic regions,** as compared to a single ASO**.** The state oversight system will need to be designed to monitor for this variation.
- To capitalize on the potential benefit of **uniformly applied PA requirements**, the state would need to develop and provide detailed guidance to all ASOs and ensure that all ASOs implement PA using the same rules and criteria.
- The ASOs will be responsible for administering **fraud, waste and abuse identification** on behalf of the State. The state will need to create guidance and conduct oversight activities to ensure that ASO processes and recoveries meet the requirements of the State and CMS.

C. Expand County-Based Purchasing Plans and County-Owned HMOs

This model entails the expansion of County Based Purchasing Plans (CBPs) and County-Owned HMOs across the State, with the goal of moving all enrollees of current Managed Care Organizations onto a CBP, County owned HMO, or onto a Medicaid FFS arrangement. This option would allow for the ongoing operation and potential expansion of Hennepin Health, as well as the three existing County Based Purchasing (CBP) plans. Collectively, Hennepin Health and the CBPs will be referred to as “CBPs and county HMOs”.

County-based managed care plans currently constitute approximately 10% of all managed care enrollment in the State of Minnesota. The current landscape of CBPs is shown in Figure 2 above.

In addition to the three CBPs outlined, there is one county-based HMO, Hennepin Health, that operates solely in Hennepin County.

Consequently, restricting managed care to only county-based managed care plans will result in a significant shift for the remaining 90% of managed care enrollees. The largest likely impact of this transition will be on counties with no county-based managed care plans. Managed care will be eliminated entirely in these counties with those enrollees being eligible to join an existing county-based managed care plan if one expanded, or a newly created plan. There will be minimal impact on counties with existing county-based managed care, because the County administered rural medical assistance (CARMA) initiative will have gone into effect on January 1, 2027, which makes the existing CBPs the single MCO in their counties. This small shift would impact the senior population who would not yet be included in the CARMA initiative.

The State will need to be decisive in its approach to ensure counties can build out existing CBPs or create new ones in areas where one does not exist. This could include legislative mechanisms, and the provision of additional start-up funding, including the use of grant funds. The State will also need to take into account the removal of the mandatory managed care requirement, and its impact on CBP enrollment.

Even with potential eligibility for Medicaid FFS, the vast majority of enrollees on a non-governmental managed care plan would transition to a CBP or county HMO. The number of newly created plans will be impacted by the capacity of existing county-based managed care plans to accommodate increases in enrollment, and expansion of their service area. Hennepin County represents an especially unique case as Hennepin Health currently serves 10% of the managed care population in Hennepin County. It is unclear if Hennepin Health, the only government owned MCO in Hennepin County, could expand their enrollment to replace all non-governmental HMOs currently serving Hennepin County. This might require the creation of a CBP that includes Hennepin County within its coverage area.

The State is implementing CARMA for **1/1/2027**. This program establishes the existing CBPs as the single MCO in their counties for all non-dual Medicaid managed care products. That would happen prior to the implementation of these large statewide initiatives and would need to consider the future ramifications of expansion, notably for counties without existing CBPs. For counties with existing CBPs, there will be significantly lower impact. Nothing in this proposal would alter that implementation plan.

Level of Risk

Financial risk would expand to county-based managed care plan(s). In counties with existing county-based options this would represent no change. Expanding CBPs and County run HMOs would shift and increase the financial risk to governmental organizations. Additionally, the state may need to consider legislative mandates or incentives to ensure CBPs are expanded or created anew. Without this mechanism there is no guarantee or likelihood that CBPs are available in areas currently without one, thus negatively impacting the outcomes of this program, as well as member choice.

Organization Responsible for Care Delivery

The designated County, or group of counties (CBPs) would represent the governing board for these entities. This would involve increased governmental oversight at both the State and County level.

Capitation

County-based managed care plans will receive capitated payments directly from the state. This will expand from the existing four total plans, as well as increasing the share of capitation payments directed to county-based plans.

Model Opportunities

- **Preserve the role of counties in care management and purchasing**, while eliminating managed care risk from non-governmental entities. Through a coordinated effort between the state and participating counties, counties have played a key role in the growth of managed care in the State of Minnesota. This option allows for the benefits of county-based managed care arrangements to be retained.
- **Leverage community partnerships, which counties and public providers program are uniquely well-positioned to do.** County involvement in managed care delivery creates unique opportunities to foster

collaboration and coordination with local providers and community resources and support provider networks at the local level.

- **Preservation of participation in State Directed payment program** for HCMC The current State Directed Payment program allows for Medicaid federal matching equal to Average Commercial Rate (ACR) payments for services rendered to Medicaid managed care enrollees including certain inpatient and outpatient hospital services, professional services at an academic medical center and ambulance services. Although the existing directed payment program could continue under this model, the proportion of total utilization paid under Medicaid managed care may decrease based on individuals opting out of managed care and the total dollar value of existing directed payments would also decrease. For utilization that shifts from managed care to fee for service following the implementation of this delivery model, a fee for service Upper Payment Limit program is in place which would allow for the recoupment of additional federal payments for similar services; however, FFS UPL payments are significantly below ACR levels available under managed care. It is also important to note that the current directed payment landscape is set to shift based on H.R. 1 requirements which will scale-back certain directed payment programs by 10% annually beginning in 2028 until they reach Medicare levels.

Model Considerations

- **Start-up costs to expand county involvement** will be incurred by the counties. These costs could create challenges when expanding statewide. Additionally, the State could incur administrative costs. The State will need to consider incentivizing the creation/expansion of CBPs across the state, including the potential of legislative mandates.
- **Reduction in Economies of Scale that can be achieved through managed care**, given that contracting entities are local. This is specifically important in rural areas.
- **Transition considerations for individuals currently enrolled with non-governmental HMOs** that reside in a county with a CBP or county HMO. There is potential that the solution identified may vary by county, which would create additional geographical disparities in care options and delivery. There are many contributing factors which would impact the next steps for counties with CBP or county HMO coverage, including whether each CBP or county HMO is willing and able to accommodate expanded enrollment as well as the additional startup cost and ramp-up-period needed to prepare for expanded enrollment.
- Mandatory Managed Care requirements would likely need to be removed to allow for individuals to select between managed care and fee for service to comply with federal requirements. Transitioning to CBPs and county HMOs would eliminate the current mandatory managed care requirement for most of Minnesota's Medicaid beneficiaries. Under the existing system, beneficiaries are required to participate in managed care and must be given a choice of at least two managed care entities in accordance with Section 1932(a)(3). While rural areas are allowed to offer only a single coverage option if they meet certain minimum standards for provider choice, this exemption does not apply to Hennepin County. By shifting enrollment toward county-based HMOs and removing the mandatory participation rule in areas currently covered by County-Based Purchasing (CBP) plans, as proposed in the CARMA initiative, the State would transition these programs from mandatory to voluntary. This change would require the State to incentivize county-based HMOs to accept new enrollees and work proactively with beneficiaries

so they fully understand their coverage options. As a result, all future CBP arrangements would become voluntary, giving members the option to participate rather than requiring enrollment.

VI. Operational Considerations

Regardless of which model is selected, changes to the managed care structure would significantly affect both operational and regulatory functions for the state. Operationally, the state would need to invest in member and support systems, enhance outreach and training efforts, and coordinate closely with counties to ensure smooth transition and ongoing service quality. Regulatorily, the state would face the need to amend multiple statutory provisions and update terminology and cross references throughout Minnesota law to align with the new delivery system, ensuring clarity and compliance with federal and state requirements.

A. Statutory and Regulatory Recommendations

Alternatives to the current delivery system would require multiple changes to state laws and regulations. Depending on which alternate model gets implemented will determine which statutory provisions to modify and how. In addition, there are numerous cross references throughout many sections of Minnesota state law that would require updates to reflect a new delivery system model.

This subsection highlights parts of the Minnesota Statutes that the Legislature may need to be aware of for potential changes including:

- Terminology in state law;
- Statutory provisions to be addressed;
- Cross references to be updated.

Terminology in State Law

One issue for consideration is the many variations on the labeling of delivery systems. Most of the references in Minnesota Statutes to “managed care organizations” refer to all types of MCOs: private as well as public. In addition, the statutory references to “managed care organizations” may apply to MCOs that serve non-Medicaid populations.

Much of the statutory language concerning the Medicaid managed care model in Minnesota refers broadly to “managed care and county-based purchasing plans….”

There are sections of state law that refer to “managed care organizations under contract with the Department of Human Services”, and these generally refer to Medicaid managed care organizations, but do not explicitly differentiate between private and public MCOs.

In this context, an alternative delivery model that eliminates privately operated managed care organizations would not necessarily require wholesale changes to the state laws.

If the State were to eliminate privately owned MCOs from the Medicaid program, then some of the provisions in state law would no longer be applicable. In this scenario, the State may find it appropriate to remove references to managed care organizations.

There are certain sections of state law that the State may want to address; those are highlighted below.

Statutory Provisions

That are four major sections of state law that may need modifications with any of the proposed alternative delivery models.

HMOs – Chapter 62

In particular Chapter 62D "Health Maintenance Organizations" includes various obligations for HMO participation in public programs. For example, Subd.5 "Participation; government programs" states that HMOs …shall, as a condition of receiving and retraining a certificate of authority participate in the medical assistance and MinnesotaCare programs."

Medical Assistance, Chapter 256

Chapter 256B "Medicaid Assistance for Needy Persons" includes several provisions for consideration.

For example, Chapter 256B.0625 ("Covered Services") includes several items for consideration including: Subd. 3c. "Health Services Advisory Council" which includes requirements on managed care plans; Subd. 5m "Certified community behavioral health clinic services" which includes requirements on managed care plans; Subd. 17a. "Payment for ambulance services" which includes requirements on managed care plans; Subd. 18h "Nonemergency medical transportation provisions related to managed care" which includes requirements on reimbursement for NEMT; Subd.54 "Services provided in birth centers" with requirements on MCOs that provide Medical Assistance coverage to reimburse birth centers at certain rates; etc.

Chapter 256B.035 "MANAGED CARE" specifically states that the Commissioner of DHS may contract with public or private entities (provided the entity is a nonprofit corporation) to deliver health care services to Medical Assistance and MinnesotaCare program recipients.

Chapters 256B.69-696 address many of the statutory provisions related to Medicaid managed care and would need revisions to align with an alternate care delivery model.

- 256B.69 "PREPAID HEALTH PLANS" specifically addresses the Commissioner of DHS to establish a Medical Assistance demonstration project involving prepaid health plans and prescribes details on the structure of a waiver program, per capita payments, contracts, etc.
- 256B.6903 "OMBUDSPERSON FOR MANAGED CARE" addresses one aspect of state oversight of managed care (i.e., ombudsman).
- 256B.691 "RISK-BASED TRANSPORTATION PAYMENTS"
- 256B.692 "COUNTY-BASED PURCHASING

- 256B.6925 “ENROLLEE INFORMATION” describes requirements on DHS as well as managed care organizations.
- 256B.6926 “STATE MONITORING”
- 256B.6927 “QUALITY ASSESSMENT AND PERFORMANCE”
- 256B.6928 “MANAGED CARE RATES AND PAYMENTS”
- 256B.693 “STATE-OPERATED SERVICES; MANAGED CARE”
- 256B.694 “SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT”
- 256B.696 “PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER” would need to consideration because it specifically addresses Medical Assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

MinnesotaCare – Chapter 256L contains specific direction to the Commissioner of DHS to establish an office for the state administration of the plan.

“MANAGED CARE ORGANIZATION ASSESSMENT” Chapter 295.525 includes the annual assessment on MCOs proposed to begin in calendar year 2026.

Cross References

In addition to the modifications to the statutory provisions described above, numerous cross references would likely need to be updated throughout chapters 256B, 256, 256L and the 62 chapters.

Recommended Statutory Changes Required for Implementation

To exclude non-governmental plans from operating in Minnesota’s Medicaid program, statutory changes would be necessary to redefine eligibility and participation criteria for managed care entities within state law. The legislature would need to amend existing statutes that authorize non-governmental organizations to serve as Medicaid managed care organizations, thereby restricting participation exclusively to government-based plans such as County-Based Purchasing (CBP) entities, County-Based HMOs, or other publicly operated arrangements.

Such amendments would require revising the statutory language within Minnesota’s Medicaid enabling laws to:

- Explicitly prohibit contracts or certification of non-governmental organizations as managed care providers for Medicaid populations.
- Define and clarify the qualifications of allowable managed care entities, emphasizing government ownership, governance, and accountability.
- Outline the transition procedures for members currently enrolled in non-governmental plans, ensuring continuity of care and compliance with federal access and quality standards.
- Establish state oversight mechanisms to monitor public plan operations and financial solvency, replacing regulatory functions previously applied to private plans.

In addition, the legislative package would need to address provider network adequacy and consumer protections, ensuring that the shift does not compromise the statewide Medicaid program’s commitments to

service availability and choice. These statutory amendments would form the basis for corresponding regulatory changes and federal approval requests, setting the legal framework for a public-only managed care system.

There are a significant number of provisions in Minnesota state law that pertain to the state's Medicaid program and the managed care model. In switching from a primarily managed care model to a primarily FFS model, the state may seek to revise statutory language to align with the changes. However, we note that there are examples in other states of retaining the statutory references to managed care to enable the state to switch back to managed care if necessary.

Other Necessary Regulatory Actions

In addition to statutory amendments, Minnesota would need to undertake several regulatory actions to operationalize the transition to a public-only managed care system. First, the state's Medicaid agency would need to revise existing rules and administrative policies to reflect the exclusion of non-governmental entities from participation. This would involve updating certification processes, contract standards, and procurement guidelines to ensure only government-operated plans are eligible.

Furthermore, new regulations would be required to specify oversight procedures, reporting requirements, and performance metrics tailored to public managed care organizations. These regulations would need to address financial management, consumer protections, grievance and appeals processes, and compliance with federal Medicaid standards. The state would also need to review and update protocols for monitoring network adequacy, ensuring that providers within government-operated plans continue to offer comprehensive access to services across Minnesota.

Other regulatory actions would include developing transition guidance for current enrollees, establishing clear timelines and milestones for moving members from non-governmental to CBPs and county HMOs or FFS, and coordinating with providers to minimize disruptions. The state may need to update or promulgate emergency rules to address immediate concerns during implementation, such as continuity of care, communication strategies for affected populations, and adaptation of IT systems to accommodate new enrollment and eligibility criteria.

Finally, Minnesota's Medicaid agency would likely want to institute ongoing stakeholder engagement mechanisms—including advisory committees, public forums, and feedback systems—to identify challenges and refine procedures throughout the transition period. These regulatory actions, implemented alongside the necessary statutory changes, would safeguard the integrity of the Medicaid program and facilitate a successful shift to exclusively government-run managed care entities.

Federal Approval Requirements

Federal Medicaid Law Section 1902 requires that Medicaid Managed Care must be implemented statewide and must offer enrollees comparable services to the FFS program and must allow enrollee freedom of choice in selecting their provider. All three of these requirements can be waived however, using one or a combination of the three main authorities: Section 1932(a) State plan authority, Section 1915(a) or 1915(b) waiver authority, or Section 1115 waiver authority.

To implement an alternative care delivery model that reduces or alters managed care coverage such as the "Eliminate Non-Governmental Risk from Status Quo" or "Expand County-Based Purchasing Plans and County-Owned HMOs" models, the State may need to seek exceptions to the State wideness policy. This consideration is not applicable to the Multiple/Regional Administrative Services Organizations (ASOs) model which would eliminate Medicaid managed care entirely.

Each authority offers different advantages and disadvantages, which should be considered by the State. As 1932(a) State plan amendments (SPAs) do not expire like the waiver authorities, this will create the least work for the State over time to implement a program where the need for flexibility in the State wideness requirement is unlikely to change.

To initiate a SPA, the state will need to:

- Develop and submit a formal proposal to CMS for a State Plan Amendment (SPA) to end its current managed care structure.
- Demonstrate how the new delivery system will still meet federal objectives for quality, access, and equity in care for Medicaid recipients.

Typically, SPAs are approved within 90 days of CMS receipt unless there is written disapproval or request for additional information. If there is additional information requested, the 90-day period begins again on the day CMS receives additional information. After approval, the state can begin transitioning from a managed care model to a different delivery system, such as fee-for-service, while still adhering to federal regulations.

Generally, federal law does not require states to provide a public comment period on a SPA. However, many states do require a comment period in state law or will utilize one without requirement as a valuable tool to procure feedback from interested parties.

Impact of New Pharmacy Policy

Pharmacy services will be carved out of Managed Care under the new PBM policy effective 1/1/27. The new pharmacy policy also requires MCOs to pay the same prescription drug dispensing fee as the Medicaid fee-for-service program. This aligns with the goal of this proposed model, where a significant portion of Medicaid enrollees would fully transition to fee-for-service. For counties where a CBP is in place, CBPs would be held to the new PBM policy, and would contract with the State's designated PBM.

Impact of New Non-Emergency Medical Transportation Policy

Under the new NEMT policy, NEMT services will be provided by a single NEMT vendor, carved out of managed care. This will align well with this proposed model, where individuals enrolled in fee-for-service will have the same access to NEMT services as the individuals enrolled in a CBP.

Impact of Dental Services Carve-Out

Under the proposed dental services carve-out,[1] dental services would be carved out to a single dental benefit administrator on January 1, 2028, if specific benchmarks are not met regarding dental service utilization. This would have varying impact on the model options due to a provision that the CBP plans are excluded from the single dental benefit administrator. The impacts are outlined below.

Option 1 - Eliminate Non-Governmental Risk from Status Quo: There would be minimal operational impact under this option because the statutory dental carve-out applies exclusively to non-governmental managed care organizations and does not extend to County-Based Purchasing (CBP) plans. Under the implementation timeline, enrollees previously served by non-governmental managed care entities would already have transitioned to the single dental benefits administrator, resulting in dental services being carved out prior to any shift in their medical coverage. Consequently, no additional realignment of dental benefit administration would be required at the point of transition. Enrollees already covered by CBPs would continue to receive dental benefits under the existing CBP-administered arrangement, as CBPs remain exempt from the carve-out requirement. This bifurcated structure preserves continuity of dental service delivery and limits administrative system changes, member communications needs, and provider contracting adjustments during the model transition

Option 2 – Multiple Regional Administrative Services Organizations (ASOs): There would be minimal operational impact under this model because the dental carve-out would already have been fully implemented prior to transition activities, resulting in all enrollees receiving dental benefit administration through the designated ASO. As a result, no additional system modifications, benefit realignments, or member transitions specific to dental services would be required at the point this model is initiated.

Option 3 – Expand County Based Purchasing Plans and County-owned HMOs: The operational impact under this model would be substantial due to the statutory exclusion of CBPs from the dental carve-out. Transitioning a majority of enrollees into CBPs would require those entities to directly administer dental benefits, resulting in a material shift in benefit management responsibilities. Because the dental carve-out would be implemented prior to the transition of members from non-governmental managed care plans to CBPs, affected enrollees would experience a misalignment in benefit administration during the transition period. This sequencing would also create significant volatility for the dental benefit administrator, whose enrollment would decline sharply following a temporary period of elevated volume. The State will need to evaluate whether adjustments to implementation timelines or mitigation strategies are necessary to manage these year-over-year enrollment fluctuations for both members and the dental administrator. Additionally, any newly established CBPs would be required to incorporate dental benefit administration into their operational frameworks.

[1] https://www.revisor.mn.gov/statutes/cite/256b.0371

B. Collaboration Requirements

Plan for Participation in Meetings with Other State Departments and Contractors Working on Health Reform Models (as requested)

Intentional collaboration across State departments and agencies will be required throughout the implementation planning, execution, and operational phases of health reform model development.

Regular meetings will be needed to promote effective organizational change and efficient and feasible implementation of the new model. Focused, topic specific workgroups will be held in addition to larger group meetings. Tasks will be delegated based on department experience.

As the model is implemented and operationalized, workgroups will be responsible for collecting and sharing data to measure program performance. Specific data to be collected will be determined by the larger group.

Additional State Support Needed (in-house or vendor-based)

Moving to a model which eliminates non-governmental risk and shifts responsibly to the State will require significantly more data warehousing and processing power from the State. Close collaboration and support with the IT Systems team will be essential to maintain systems capable of an increased volume of supporting member and provider data. DHS may choose to hire a vendor depending on the in-house capacity available.

In addition, the following resources may be employed to collect feedback from stakeholders.

- Call Center/Open mailbox for provider concerns
- Call Center/Open mailbox for member concerns

C. Information Systems and Accessibility

Description of Any Information Systems, Tools, or Products Developed Under This Plan

As there is an existing FFS model, there will be no need for additional information systems or products to operate the program, however, this model will shift enrollment towards FFS, which may stress existing state resources to manage the FFS population. To ensure that the state adequately resources the departments that will be impacted by an increase in FFS enrollment, a review of all state systems in use for the FFS program, and the capacity for staff to meet the growing needs should be conducted. Automated tools for data collection and processing may be needed to cover the state's growing role in program administration.

Plan for Compliance with State of Minnesota Accessibility Standards (WCAG 2.0 Level AA and Section 508)

Section 508 mandates accessibility for individuals with disabilities in the U.S. federal government, while WCAG 2.0 Level AA provides the specific, internationally recognized technical standards for what constitutes accessible content.

To guarantee that all guidance and documentation produced during the implementation of the new policy is fully compliant with WCAG 2.0 Level AA and Section 508 standards, Minnesota should establish a comprehensive accessibility framework spanning development, review, and publication processes.

First, all project teams and contractors responsible for creating materials must receive training in accessibility principles, including the requirements of WCAG 2.0 Level AA and Section 508. This training should cover best practices for document formatting, color contrast, text alternatives for images, navigation structure, and the use of accessible templates for both digital and print documents.

The state should mandate the use of document creation tools that support accessibility features—such as Microsoft Word and Adobe Acrobat with built-in accessibility checkers—and require that all web-based guidance, manuals, or forms undergo automated and manual accessibility testing before publication. Automated tools can detect common issues (such as missing alt text or improper heading structure), while manual reviews help identify more subtle barriers, including the clarity of instructions for screen readers or logical tab order.

Accessibility should be embedded early and throughout the document development lifecycle. Draft documents should be reviewed by individuals with expertise in digital accessibility, and, where possible, tested by users with disabilities to confirm practical usability and compliance. Feedback loops must be in place to address any identified deficiencies quickly.

Additionally, Minnesota should develop and maintain standardized accessible templates for all official documentation, ensuring consistency in compliance and reducing the risk of inadvertent barriers. All guidance documents, whether static PDFs, interactive forms, or web-based FAQs, must be made available in alternative formats upon request.

For ongoing compliance, the state can implement regular audits of published materials and maintain an open channel for stakeholders and end-users to report accessibility issues. Incorporating accessibility requirements into vendor agreements and project charters will reinforce accountability.

Finally, all public-facing documentation should include a clear accessibility statement and contact information for requesting accommodations, allowing users to seek assistance or alternative formats as needed. Through these integrated practices, Minnesota can reliably ensure that all materials supporting the transition away from non-governmental managed care are fully accessible and compliant with WCAG 2.0 Level AA and Section 508 standards.

VII. Plan for Member and Provider Support

As the state transitions away from non-governmental managed care options, targeted support for both members and providers will be essential to ensure continuity of care and minimize disruption. Members will require clear, accessible communication about changes to their coverage, especially those moving from managed care plans to Fee for Service (FFS) arrangements. Outreach initiatives such as dedicated helplines, informational materials, and in-person assistance at county offices can help beneficiaries understand their new way to access benefits, and provider options. Providers, meanwhile, will benefit from training sessions and resource guides detailing new billing procedures, reimbursement methodologies, and compliance requirements associated with FFS. Coordination between counties, state agencies, and provider organizations will be necessary to anticipate challenges and swiftly address issues as they arise.

During the initial phase of the transition, ongoing support must be tailored to address the diversity of county arrangements and coverage types. Counties with existing CBP and county HMO programs may need additional technical and financial resources to ramp up capacity and accommodate expanded enrollment, should that become necessary. Providers in these counties will require guidance on any changes in network composition, prior authorization processes, and service delivery expectations to ensure that patient care remains uninterrupted. In counties shifting fully to FFS, both members and providers may need more intensive support adapting to a less centralized model of care coordination, where individuals are responsible for selecting providers and navigating benefits independently. Outreach must be sensitive to geographic disparities and ensure equitable access to information and services, regardless of county or coverage status.

Once the transition is complete, the state's ongoing support under the FFS program will focus on standardizing reimbursement practices, administering fraud prevention measures, and maintaining consistent quality oversight. Members will continue to benefit from state and county-level customer service, eligibility assistance, and provider directories to help them access services. Providers will be supported through regular updates on policy changes, technical assistance related to FFS billing and compliance, and opportunities for collaboration with county agencies to streamline care coordination. The state will be responsible for oversight and guidance to ensure that practices meet CMS and state standards. Through these efforts, the state aims to maintain high levels of service quality, fairness in reimbursement, and robust community partnerships throughout the managed care transition and under the ongoing FFS model. DHS offers an Ombudsperson for Public Managed Care Programs, however there is not a similar resource in place for FFS. The State could consider expanding the role of this office to support all MinnesotaCare enrollees.

A. Care Coordination Landscape in Minnesota

Minnesota currently has five different managed care programs:

- Medical Assistance for Families and Children (Prepaid Medicaid Assistance Programs (PMAPs))
- MinnesotaCare
- Minnesota Senior Health Options (MSHO)

- Minnesota Senior Care Plus (MSC+)
- Special Needs BasicCare (SNBC) – integrated (I-SNBC) and non-integrated (SNBC)

Medical Assistance for Families and Children (Prepaid Medicaid Assistance Program (PMAP)

Medical Assistance for Families and Children is delivered through Prepaid Medicaid Assistance Program (PMAP), which provides comprehensive health coverage to eligible low-income families and children in Minnesota. This program operates under a managed care model, where enrollees receive medical, dental, and behavioral health services from networks of providers coordinated by contracted health plans. PMAP is administered through a mix of CBPs and HMOs that collectively provide coverage statewide.

MinnesotaCare

MinnesotaCare is Minnesota's Basic Health Program, a publicly subsidized health insurance program serving individuals and families who do not qualify for Medical Assistance but meet certain income criteria. MinnesotaCare is funded through a combination of enrollee premiums and state and federal dollars, with an emphasis on reducing barriers to care and promoting health equity.

Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+)

MSHO is a specialized managed care program for older adults who are eligible for both Medicare (parts A and B) and Medicaid. Participants enroll into an integrated Medicare and Medicaid plan offered by the same health plan, allowing for seamless coverage regardless of the payor. Participants benefit from care coordination, access to home and community-based services, and comprehensive coverage tailored to the needs of seniors, particularly those with complex medical and social requirements. Those who are enrolled in MSHO are assigned to a care coordinator to help with healthcare needs and navigation of Medicare and Medicaid coverage. Individuals who do not select a plan or disenroll from MSHO are automatically enrolled in MSC+. This program is administered by DHS and several health plans.

MSC+ is another managed care program for seniors on Medical Assistance, particularly those who do not qualify for MSHO, or choose not to enroll in it. MSC+ provides essential medical and long-term care services, including nursing facility care, home health, and personal support, through health plans that emphasize care coordination and individualized service planning.

Special Needs BasicCare (SNBC) for People with Disabilities

SNBC serves Minnesotans with disabilities and significant health needs. SNBC includes both integrated (I-SNBC) and non-integrated options, allowing enrollees dually eligible for both programs to choose the level of coordination between their Medicare and Medicaid benefits. Integrated SNBC offers streamlined, comprehensive coverage under a single health plan, while non-integrated SNBC provides managed Medicaid benefits for those not also eligible for Medicare or for those who prefer to keep their Medicare coverage separate. Both options are designed to support individuals with special needs, promote continuity of care, and improve health and quality of life through proactive case management and access to a broad spectrum of services.

B. Impact of Each Model on Care Coordination

To facilitate continuity of care throughout the transition from managed care, existing plans must coordinate effectively with established county-based entities and care coordinators across the various Medicaid programs. Given the substantial enrollment figures, additional transition coordinators may be required at the state or county level to support individuals transitioning from non-governmental managed care offered care coordination to FFS or an ASO or governmental MCO. Although enrollees in PMAP and MinnesotaCare are not generally assigned a care coordinator, there are currently various care coordination activities provided by non-governmental HMOs including service coordination and assistance in accessing resources. Most MCOs provide more intensive care coordination for enrollees who are pregnant, have behavioral health needs, or have complex conditions. The state may need to evaluate the use of subcontractors—including those with technology expertise to support transition monitoring and care coordinators to deliver online or offline assistance to enrollees. To maintain continuity of care, the state should also consider establishing a temporary claim and reporting framework to ensure uninterrupted care delivery.

Availability of integrated plans by government led or run managed care plans is limited, and therefore the transition to FFS will leave many seniors and integrated SNBC enrollees in a situation where they will be receiving their Medicare Part A, Medicare Part B, Medicare Part D and Medical Assistance benefits separately under the FFS model. PrimeWest Health and South Country Health Alliance offer all products for older adults and people with disabilities. IMCare offers MSHO and MSC+ which would leave Itasca County with no integrated SNBC option. Hennepin Health does not currently participate in Medicare and therefore does not offer MSHO or integrated SNBC. Hennepin county residents would be left with no integrated health plan options when currently 62% of eligible enrollees have selected integrated Medicare/Medicaid plans.

The MSHO, SNBC, and MSC+ plans currently provide care coordinators for enrolled members. To ensure uninterrupted care coordination and maintain high quality of care for dual-eligible individuals currently served by HMOs, the state should establish a structured transition protocol and care coordination model, see below, that closely mirrors the comprehensive support models offered by the existing MSHO, SNBC, and MSC+ programs. Assigning dedicated care coordinators with expertise in both Medicare and Medicaid benefits is critical, as these professionals can provide individualized care planning, assist with medication management, and facilitate referrals and follow-ups during and after the transition to fee-for-service or county-based systems. Leveraging technology to actively monitor care transitions and outcomes, and creating robust communication channels between providers, counties, members, and family supports, will help identify care gaps early and ensure continuity. Continuous staff training, clear workflows, and adherence to established best practices for care coordination can further safeguard quality, so that even as organizational structures change, dual-eligible members experience minimal disruption and continue to receive holistic, person-centered care.

Eliminating Non-Governmental Risk from the Status Quo

If DHS will be implementing a state operated care-coordination model for seniors and enrollees with disabilities who will be enrolled in the FFS program, they will need to follow this below general model for implementing the new program:

- **Define Care Coordination Functions** Specify core activities—comprehensive assessments, medication reconciliation, care planning, referrals, follow-up, and transitions of care. These models should align as closely as possible to the offerings under the MHSO, integrated SNBC, and MSC+ programs, to provide the best continuity and parity across counties.
- **Outline Staffing Requirements** Determine the mix of care coordinators (nurses, social workers, community health workers), supervision, caseload size, and training needs. This will be the core driver of program cost to the State, so scope and scale should be considered closely.
- **Develop Workflow and Protocols** Create standardized workflows for intake, assessment, care planning, ongoing monitoring, and escalation of urgent needs. Many of these may exist as guidance for the existing MHSO/Dual and MSC+ programs operated by HMOs.
- **Establish Documentation Standards** Ensure compliance with billing requirements for fee-for-service reimbursement and develop templates for care plans and progress notes. These are likely already in place for the program, but completion of the workflow by state staff or a third party will need to be considered in the fiscal impact of the model.

Multiple/Regional ASOs

One of the greatest benefits of an ASO model is that the ASO will continue to coordinate care for members who are currently receiving care coordination from an MCO/HMO. Moving from a managed care environment to one where many member services are managed by an ASO should have minimal impact on the member's experience of care. If the ASO is an existing MCO/HMO in the State, it is entirely possible for some members to see no difference at all in their care coordination as part of the transition.

Expand County-Based Purchasing Plans and County-Owned HMOs

Expanding the CBP and county HMO offerings would require review by the State to ensure continuity of care for enrollees. As noted above, the MSHO, SNBC, and MSC+ plans currently provide care coordinators for enrolled members, but IMCare does not offer a SNBC plan, while Hennepin Health does not participate with Medicare, and thus does not have an integrated offering. Enrollees in Itasca and Hennepin Counties who are currently enrolled in an existing MCO/HMO that offers care coordination would be left without care coordination unless the care coordination model noted above is implemented.

Beyond the current CBPs and county HMO, the State will need to consider how to ensure care coordination for enrollees in counties that might have a newly established CBP or county HMO. The State would have two distinct options to consider. These include:

- Mandate all **county based** managed care plans offer **integrated plans (**MSHO, and SNBC). This would mandate IMCare and Hennepin Health to expand its offerings, which could place additional administrative burden on the counties including an increase in number of staff, and other resources. Additionally, this would require participating in Medicare, adding another layer of administrative work for the plans. The added financial requirements could require the State to review if additional funding is needed. This would also mandate that any newly created CBPs and county HMOs include all integrated offerings.

- **Do not mandate integrated plan offerings, State fill in gaps in care coordination** by taking this route the State would be handling care coordination for eligible members. The State would provide care coordination for any enrollee on Medicaid FFS, and potentially any county based managed care plan enrollee who is also eligible for care coordination. The State would need to consider if enrollees who are dually eligible would be able to enroll in a CBP or county HMO or whether they would only be able to enroll with Medicaid FFS.

C. Continuity Of Care for Individuals Who Relocate Within Minnesota

Only 3 CBPs (South Country Health Alliance, Primewest, and IMCare) offer MSHO, MSC+, and the 2 CBPs and Hennepin Health offer an SNBC plan, meaning many counties will be left without coverage under the transition from non-governmental managed care. If the state does not develop a comparable care coordination offering for FFS only counties, individuals moving between counties would lose care coordination services when moving into a county that does not have a CBP that offers MSHO, SNBC, or MSC+. To maintain continuity of care for individuals who relocate within Minnesota, two barriers must be addressed:

- The availability of the care coordination service in all counties, and
- The ability to exchange information for patients between care coordination programs.

The State could work with CBPs to expand the geographic coverage of these plans, or the state can elect to create a care coordination program operated by a TPA that can serve patients in these populations across the State to ensure statewide coverage. If the State operates a care coordination program, patients enrolled in the existing MSHO/Dual or MSC+ plans would continue to receive care coordination through their plans, while patients enrolled in FFS could opt in to the State run care coordination program.

The state will need to work closely with MSHO, SNBC, and MSC+ plan providers to ensure sufficient data exchange to ensure continuity of care as enrollees move between counties. A state-wide monitoring system may need to be established to maintain an active record of coverage for members. To maintain only CBP and county HMO systems on an individual framework may cause gaps in care continuity as system transfers and transition documentation could lead to delays. Additionally, other challenges might arise from the introduction of new plans.

Considerations for Dual Eligible Enrollees & MSHO program

The MSHO program provides coordinated managed care for Medicare and Medicaid dual eligible individuals. The focus of the MSHO program is enhancing care coordination, avoiding cost shifting from Medicare to Medicaid, and boosting care quality. Below are key considerations in regard to the MSHO program.

Procedures for ensuring continuity of care from non-governmental managed care plans would require increased support with the county programs currently in place. Currently, the MSHO program is offered to individuals who are eligible and enrolled in both Medicare Parts A and B, who are at least 65 years old and live in a county where a health plan offers MSHO. The current MSHO program is managed by non-governmental managed care plans which would be eliminated under the proposed Medicaid care delivery model.

Eliminate Non-Governmental Risk from Status Quo

The transition to this model allows for CBP and county HMO arrangements to remain intact; however, current MSHO offerings rely on non-governmental options. It is very common that enrollees are first enrolled in a Medicare plan prior to becoming eligible for Medical Assistance. As a result, Medicare options drive enrollee selection of Medical Assistance plans. Regarding relocations for the MSHO program, the receiving county would need to have health plans that offer MSHO, as is the case prior to the transition to this model, in order to maintain coverage. MSHO-enrolled individuals are assigned a care coordinator to help with healthcare needs and other services. Those individuals that do not enroll in MSHO or who disenroll are automatically enrolled in Minnesota Senior Care Plus (MSC+) which is also a county based managed care program. MSC+ is for those seniors who only have MA who chose not to integrate their Medicare while MSHO is for dual eligible individuals who choose to integrate their Medicare.

Multiple/Regional ASOs

ASOs will not be able to offer the same level of care coordination that is available today under the MSHO model. Under the MSHO model, care coordinators can see both Medicaid and Medicare utilization for the enrollee. Under the ASO model, integration of Medicare data will be lost.

Expand County-Based Purchasing Plans and County-Owned HMOs

The transition to this model allows for CBP and county HMO arrangements to remain intact; however, current MSHO offerings rely on non-governmental options. It is not known at this time how many county plans would offer an MSHO option.

Considerations for Other High-Need Populations

Medically complex individuals and individuals who receive care coordination via SNBC programs depend on highly coordinated treatment plans and frequent contact with a range of providers. The state should consider developing transition protocols that emphasize proactive communication channels between outgoing and incoming care teams. Enrollees of SNBC programs and individuals with medically complex conditions should be informed about upcoming changes to their care plans to allow them to make any needed arrangements. Failure to do so may result in unwanted gaps in essential therapies and a decline in health status.

Additionally, many enrollees may face barriers related to income, housing instability, transportation, and limited digital literacy. Plans must ensure that administrative processes, such as eligibility verification and plan selection, are accessible regardless of socioeconomic status. Outreach should include multilingual materials and options for in-person assistance, especially in rural or underserved urban areas. The state should consider implementing mobile care teams or telehealth options to reach individuals who cannot easily travel to clinics or offices.

D. Outreach Initiatives

For individuals who will be transitioning from a Medicaid Managed Care plan to Medicaid FFS, or an ASO model, it will be important that the FFS program or the ASO offers equivalent or more comprehensive care coordination and outreach programs to that which was offered through the Medicaid Managed Care plan. To ensure successful outreach and coordination of care for high-needs patients, especially those living with behavioral health diagnoses, experiencing homelessness, or facing other significant barriers to care, Minnesota will need to prioritize developing a robust, multi-pronged community engagement strategy.

Leveraging trusted community organizations, local advocacy groups, shelters, and faith-based institutions can help bridge the gap between clinical systems and individuals who are traditionally underserved or disconnected from formal healthcare. Deploying culturally competent community health workers and peer navigators embedded within these networks will promote trust, offer person-centered guidance, and help individuals navigate enrollment and transition processes. Additionally, partnerships with social service agencies and housing providers can support wraparound care, addressing not only medical, but also social determinants of health. Where this is currently in the purview of the existing Managed Care Plans, DHS should, as part of the transition planning, work with plans to identify current partners so that they can be engaged by the state to ensure continuity of support through the transition period.

Simultaneously, Minnesota can bolster care coordination by engaging cross-sector case management teams that integrate behavioral health, medical, and social service expertise. Where non-governmental managed care providers have previously subcontracted this work to care management agencies, it may be possible for DHS to engage these same care management agencies to ensure a smooth transition.

Where this is not possible, DHS will need to develop capacity to ensure that patients retain access to vital supports such as medication management, counseling, and housing navigation. Outreach should employ multimodal communication—tailored mailings, text messaging, phone outreach, and in-person contacts at familiar community sites—to ensure that individuals, regardless of technological or linguistic barriers, receive consistent and clear information about their options.

Strategies to Engage Hard to Reach Populations

Eliminate Non-Governmental Risk from Status Quo To effectively engage hard-to-reach populations in fee-for-service (FFS) programs, DHS can leverage existing trusted networks such as community organizations, faith institutions, schools, libraries, and grassroots advocacy groups to build trust and facilitate outreach. Employing community health workers and leaders within cultural groups can further strengthen connections by providing culturally relevant guidance and support. DHS should utilize multimodal communication strategies, including mail, text messages, phone calls, emails, and in-person outreach at locations frequented by the target audience to ensure accessibility and broad reach. Designing culturally and linguistically appropriate messaging and materials, such as inclusive spaces with bilingual signage, will help make information and services more accessible. Finally, empowering members of the target population to serve as advisors and change agents can foster greater trust and participation, creating a sustainable feedback loop for continuous improvement in outreach efforts.

Multiple/Regional ASOs

Administrative Services Organizations (ASOs) can have a leading role in the engagement of hard-to-reach populations. By employing culturally competent community health workers and peer navigators from within these populations, ASOs can provide personalized support that addresses language, cultural, and literacy barriers. Additionally, ASOs can leverage the above communication techniques to ensure that individuals receive accessible information and assistance, ultimately fostering greater participation and continuity of care for those who might otherwise remain disconnected from essential health services.

Expand County-Based Purchasing Plans and County-Owned HMOs

Expanding the number and reach of CBP and county HMO plans strengthens the State's ability to engage hard-to-reach populations. The structure of these plans naturally integrates county programs and leverages their comprehensive understanding of local needs and barriers. CBP and county HMO plans can draw on established community networks, such as faith organizations, schools, libraries, and grassroots groups, as well as relationships with community health workers and cultural leaders to support effective outreach. While some counties may require assistance from DHS to develop standardized materials or large-scale communication tools, counties remain well positioned to identify and engage target populations within their communities.
Payment Arrangements for Care Coordination

Currently, managed care plans offer varying care coordination programs to facilitate access to quality care including prevention, screening and specialty care and reduce service duplication. They also have care coordination programs for specific populations including pregnant enrollees, enrollees with behavioral health needs, and enrollees with complex conditions. Care coordination is a critical component of the MSHO program which reduces the administrative burden of coordination of benefits, ensures access to covered services under both Medicare and Medicaid and avoids cost shifting between Medicare and Medicaid.

Reimbursement for care coordination programs varies widely and options include fee for service rates set to ensure sustainable access as well as per member per month rates for longer-term care coordination services. Care coordination programs may also incorporate value-based purchasing arrangements and alternative payment methodologies.

Eliminate Non-Governmental Risk from Status Quo

This model will result in the absence of managed care in certain counties coupled with the reduction in managed care options and coverage in others, creating an increased need for care coordination under Medicaid fee for service.

Given the reduction in care coordination offerings currently provided through managed care payment arrangements, the state may consider enhanced care coordination. Care Coordination programs can be added and evaluated under Medicaid State Plans or waivers and fee for service reimbursement rates will need to be established to compensate for care coordination services.

Multiple/Regional ASOs

This model will introduce non-risk ASOs in place of managed care, creating an increased need for care coordination under Medicaid fee for service. Given the potential for reduction in care coordination offerings currently provided through managed care payment arrangements, the state may consider enhanced care coordination. Care Coordination programs can be added and evaluated under Medicaid State Plans or waivers and fee for service reimbursement rates will need to be established to compensate for care coordination services.

Expand County-Based Purchasing Plans and County-Owned HMOs

Under this model, care coordination would continue to be offered by CBP and county HMO plans. There is a potential for more individuals to opt out of managed care and move to an FFS delivery model, creating an increased need to consider care coordination offerings and reimbursement for an FFS population.

Coordination programs can be added and evaluated under Medicaid State Plans or waivers.

E. Quality Measurement

As a significant portion of the population will no longer be covered under Medicaid Managed Care under each model, it is important that the State identifies core measures to ensure that all enrollment groups are receiving comparable and high-quality care.

The State currently provides oversight of Managed Care through a variety of clinical quality measures including the CMS's Medicaid core set measures: the Child core set and the Adult core set, and annual external independent reviews by an External Quality Review Organization (EQRO). The state also requires plans to participate in performance improvement projects, manage grievances in partnership with the Managed Care Ombudsperson, and conduct surveys of consumer experience. For more information on current quality measurement activities, please see the State's Quality Measurement Strategy.

Eliminate Non-Governmental Risk from Status Quo

While EQRO reviews are mandated for MCOs, they are not required for FFS. The state will need to determine whether they want to conduct evaluations similar to those an EQRO would provide for the population enrolled in FFS.

The state will need to determine which of the over 50 measures of clinical quality currently calculated will be applied to the growing FFS population, and if any additional data will need to be collected to meet measurement needs.

Under this model, there would be no non-governmental HMOs for MDH to review, although audits and compliance reports would continue for CBPs and the Hennepin Health HMO. We would recommend including a review of the FFS population on specific quality measure performance, to ensure parity in quality of care across CBP and FFS enrollees.

If the state does not currently calculate performance on HEDIS measures for the FFS population, this will be an additional cost and administrative burden to the state for the coding and calculation of the measures, and continued alignment with annual HEDIS measure updates.

Multiple/Regional ASOs

Under this model, ASOs would continue to be held to clinical quality measurement standards within the Child core set and the Adult core set, but while EQRO reviews are mandated for MCOs, they are not required for ASOs. The state will need to determine whether they want to conduct evaluations similar to those an EQRO would provide for the population enrolled in ASOs. The state will need to decide whether to require ASO's participate in performance improvement projects just as the MCOs do.

Expand County-Based Purchasing Plans and County-Owned HMOs

Under this model, CBPs and County HMOs would continue to be held to clinical quality measurement standards within the Child core set and the Adult core set, as well as EQRO reviews and performance improvement projects.

Recommended Quality Metrics for Health Care Service Delivery

Managed Care Plans in Minnesota are all required to calculate performance on the Healthcare Effectiveness Data and Information Set (HEDIS) measures, across several domains:

- Effectiveness of Care
- Access/Availability of Care
- Utilization and Risk-Adjusted Utilization
- Experience of Care
- Disease Specific Measures (e.g., Breast Cancer, Diabetes, Asthma)

NCQA requires health plans to collect this information in the same manner so that results can be compared to one another. For models where more individuals are expected to be served through FFS, we would recommend that the state select a subset of HEDIS measures to monitor for the FFS population so as to compare performance across FFS enrollees and those enrolled in each CBP and county HMO plan.

Plan for Ongoing Evaluation and Reporting of Quality Outcomes

Minnesota Department of Health (MDH) currently conducts Triennial Quality Audits and produces Compliance reports for HMOs and CBPs that provide coverage to enrollees in the state Medical Assistance (Medicaid) and MinnesotaCare programs, on behalf of the Minnesota DHS.

F. Basic Health Program Compliance

MinnesotaCare is Minnesota's Basic Health Program (BHP). It is required under 42 CFR Part 600 to be competitively contracted and for there to be choice of at least two health plans. In the absence of multiple BHP offerors, the state would need to request an exception from this requirement. Given the removal of non-governmental managed care across all models, all models present a potential challenge for the BHP.

G. Managed Care Opt-Out

Consideration and Recommendations for Allowing Individuals to opt Out of Managed Care (Eliminate Non-Governmental Risk from Status Quo)

Currently in Minnesota, everyone who has MinnesotaCare and many people who have Medical Assistance (MA) must enroll in a health plan. This will become more complex as non-governmental organizations are no longer able to offer the managed care benefit in the state.

Under the model to Eliminate Non-Governmental Risk from Status Quo, some counties will continue to have a single CBP or county HMO plan available, and other counties will only have FFS.

While Federal regulation requires that Medicaid beneficiaries in a managed care program must be given a choice of at least two MCOs, with limited exceptions for rural areas,[2] this provision does not apply, when the managed care provider is a county–operated health insuring organization [Section 1932(a)(3)(C)].

When the CARMA model is implemented in 2027, enrollees will have the option to opt out of a CARMA plan offered by a CBPP and receive their coverage through FFS. A similar policy could apply to any county health plan operating under this model.

VII. Financial Analysis

This section evaluates the financial impact of a shift in payment model from the perspective of the state Medicaid program as well as the providers serving Medicaid enrollees. The financial impact will consider many factors as outlined below. Underscoring each of these factors is a need to ensure continuous compliance with federal and state regulations and maintain continuous access to quality care for Minnesotans.

[2] For residents of rural areas, a state may offer only a single MCO. In this case, however, beneficiaries must still be able to choose from at least two primary care providers within that single plan. [§ 438.52(b)]

A. Overarching Assumptions

Eliminating Non-Governmental Risk from Status Quo

Switching to the Eliminating Non-Governmental Risk from Status Quo care delivery model, which removes non-governmental managed care, is expected to boost Medicaid FFS enrollment in counties without CBP coverage, while increasing FFS and CBP enrollment where CBPs and non-governmental HMOs overlap.

The following are key assumptions relating to Eliminating Non-Governmental Risk from Status Quo:

- Percent of Non-Governmental HMO-covered individuals in counties with CBP coverage likely to shift to Medicaid CBP coverage vs. FFS coverage
    - Beginning in 2026, 100% of the PMAP population will shift to CBP coverage.
    - Beginning with model implementation:
        - 20% of existing CBP population shifts to FFS in counties with CBP coverage (including PMAP population previously shifted to CBPs)
        - 20% of PMAP Seniors and SNBC populations covered by non-governmental HMOs also shift to FFS with the remaining 80% moving to CBPs.
- 100% of Non-Governmental HMO-covered individuals in counties with no CBP shift to Medicaid FFS
- Hennepin Health overall Medicaid coverage remains unchanged

All modeling is based on the most current available enrollment data. Managed care average monthly enrollment is based on the publicly available Minnesota Managed Care Enrollment Figures Totals Reports using data from calendar year 2024 time period.[3] Fee for service monthly enrollment data is calculated by netting out monthly managed care enrollment from overall Medicaid enrollment values by county. Overall Medicaid enrollment totals are based on data published by DHS from calendar year 2024 time period.[4]

Below, estimated enrollment is presented as a percentage of the overall Medicaid-eligible population. It is likely that significant shifts in eligibility may occur stemming from H.R. 1 implications as well as other factors including overall population shifts.

Beginning in FY26, all PMAP Group enrollees in CBP coverage areas will shift to CBP reimbursement resulting in an increase in CBP enrollment coupled with a reduction in non-governmental HMO enrollment. Given that this shift will occur prior to the implementation of an alternative payment model, the table below includes a column highlighting the impact on enrollment. This forms the "baseline" which we will compare to Eliminating Non-Governmental Risk from Status Quo.

[3] Minnesota Managed Care Enrollment Figures Totals Reports accessed 12/5/25

[4] Who Medicaid and MinnesotaCare serve / Minnesota Department of Human Services accessed 12/5/25

All financial modeling assumes that these relative percentages remain fixed even as the overall population of Medicaid enrollees changes leading up to the potential implementation date in 2029.

Table 1. Estimated Enrollment and Medicaid Coverage for Eliminating Non-Governmental Risk from Status Quo

Coverage Type	Current Estimated % of Statewide Medicaid Coverage	Modified for PMAP Group Moving to CBP (effective 2026)	Estimated % of Statewide Medicaid Coverage After Eliminating Non-Governmental Risk from Status Quo
Fee For Service (FFS)	**16%**	**16%**	**90%**
County Based HMO (Hennepin Health)	**2%**	**2%**	**2%**
County Based Purchasing (CBP)	**6%**	**9%**	**8%**
Non-Governmental HMO	**76%**	**73%**	**0%**

Multiple/Regional Administrative Services Organization(s) (ASO)

Switching to the Regional ASO care delivery model, which will replace all managed care plans including CBPs and county HMOs with multiple regional ASOs will significantly shift Medicaid enrollment, cost and reimbursement.

All modeling is based on the most current available enrollment data. Managed care average monthly enrollment is based on the publicly available Minnesota Managed Care Enrollment Figures Totals Reports using data from calendar year 2024 time period.[5] Fee for service monthly enrollment data is calculated by netting out monthly managed care enrollment from overall Medicaid enrollment values by county. Overall Medicaid enrollment totals are based on data published by DHS from calendar year 2024 time period.[6]

[5] Minnesota Managed Care Enrollment Figures Totals Reports accessed 12/5/25

[6] Who Medicaid and MinnesotaCare serve / Minnesota Department of Human Services accessed 12/5/25

Below, estimated enrollment is presented as a percentage of the overall Medicaid-eligible population. It is likely that significant shifts in eligibility may occur stemming from H.R. 1 implications as well as other factors including overall population shifts.

Beginning in FY26, all PMAP Group enrollees in CBP coverage areas will shift to CBP reimbursement resulting in an increase in CBP enrollment coupled with a reduction in non-governmental HMO enrollment. Given that this shift will occur prior to the implementation of an alternative payment model, the table below includes a column highlighting the impact on enrollment. This forms the "baseline" which we will compare to Eliminating Non-Governmental Risk from Status Quo.

All financial modeling assumes that these relative percentages remain fixed even as the overall population of Medicaid enrollees changes leading up to the potential implementation date in 2028.

Table 2. Estimated Enrollment and Medicaid Coverage for Multiple/Regional Administrative Services Organization(s) (ASO)

Coverage Type	Current Estimated % of Statewide Medicaid Coverage	Modified for PMAP Group Moving to CBP (effective 2026)	Regional ASO Estimated % of Statewide Medicaid Coverage
Fee For Service (FFS)	16%	16%	100%
County Based HMO (Hennepin Health)	2%	2%	0%
County Based Purchasing (CBP)	6%	9%	0%
Non-Governmental HMO	76%	73%	0%

Expand County-Based Purchasing Plans and County-Owned HMOs

Expanding CBPs and county HMOs to replace non-governmental HMOs will significantly shift Medicaid enrollment, cost and reimbursement. There are noteworthy differences in overall spending and administrative costs associated with county-based models. At this time, it is unclear the extent to which existing CBPs will expand their coverage areas, new CBPs will emerge or one or more County-Based HMOs will join Hennepin Health. Counties will also need to understand the financial sustainability of their individual role in Managed Care delivery. Recruiting enough CBPs and county HMOs to ensure statewide coverage may depend on the state's up-front investments and ongoing support options to counties. The State might need to implement legislative requirements to ensure new CBPs or county HMOs are created, and/or existing CBPs expand. Without a mechanism in place that outlines expansion requirements there would be the distinct possibility that some

counties do not have a CBP or county HMO offering, or that CBP and county HMO expansion efforts differ greatly, creating an unbalanced situation that could negatively impact enrollees.

Currently, most of Minnesota's Medicaid beneficiaries participate in mandatory managed care. One key underlying requirement of mandatory managed care is choice of coverage. Consistent with Section 1932 (a)(3), In order to maintain choice of coverage "a State must permit an individual to choose a managed care entity from not less than two such entities". There are exemptions for individuals residing in rural areas which allow for a single coverage option as long as certain minimum criteria are met to ensure beneficiaries have choice in providers.

The following is a key assumption relating to Expanding CBPs and County-Owned HMOs:

- FFS enrollment will increase under this model as individuals currently enrolled in non-governmental managed care as well as individuals currently enrolled with CBPs or Hennepin Health would have the option to enroll in FFS or CBPs or county HMOs. In the absence of mandatory managed care, it is possible that some individuals will choose FFS over CBPs and county HMOs. Although the proportion of individuals that will opt out of managed care is unknown at this time, the current model assumes 80% of those currently covered under managed care will retain managed care coverage (including those shifting from non-governmental HMOs to CBPs and county HMOs managed care plans). The remaining 20% will move to FFS roughly doubling FFS enrollment in the State.

All modeling is based on the most current available enrollment data. Managed care average monthly enrollment is based on the publicly available Minnesota Managed Care Enrollment Figures Totals Reports using data from calendar year 2024 time period.7 Fee for service monthly enrollment data is calculated by netting out monthly managed care enrollment from overall Medicaid enrollment values by county. Overall Medicaid enrollment totals are based on data published by DHS from calendar year 2024 time period.8

Below in table 3, estimated enrollment is presented as a percentage of the overall Medicaid-eligible population. It is likely that significant shifts in eligibility may occur stemming from H.R. 1 implications as well as other factors including overall population shifts. All financial modeling assumes that these relative percentages remain fixed even as the overall population of Medicaid enrollees changes leading up to the potential CBP and county HMO managed care expansion implementation date in 2029.

[7] Minnesota Managed Care Enrollment Figures Totals Reports accessed 12/5/25

[8] Who Medicaid and MinnesotaCare serve / Minnesota Department of Human Services accessed 12/5/25

Table 3. Estimated Enrollment and Medicaid Coverage for Expanding County-Based Purchasing Plans and County-Owned HMOs

Coverage Type	Current Estimated % of Statewide Medicaid Coverage	Modified for PMAP Group Moving to CBP (effective 2026)	Expanded County-Based Managed Care Estimated % of Statewide Medicaid Coverage
Fee For Service (FFS)	16%	16%	32%
County Based HMO (Hennepin Health)	2%	2%	2%
Legacy County Based Purchasing (CBP) Plans	6%	9%	9%
Expanded County Based Managed Care (CBP or HMO)			57%
Non-Governmental HMO	76%	73%	0%

**Reflects estimated anticipated growth in County-Owned Managed Care overall including both CBPs and county HMOs*

B. Financial Impact to the State

The financial analysis evaluates potential differences in Medicaid service and administrative costs. Service costs will compare state spending to support healthcare services provided to beneficiaries, such as payments to providers under fee-for-service (FFS) models or capitation payments in managed care.

Administrative costs, on the other hand, include expenses related to oversight, coding and calculating performance measures, and managing in-house or vendor-supported initiatives.

While service costs represent the majority of Medicaid spending, administrative costs, though smaller, are likely to vary significantly across delivery models. Service costs are also broken into claims costs and separate supplemental payment costs. The current structure of available and pending supplemental payment programs varies widely between FFS and managed care.

In addition to state expenditures, the net financial effect on the state is also influenced by the sources of revenue used to fund the Medicaid program. This includes an evaluation of differences in federal Medicaid support as well as the impact of changes to the delivery model on provider taxes, intergovernmental transfers, and additional non-federal funding sources. According to state statute 256B.19, counties cover anywhere from 0% to 50% of the non-federal portion of Medicaid funding, depending on the benefit type and recipients. If a greater share of Medicaid spending is under a fee-for-service delivery system, more of the cost burden could shift from the state to the counties.

C. Financial Impact to Providers

Financial impact should be considered from the perspective of Medicaid providers to assess the long-term sustainability of varying provider types as well as the likelihood that a shift in delivery model could significantly impact access to care.

Specific focus areas to be evaluated include:

- Differences in reimbursement rates and incentive structures between FFS and managed care.
- Differences in applicable supplemental payment programs between the Fee for Service supplemental payment programs and the managed care Directed Payment Programs

D. Payment Rate Adjustments

Assessment of Any Necessary Modifications to Fee-for-Service Payment Rates

It is expected that an increase in fee-for-service in place of some or all managed care arrangements may lead to significant shifts in reimbursement for many providers. In general, fewer managed care arrangements and more fee for service will lead to more consistent reimbursement levels and greater revenue predictability. However, the removal of certain managed care arrangements could reduce payments and alter coverage of enhanced services.

A detailed assessment of historical reimbursement arrangements across payment models, services categories and geographic regions will be essential to anticipate the potential future impact of a shift in payment models on coverage, quality and access. The assessment will need to factor in interim reimbursement rates as well as payments received through supplemental payment programs which may be subject to change based on delivery model.

Gaining an understanding of current reimbursement levels will help to proactively identify gaps which could limit access to care as well as ensure ongoing compliance with federal reimbursement regulations. 42 CFR § 447.204 establishes two competing priorities when it comes to establishing reimbursement rates – 1) ensuring rates are reasonable and 2) ensuring Medicaid beneficiaries have access to quality care at a level that is comparable to the general population. Per 42 CFR:

The agency's payments must be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

In general, higher rates enhance quality and provider participation while moving away from "efficiency and economy" of care.

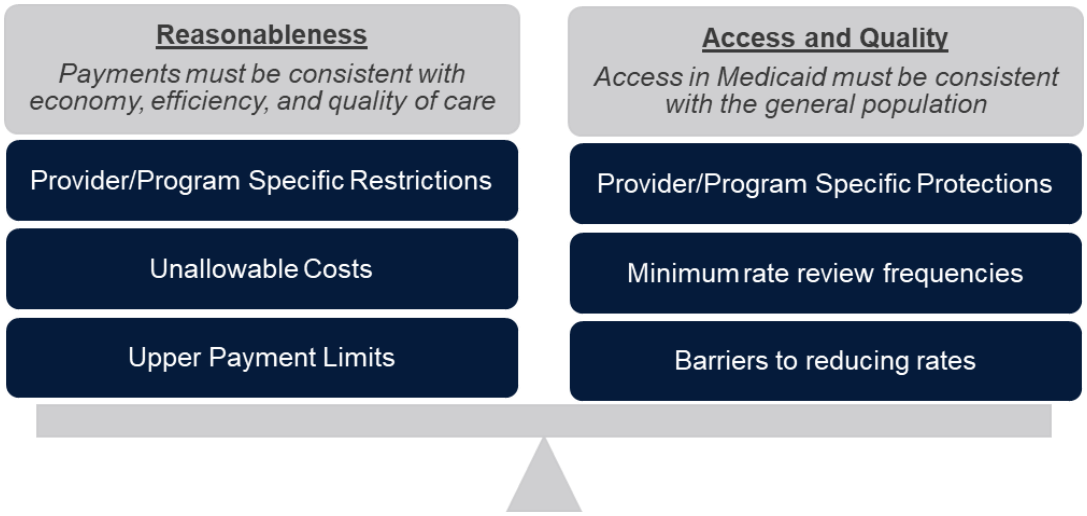


Figure 3: Balancing Medicaid FFS Rates

Strategies to Ensure Provider Access and High-Quality Care

Achieving consistent provider access and high-quality care amid shifts in the healthcare system demands a thoughtful and unified approach. While fee-for-service (FFS) models have traditionally focused on standardizing payment rates rather than guaranteeing quality, it is possible for these priorities to coexist within an FFS framework. With deliberate strategies, FFS systems can be leveraged to support both payment consistency and superior care outcomes.

First and foremost, leveraging advances in technology and data collection is essential for monitoring quality and access. The State may utilize a comprehensive set of quality metrics—such as select health outcomes, historical network adequacy, enrolled versus active providers, and pay-to-charge ratios, to assess and track provider participation and performance over time.

By establishing robust accountability and clear reporting standards, the State can proactively identify and address gaps in access. Adopting evidence-based quality measures that align with patient outcomes, care experience, and reliable processes is key to this effort. These metrics support not only the improvement of care delivery but also transparency for both providers and patients.

Integrating preventive care, population health management, and strategies to address social determinants of health will further reinforce provider capacity and care quality. Streamlining efforts, particularly by reducing administrative complexities, will allow the State to deliver patient-centered care efficiently, promoting patient

engagement and shared decision-making. Embedding preventive services and public health initiatives enhances community outreach, health education, and population health insights through better data sharing.

Collaboration is also vital. By building strong partnerships with community organizations, public health agencies, and patients, the State can foster trust and ensure that care remains responsive to local needs, particularly for marginalized and vulnerable populations. Community engagement strengthens outreach and helps address disparities in access and outcomes.

To sustain these improvements, incentive structures should be aligned with access and quality goals, encouraging providers to prioritize patient needs. While these strategies lay a strong foundation, it is equally important to anticipate and address potential challenges, including transition costs, workforce distribution, and the need to balance standardization with local flexibility.

Ultimately, with ongoing dialogue, adaptive policymaking, and shared accountability among all stakeholders, the State can create a healthcare delivery model that ensures reliable provider access and consistently high-quality care for all communities.

Table 4: Model-Specific Considerations to Ensure Provider Access and High-Quality Care

Model	Strategies
Eliminating Non-Governmental Risk from Status Quo	This model's emphasis on county-run managed care programs may support efforts to maintain local provider networks and a collaborative approach to care delivery; however, not all counties have CBP or county HMO coverage which could lead to inconsistencies.
Multiple/Regional Administrative Services Organization(s) (ASO)	The regional structure of the ASOs could create opportunities to develop community-focused networks similar to those currently managed by CBPs and HMOs.
Expand County-Based Purchasing Plans and County-Owned HMOs	Similar to eliminating non-governmental risk from the status quo, this model may support efforts to maintain local provider networks and a collaborative approach to care delivery; but it will be vital to ensure adequate networks in counties where existing county-run managed care programs are expanding, as well as for newly created plans.

Approaches to Reduce Health Disparities

Many of the same approaches to ensuring access and high-quality care can be leveraged to reduce health disparities. These foundational elements serve as the building blocks for achieving many of the State's goals. With strategic initiatives, FFS systems can be transformed to promote both payment consistency and superior care outcomes.

A pivotal aspect of this process is harnessing technology and refined data analytics to oversee both access and quality. By implementing a broad set of quality indicators, the State can ensure ongoing evaluation of provider involvement and effectiveness. Establishing firm standards for accountability and reporting empowers Minnesota to swiftly pinpoint and resolve shortcomings in care access, while enhancing openness and clarity for all stakeholders.

As noted in relation to integrating preventive care, population health management, and strategies to address social determinants of health will reinforce provider capacity and elevate quality. Simplifying administrative processes enables patient-centered care delivery, strengthens patient engagement, and supports shared decision-making. Embedding preventive services and public health initiatives further advances community outreach, health education, and data sharing—all essential for population health improvement.

Collaboration is equally vital. By partnering with community organizations, public health agencies, and patients themselves, the State can foster trust and ensure care remains responsive to local needs, particularly for marginalized and vulnerable populations. Community engagement not only strengthens outreach but also helps address disparities in both access and outcomes.

Sustaining improvements requires aligning incentive structures with access and quality goals, encouraging providers to prioritize patient outcomes. While these strategies establish a solid foundation, it is crucial to anticipate and overcome challenges such as transition costs, workforce distribution, and the balance between standardization and local flexibility.

To advance these aims, Minnesota should further embrace Value-Based Payment (VBP) models, which shift the focus from volume-based reimbursement to equitable, outcome-driven care. Incremental expansion of VBP, through population health management, care coordination, and targeted pilot programs, can drive measurable improvements in outcomes and system performance.

Robust data infrastructure is essential for this transition. Investments in advanced information systems will allow for comprehensive data capture and analysis, supporting evidence-based practice and enabling effective population health management. Data-driven decision-making will also facilitate transparency and accountability across the healthcare system.

Effective VBP initiatives require collaboration beyond traditional boundaries. Partnerships with public health agencies, social service organizations, and community stakeholders help address social determinants of health, which can significantly impact patient outcomes. Coordinated, cross-sector interventions are essential to reducing disparities.

To prepare for ongoing market evolution, investments in operational efficiency and capacity building will ensure organizations are adaptable, innovative, and ready to align incentives with quality and value. Even within FFS constraints, organizations can pursue novel approaches to care delivery, technology adoption, and patient engagement that set the stage for future VBP success.

Minnesota can leverage multiple VBP strategies:

- Pay-for-Performance (P4P) Programs: Reward providers for achieving quality and efficiency targets, such as improved preventive screening rates and better chronic disease management, directly benefiting underserved populations.
- Bundled Payments: Reimburse providers for all services related to an episode of care, encouraging efficiency and improved outcomes for populations with significant health disparities.
- Accountable Care Organization (ACO) Participation: Enable shared savings for meeting cost and quality benchmarks, fostering coordinated, high-quality care for populations facing barriers to access. For example, MN currently has an Integrated Health Partnership (IHP) program that has been in existence since 2013. This VBP strategy would result in the identification of additional VBP arrangements and/or the expansion of existing arrangements to augment the current program.
- Clinical Integration Networks (CINs): Coordinate care and negotiate value-based incentives, leveraging resources to improve access and ensure evidence-based treatments for all patients.
- Risk-Based Pilots and Demonstrations: Test new models and build capacity by targeting populations with notable health disparities, identifying effective strategies for reducing inequities.

Adopting these strategies is not without challenges. Limited financial incentives, fragmented data systems, operational complexity, payer resistance, and regulatory barriers can impede progress. Solutions include phased implementation, demonstration pilots, and continuous stakeholder engagement to ensure sustainable change.

By embracing innovative payment models, investing in robust data infrastructure, and championing cross-sector collaboration, Minnesota can lead the nation in reducing health disparities and promoting equitable, patient-centered care. These reforms will not only strengthen our healthcare system for today's needs but will also build resilience and adaptability for tomorrow.

E. Supplemental Payments for Hospitals and Other Provider Types

The passage of H.R. 1 in July 2025 introduced a significant shift in managed care supplemental payments which will be phased in gradually beginning in 2028. This includes the eventual reduction of certain state directed payment (SDP) programs to 100% of Medicare reimbursement as well as a reduction in many state Provider Tax programs. It is also likely that H.R. 1 and other shifts will impact overall Medicaid enrollment which could significantly alter the total supplemental payments received by Minnesota's providers under both FFS and managed care.

The timing of these and other state and federal shifts could coincide with a shift to an alternative payment model, making it challenging for the state to isolate the financial impacts that are directly related to the payment model.

Currently, Minnesota has a range of supplemental payment programs in place under Medicaid Fee for Service including the following:

- Upper payment limit programs for inpatient and outpatient hospital services based on provider cost available to a limited number of hospital providers.
- Average Commercial Rate supplemental payment programs for certain ambulance, dental, anesthesia and physician services providers.

Under Managed Care, there are multiple State Directed Payment (SDP) programs currently in place with one additional new program pending approval by CMS. SDPs fall into one of two categories – "FFS Floor Arrangements" which require managed care plans to reimburse at the same or greater levels than Medicaid FFS or Supplemental Payment programs which provide lump-sum payments or rate add-ons in addition to Medicaid base rates. The following is an overview of current and pending State Directed Payments:

- FFS Floor Arrangement SDPs:
    - Behavioral Health Homes
    - Certified Community Behavioral Health Clinics (CCBHCs)
    - Dental Services
    - Long-Acting Reversible Contraceptives
    - Medical Transportation
    - Designated Mental Health and Substance Use Disorder (SUD) programs
- Existing Supplemental Payment SDPs:
    - Integrated Health Partnership
    - Hennepin County Medical Center (HCMC) Inpatient/Outpatient, Physician Services Directed Payment programs
        - Began in January 2022
        - Estimated to direct payment of $283M in CY25
- New/Pending SDPs:
    - Outpatient pharmacy Directed Payment Program
        - Effective upon approval
        - Estimated to direct payment of $12.6M in CY25

Shifting more beneficiaries to a Fee for Service delivery model will result in a decrease in the overall value of each existing and proposed supplemental payment SDP; however, in most cases corresponding increases in FFS supplemental payment programs will offset or even exceed current SDP payments.

Figure 4 below reflects the potential future state of provider revenue broken out across Base Payments and Supplemental Payments. Most claims and supplemental payments for these provider types currently stem from managed care.

Figure 4 is based on actual SFY25 claims data as well as 2025 supplemental payment information provided by DHS. FFS Ambulance Supplemental Payment data includes St. Paul Fire and HCMC only. Although there is a proposed Directed Payment Program for Pharmacy providers, Pharmacy has been excluded from the chart

below (Figure 4) and the subsequent description due to pending changes in Pharmacy delivery and ongoing CMS review of the proposed Directed Payment program for rural pharmacy providers.

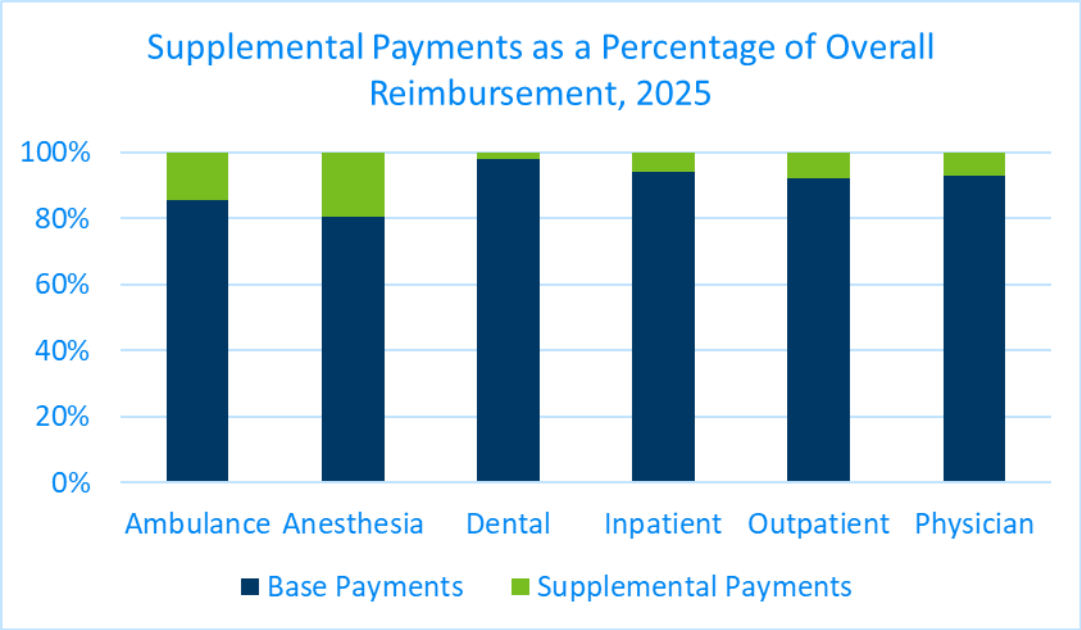


Figure 4. Estimated Supplemental Payment Revenue as a Percentage of Overall Provider Revenue

Below summarizes the current state of supplemental payments as well as future opportunities and overarching takeaways. The future state of managed care supplemental payments would be a decrease under the Expand County-Based Purchasing Plans and County-Owned HMOs model and a larger decrease under the Eliminating Non-Governmental Risk from Status Quo model. The future opportunities column relating to managed care supplemental payments does not apply to the Multiple/Regional Administrative Services Organization(s) (ASO) model given that managed care would be eliminated in its entirety and all Medicaid reimbursement would occur under a FFS delivery model.

On the whole, the current state of supplemental payments is more advantageous to some providers under Managed Care and others under FFS.

Currently, states can direct managed care payments to hospitals and physician services at an academic medical center up to Average Commercial Rates (ACR), while the Fee-For-Service Upper Payment Limit (UPL) is based on typically lower Medicare rates. Reductions to hospital managed care directed payments of 10% annually will begin in 2028 and continue until current programs in Medicaid expansion states aligns with Medicare UPLs in place under FFS. Depending on the timing of when the alternative care delivery model is implemented, there could be significant losses to HCMC if a shift occurs while the current HCMC hospital and Physician Services State Directed Payment is still above Medicare reimbursement levels.

For Anesthesia, Physician Services and Ambulance services, there are broader opportunities for participation in supplemental payment models under a Fee for Service delivery system and a shift to higher levels of FFS

enrollment will likely increase the value to providers overall. This is anticipated to occur at no cost to the state given that the funding source for these programs stems primarily from provider taxes, IGTs and CPEs.

The subsequent paragraphs reflect the current and future supplemental payment scenarios by provider type for two alternative care delivery models - Expand County-Based Purchasing Plans and County-Owned HMOs and Eliminating Non-Governmental Risk from Status Quo Models. Under the Multiple/Regional Administrative Services Organization(s) (ASO) model, all FFS supplemental payments outlined below would expand in proportion with the increase in FFS enrollees while all Managed Care directed payment programs would be eliminated completely.

Hospital Inpatient Hospital Outpatient

- **Current State**
    - **FFS:** Upper Payment Limit (UPL) program based on a Medicare Equivalent applicable to only HCMC and Regions Hospitals.
    - **Managed Care:** Directed Payment program for HCMC funded by an Intergovernmental Transfer (IGT).
- **Future Opportunities**
    - **FFS:** Increases in total FFS enrollment would lead to higher UPL payments for eligible facilities.
    - **Managed Care:** Directed Payment program could continue but will begin declining to align with Medicare reimbursement levels in 2028 as a result of H.R. 1. Directed payment program would be significantly smaller with fewer individuals covered under Medicaid managed care.
- **Overarching Takeaways**
    - Under the status quo, the Managed Care Directed payment results in higher overall reimbursement to HCMC; however, fewer hospitals are eligible for supplemental payments under managed care. The state is required to phase in H.R.1 reductions to hospital Directed Payments beginning in 2028. It is likely that in 2029, the hospital directed payments will still yield higher reimbursement than a FFS equivalent; but in the long-term allowable supplemental payment programs to hospitals could be comparable under fee for service and managed care.

Anesthesia

- **Current State**
    - **FFS:** ACR-based supplemental payment for HCMC, Regions and University of Minnesota.
    - **Managed Care:** ACR-based Directed Payment for HCMC only.
- **Future Opportunities**

- **FFS:** Currently, the FFS supplemental payment is available to more anesthesia providers. Expanding FFS could result in an increase in Anesthesia payments.
- **Managed Care:** Directed payments would decline significantly with fewer individuals covered under Medicaid managed care but the shift would likely be offset by corresponding FFS increases.

- **Overarching Takeaways**
  - Based on the programs currently in place, it is likely that total supplemental payments to Anesthesia providers would increase if FFS expanded and managed care declined.

Physician Services

- **Current State**
  - **FFS:** ACR-based supplemental payment for HCMC, Health Partners, Regions and University of Minnesota.
  - **Managed Care:** ACR-based Directed Payment for HCMC only.

- **Future Opportunities**
  - **FFS:** Currently, the FFS supplemental payment is available to more physician services providers. Expanding FFS could result in an increase in Physician Services payments.
  - **Managed Care:** Directed payments would decline significantly with fewer individuals covered under Medicaid managed care. Similar to hospital inpatient and outpatient directed payments, physician services directed payments are set to decline beginning in 2028 to be phased-down to Medicare reimbursement levels.

- **Overarching Takeaways**
  - An increase in FFS could be beneficial for reimbursement to physician services providers including hospitals with academic medical centers. Based on the programs currently in place, it is likely that total supplemental payments to Physician Services providers would increase if FFS expanded and managed care declined. On the FFS side, utilizing an average commercial rate remains an allowable supplemental payment methodology. Beginning in 2028, Managed Care Directed Payments will be phased down to align with Medicare reimbursement.

Ambulance

- **Current State**
  - **FFS:** ACR-based supplemental payment for any non-state, government-owned ambulance Provider.

- **Managed Care:** ACR-based Directed Payment for HCMC only.

- **Future Opportunities**
  - **FFS:** Currently, the FFS supplemental payment is available to more ambulance services providers. Expanding FFS could result in an increase in Ambulance supplemental payments.
  - **Managed Care:** Directed payments would decline significantly with fewer individuals covered under Medicaid managed care but the shift would likely be offset by corresponding FFS increases.

- **Overarching Takeaways**
  - Based on the programs currently in place, it is likely that total supplemental payments to Ambulance providers would increase if FFS expanded and managed care declined.

Dental

- **Current State**
  - **FFS:** ACR-based supplemental payment for HCMC and University of Minnesota School of Dentistry.
  - **Managed Care:** N/A

- **Future Opportunities**
  - **FFS:** The FFS supplemental payments are likely to continue under a new care delivery model.
  - **Managed Care:** N/A

- **Overarching Takeaways**
  - It is likely that Dental services supplemental payments will increase as more claiming activity shifts to FFS.

Estimates of Revenue Loss and Potential Cost Savings from Payment Enhancements and Pass-throughs

The state's HCMC directed payment program is currently funded using Intergovernmental Transfer (IGT) payments, allowing Minnesota managed care plans to make enhanced payments to HCMC without impacting state funding. Currently, most supplemental payment programs primarily impact a small number of providers in the state.

The federal share of funding for Managed Care supplemental SDPs is 61% compared to 51% federal match overall for FFS supplemental payment programs. While this is noteworthy, it is likely caused by the higher FMAPs applicable on average to current managed care enrollees. If more individuals in populations eligible for

enhanced federal matching shifted to FFS delivery models, the state may have an opportunity to increase the FMAP for FFS supplemental payment programs.

Impact on Taxes, Surcharges, and Other Federally Approved Arrangements

Currently, MN's state budget is supported by a 1.0 percent HMO gross premium tax as well as a 0.6% medical care surcharge. Both the tax and the surcharge are indexed to HMO premium revenues, leading to a potentially significant reduction in revenues as the prevalence of HMOs is reduced. Estimated HMO premium tax and surcharge payments are over $90M annually, resulting in a significant loss in revenue to the state in the absence or reduction of HMOs. CBPs are currently exempt from these payments.

Additionally, Minnesota's 1.8% Healthcare Provider Tax partially funds the Health Care Access Fund (HCAF). Given that the provider tax is an existing program and the amount is less than 3.5% of net patient revenues, the current program is anticipated to remain viable.

Two provider taxes passed during the 2025 legislative session, and both are under review; however, based on recent guidance from CMS relating to H.R. 1 it is expected that neither will be enacted, or if enacted they are likely to be time limited. There are strict limitations on new provider taxes initiated after the passage of H.R. 1 which are likely to prevent both pending programs from taking effect.

F. Financial Analysis

Potential Fiscal Impact

The potential fiscal impacts on the State budget include many issues. The change in net state costs is an important calculation and determining the net state cost changes resulting from a change in delivery system model is complex. It is useful to consider the delivery system costs in two categories: administrative costs and service costs.

Administrative Costs

As a percentage of total costs, the administrative costs associated with a delivery system are relatively small but nonetheless are significant. In addition, they merit careful consideration by the state because administrative tasks involved in the management of a delivery system can determine the effectiveness of the delivery system.

DHS and its actuarial vendor determine the managed care capitation rates, and the capitated rates include a component for administration and profit. The state's actuary is responsible for ensuring that the capitation rates, including the administrative portion, are "actuarially sound".

The state monitors the Medical Loss Ratio (MLR) for each managed care organization through annual reports. These reports illustrate the portion of capitation payments that are expended on services, administrative costs, and other components. The most recent data available (for the Rate Year 2024) indicates that the average portion of capitation rates related to administrative costs was 8.3%.

That aligns with DHS internal analysis of Departmental administrative costs. Based on DHS internal analyses, the Department's administrative costs to manage the fee for service program, typically average 5% to 7% of total DHS budgets.

Eliminating Non-Governmental Risk from Status Quo Would Shift Administrative Costs from MCOs to the State

Given that many counties would shift to FFS delivery, the primary fiscal impact considerations are based on the increase in FFS. Currently much of the administrative activity is conducted by managed care organizations. In shifting those responsibilities to the State, the related costs would shift as well. The significance of these "cost shifts" is that the state is currently bearing the costs through its capitation payments to managed care organizations so there would not necessarily be "new" costs to the state budget in a switch to a FFS model.

However, it is over-simplifying to do a straight comparison of the state's administrative costs to private managed care organizations' administrative costs. These relatively low percentages (i.e., 5% to 7%) may indicate administrative efficiencies by the Department and economies of scale given the magnitude of the Medicaid program. Many of the factors impacting future administrative spending are decisions yet to be made such as changes in coverage, expansion of current state administrative functions specific to the FFS program and the extent to which reimbursement rates may be adjusted in the absence of managed care.

Another issue that makes comparison of administrative costs between FFS and managed care systems challenging is that federal regulations require many administrative tasks of managed care plans that are not necessarily required in a state's administration of a FFS model. Federal requirements are expressed in federal regulations (generally at 42 CFR Part 4389) as well as in CMS guidance documents (e.g., State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval). State Medicaid agencies – including MN DHS – must incorporate these requirements in the Department's contracts with managed care plans as well as in the capitation rates. For example:

- Member enrollment and disenrollment processes
- Member notifications
- Provider and provider network selection and management, monitoring of network adequacy standards, provider grievance and appeals management
- Member grievances and appeals;
- Quality and utilization management, including:
    - care coordination;
    - authorization management;
    - cultural competence,
    - special health needs assessment and care plans,
    - accreditation; and
    - oversight and reporting on quality measures
- Program integrity
- Maintenance of health information systems and enrollee data
- Reporting requirements (including collection of encounter data, MLR reports, etc.)

- Compliance with Medicaid regulatory and contractual requirements.

Further, most managed care plans also are subject to oversight by state insurance regulators (e.g., Minnesota Department of Commerce's Insurance Division). As members of the insurance industry, managed care plans incur administrative costs related to their state licensing and related business requirements such as reporting of their respective financial statements and related audits.

Another issue worth consideration in terms of administrative costs is the state's decisions on features of its FFS oversight in a newly expanded FFS model. The managed care model has an emphasis on coordination of care. If Minnesota decides to enhance the care coordination component of the newly expanded FFS model, then administrative costs could rise above the historical average. An increased emphasis on care coordination could ultimately result in reduced spending on direct services, but it still is worth acknowledging that the state may increase its administrative spending.

Multiple/Regional Administrative Services Organization(s) (ASO) Would Shift Administrative Costs from MCOs to the State Agency and ASOs

Currently much of the administrative activity in Minnesota's Medical Assistance program is conducted by managed care organizations. In shifting those administrative responsibilities to the State as well as the ASOs, the related administrative costs would shift as well. The significance of these "cost shifts" is that the state is currently bearing the costs through its capitation payments to managed care organizations so there would not necessarily be "new" costs to the state budget in a switch to an ASO model. Still, it is important for the state to consider the net change in the State's General Fund spending when changing from one model to another.

Similar to comparing administrative spending across FFS and managed care, it would be an over-simplification to do a straight comparison of administrative costs between MCOs and an ASO model. Many of the factors impacting future administrative spending are decisions yet to be made such as the specific functions to be performed by the ASOs and the extent to which reimbursement rates may be adjusted in the absence of managed care.

Another reason that makes comparison of administrative costs between managed care and an ASO model challenging is that federal regulations require many administrative tasks of Medicaid managed care plans that are not necessarily required in a state's ASO model. In fact, there are relatively few federal requirements on Medicaid ASOs, in contrast to the many federal requirements on Medicaid managed care organizations as outlined above.

Expanding County-Based Purchasing Plans and County-Owned HMOs Would Shift Administrative Costs from Privately Owned MCOs to CBPs and a State Operated FFS model

Expanding CBPs and County-owned HMOs across the state will have some financial implications for the Minnesota state budget. In examining these implications, we must assume that not all counties will be willing or able to develop CBPs or County-Owned HMOs; therefore it is possible that some counties will default to a FFS model. Another possibility is that statewide coverage of CBPs and County-owned HMOs is legislatively mandated.

There is also a likelihood that up-front investment in administrative resources and infrastructure to support emerging and expanding CBPs and county HMOs may be a barrier to expansion of this model statewide. The legislature may want to consider the extent to which administrative costs associated with tasks like planning and coordination of CBP and county HMO expansion could be supported by the state to incentivize expansion.

Currently much of the administrative activity in Minnesota's Medical Assistance program is conducted by privately owned managed care organizations. In shifting those administrative responsibilities to the County Owned Plans (and in counties where there are no CBPs, to a state managed FFS model), the related administrative costs would shift as well. The significance of these shifts is that the state is currently bearing the costs through its capitation payments to privately managed care organizations so there would not necessarily be "new" costs to the state budget in a switch to a new model. Still, it is important for the state to consider the net change in the State's General Fund spending when changing from one model to another.

In reviewing the 2024 MLR report, the administrative percentages for all of the plans were reported as follows:

Table 5. Administrative Percentage Comparison

CBP and Hennepin Health Average 2024 Administrative Percentage	Non-Governmental HMO Average 2024 Administrative Percentage	All Plans
9.09%	8.20%	8.30%

County-owned plans (Itasca, Hennepin Health, Prime West, and South County) and privately owned plans both show varying administrative cost percentages. In 2024, some county and private plans had above-average administrative costs, with multiple possible causes for these differences.

One would expect that the privately owned plans may be able to leverage economies of scale based on their larger parent companies which provide an array of products in Minnesota and other states. Likewise, it would be reasonable to expect that the number of covered lives would also lead to economies of scale with respect to administrative costs; but we do not see an exact correlation in this data.

In reviewing the historical data (see bar chart below), the salient characteristics are that:

- Administrative cost ratios vary from year to year
- CBP administrative ratios have in some years been higher than non-CBP plans and some years lower. In the most recent year available, 2024, the administrative ratios are quite similar (8.4% for non-CBP and 8.3% for CBP).

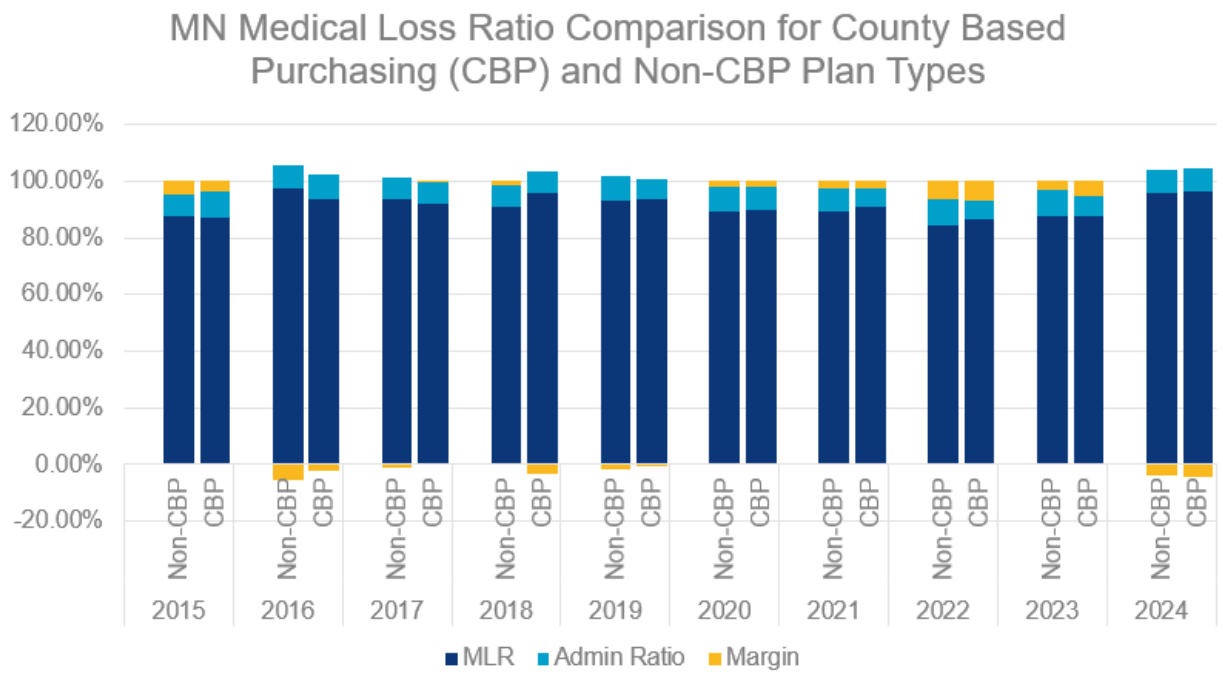


Figure 5. Administrative Percentage Comparison CBP vs. HMO

Based on historical information, one could not say with certainty that administrative costs would be higher or lower when switching from privately owned managed care plans to County-Owned Plans. Rather it is reasonable to state that administrative costs probably would vary between plans as they do in the current arrangement.

The notable exception would be in those start-up situations in which counties with no CBP or county HMO go through the process of designing and implementing their own plans; the start-up costs would be notable but after the initial period, it is expected that administrative costs would return to the levels comparable to the current CBPs and county HMO.

Analyzing administrative costs for Expand County-Based Purchasing Plans and County-Owned HMOs also requires some assumptions. If county participation is not legislatively mandated, it is possible that some counties in Minnesota will not be willing or able to develop their own County-Owned Plans. In addition, some percentage of beneficiaries may actively opt to transition to a FFS model. We cannot predict which or how many counties would opt out of developing their own CBPs or county HMOs. Therefore, this report describes the financial impact in general terms.

For the purposes of this report, the assumption in this model is that of the people currently enrolled in non-governmental HMOs, approximately 80% would shift to CBPs and approximately 20% of those currently covered under managed care plans would elect to move to FFS. Ultimately, the decision is contingent on state and federal regulations in terms of the extent to which individuals are required to enroll with CBPs and county HMOs. But for the purposes of this report, the assumption is that of the approximately 1 million beneficiaries enrolled in non-CBPs:

- Approximately 80% would transition to CBPs where total administrative costs and net state administrative costs would be roughly equivalent.
- Approximately 20% would transition to FFS model.

In addition to expanding the role of CBPs and county HMOs, this model is expected to result in an increase in FFS enrollment. The FFS system is managed by DHS. In shifting those administrative responsibilities to the State, the related administrative costs would shift as well. The transition from managed care to fee-for-service (FFS) demonstrates a partial alignment with the administrative cost factors outlined in the "Eliminating Non-Governmental Risk from Status Quo" model, which anticipates a significant movement of managed care enrollees to FFS arrangements.

Federal Matching Rates for Administrative Expenses

It is important to emphasize the role of federal matching rates on administrative costs because it speaks to the complexity of comparing administrative costs between FFS and managed care models. Specifically, this issue speaks to the amount of net state costs in terms of administration.

In a FFS model, state agency administrative costs may be eligible for federal matching funds at 50%, 75%, or 90%, depending on the nature of the activities. In practice, the majority of costs are eligible for 50% federal match. The notable exceptions are systems related costs (90% for design, development, and implementation; 75% for ongoing maintenance) and certain specialized administrative tasks (e.g., 75% for Skilled Professional Medical Personnel (SPMP); 75% for medical and utilization review activities performed by an external quality review organization or quality improvement organization**;** operation of a state Medicaid fraud control unit).

In a managed care model, the administrative costs receive the same federal matching rate as the service costs in the capitation rate, which is the state's FMAP. For Minnesota, there are three FMAPs (FFY 2026): traditional Medicaid at 50.68%, 65.48% for CHIP enrollees, and 90% for members of the Medicaid expansion group. In Minnesota, approximately 20% of people in Medicaid managed care (approximately 200,000 people) are in the Medicaid expansion group and their capitation rates – including administrative costs – receive 90% federal reimbursement.

Generally speaking, this means that the state receives a greater amount of federal matching funds for administrative costs in a managed care model than in a FFS model. From a state budget perspective, the significance of this is that the state's net costs for administrative spending in managed care models is less than in FFS models.

A final part of the financial consideration, and future modeling, will be the estimated impact of increased care coordination benefit for seniors, and enrollees with disabilities, as outlined earlier in this report. It will be vital to outline Staffing Requirements, determine the mix of care coordinators (nurses, social workers, community health workers), supervision, caseload size, and training needs. This has the potential to be a cost driver of program cost to the State, so scope and scale will need to be considered.

Projected Administrative Cost Comparison with Existing System

As described in the previous section (Potential Fiscal Impacts: Administrative Costs), the total level of spending on administrative costs (as a percentage of direct service costs) does tend to be higher in the managed care model; however, differences in federal funding of administrative costs varies significantly in a managed care environment. The following examples focus on the expansion population and show how reduced managed care coverage could affect federal funding for each model.

Eliminating Non-Governmental Risk from Status Quo

Under the eliminating non-governmental risk from the status quo model, it is expected that most managed care enrollees will shift to FFS in the absence of CBP and county HMO alternatives. To illustrate the change in net state costs for administrative spending, it is useful to use the Medicaid Expansion Group as a reference point.

- Assume that approximately 168,000 Expansion Group members would switch from managed care to FFS. In the context of this report, we assume implementation of the expanded FFS model in 2029; there may well be changes in enrollment over the next three years (e.g., due to new Medicaid eligibility provisions in H.R. 1) but projecting the potential change in enrollment is outside the scope of this report.
- Assume that the PMPM administrative costs associated with people enrolled in managed care is $131.50. (This figure is from the 2024 MLR report, 2024 PMPMs tab). Again, we assume that the PMPM figures will change by 2029, but it is outside the scope of this project to estimate the changes.
- In a managed care model, the 168,000 Expansion group members' administrative components of their capitation rates are matched at 90% FMAP.
- Therefore, the total annual administrative costs of that cohort would be 168,000 x $131.50 x 12, or $265.1 Million. At the 90% FMAP, the federal share is $238.6 Million, and the state share is $26.5 Million
- In a FFS model, where most costs are eligible for 50% federal match, the state share of the administrative costs would be $132.6 Million.

The example above illustrates a potential difference in Federal matching rates for administrative cost under a primarily FFS delivery system of over $100 Million. In practice, the extent to which variation in federal matching rates would impact the state's bottom line is contingent on other factors including differences in overall administrative spending. As mentioned above, it is expected that overall administrative spending will be less under FFS. Since the Expansion group makes up only 20% of the population anticipated to move to FFS under this model, reductions in total spending on Medicaid administration across all populations could offset the impact to the state's budget. The state would need to realize administrative spending reductions estimated at approximately 16% for the population shifting from Managed Care to FFS in order to "break even" or offset the impact of lower average federal matching rates for administrative spending.

Multiple/Regional Administrative Services Organization(s) (ASO)

Under an ASO model all managed care enrollees shift to a fee for service delivery system. To illustrate the change in net state costs for administrative spending, it is useful to use the Medicaid Expansion Group as a reference point.

- Assume that approximately 191,000 Expansion Group members would switch from managed care to FFS. In the context of this report, we assume implementation of the expanded FFS model in 2029; there may well be changes in enrollment over the next three years (e.g., due to new Medicaid eligibility provisions in H.R. 1) but projecting the potential change in enrollment is outside the scope of this report.
- Assume that the PMPM administrative costs associated with people enrolled in managed care is $131.50. (This figure is from the 2024 MLR report, 2024 PMPMs tab). Again, we assume that the PMPM figures will change by 2029 but it is outside the scope of this project to estimate the changes.
- In a managed care model, the 191,000 Expansion group members' administrative components of their capitation rates are matched at 90% FMAP.
- Therefore, the total annual administrative costs of that cohort would be 191,000 x $131.50 x 12, or $301 Million. At the 90% FMAP, the federal share is $271.3 Million, and the state share is $30.1 Million
- In an ASO model, where most costs are eligible for 50% federal match, the state share of the administrative costs would be $150.7 Million.

The example above illustrates a potential difference in Federal matching rates for administrative cost under an ASO delivery system of over $120 Million. In practice, the extent to which variation in federal matching rates would impact the state's bottom line is contingent on other factors including differences in overall administrative spending. As mentioned above, it is expected that overall administrative spending will be less under an ASO model. Since the Expansion group makes up only 20% of the population anticipated to move to an ASO under this model, reductions in total spending on Medicaid administration across all populations could offset the impact to the state's budget. The state would need to realize administrative spending reductions estimated at approximately 16% for the population shifting from Managed Care to an ASO in order to "break even" or offset the impact of lower average federal matching rates for administrative spending.

Expand County-Based Purchasing Plans and County-Owned HMOs

Given the possibility that the shift to CBPs and county HMOs results in an overall increase in fee for service enrollment for individuals who opt out of managed care, the subsequent paragraphs focus on the difference in federal matching rates for administrative spending under FFS compared to managed care.

To illustrate the change in net state costs for administrative spending, it is useful to use the Medicaid Expansion Group as a reference point.

- Assume that approximately 36,000 Expansion Group members would switch from managed care to FFS. In the context of this report, we assume implementation of the expanded FFS model in 2029; there may well be changes in enrollment over the next three years (e.g., due to new Medicaid eligibility provisions in H.R. 1) but projecting the potential change in enrollment is outside the scope of this report.
- Assume that the PMPM administrative costs associated with people enrolled in managed care is $131.50. (This figure is from the 2024 MLR report, 2024 PMPMs tab). Again, we assume that the PMPM figures will change by 2029 but it is outside the scope of this project to estimate the changes.
- In a managed care model, the 36,000 Expansion group members' administrative components of their capitation rates are matched at 90% FMAP.

- Therefore, the total annual administrative costs of that cohort would be 168,000 x $131.50 x 12, or $56.8 Million. At the 90% FMAP, the federal share is $51.1 Million, and the state share is $5.6 Million
- In a FFS model, where most costs are eligible for 50% federal match, the state share of the administrative costs would be $28.4 Million.

The example above illustrates a potential difference in Federal matching rates for administrative cost under a primarily FFS delivery system of over $20 Million. In practice, the extent to which variation in federal matching rates would impact the state's bottom line is contingent on other factors including differences in overall administrative spending. Since the Expansion group makes up only 20% of the population anticipated to move to FFS under this model, reductions in total spending on Medicaid administration across all populations could offset the impact to the state's budget. The state would need to realize administrative spending reductions estimated at approximately 16% for the population shifting from Managed Care to FFS in order to "break even" or offset the impact of lower average federal matching rates for administrative spending.

Elimination of Managed Care Withholds

In addition to ongoing shifts in administrative and service cost, as more individuals move to a FFS delivery system the state will incur a one-time cost associated with outstanding managed care withholds. If Minnesota were to eliminate managed care, there is a one-time cost of approximately $490M to account for the withhold arrangements required under Minnesota Statutes § 256b.69, Subd.5a.

Table 6. Model-Specific Withhold Cost Estimates

Model	Model-Specific Withhold Cost Estimates
Eliminating Non-Governmental Risk from Status Quo	Under this model, it is estimated that 90% of enrollees would be under FFS resulting in a significant decline in managed care enrollment and an estimated one-time cost of approximately $432M.
Multiple/Regional Administrative Services Organization(S) (ASO)	Under this model, it is estimated that the full $490M would be incurred as all enrollees currently covered under managed care would shift to FFS.
Expand County-Based Purchasing Plans and County-Owned HMOs	Under this model, it is estimated that the approximately $93M would be incurred as a portion of enrollees currently covered under managed care would shift to FFS.

Service Cost

All three proposed models result in shifting some or all enrollees from managed care to a fee for service delivery system. Consequently, it is important to consider historical differences in reimbursement rates between FFS and managed care. Estimating the financial impact to the State of the cost associated with Medicaid service delivery under FFS vs. Managed care is contingent on many factors which are likely to shift significantly in the next four years:

- Current Medicaid FFS fee schedule rates;
- Prevalence of alternative payment methods and value-based payments under FFS and managed care;
- Shifts in healthcare service delivery and corresponding shifts in Medicaid coverage and reimbursement;
- Shifts in total enrollment due to initiatives such as H.R. 1 Community Engagement Requirements and more frequent eligibility checks as well as general population shifts.

An analysis of current reimbursement levels shows the following:

- 31 distinct service types currently reimbursed almost exclusively under FFS which are likely to be unimpacted by a shift in care delivery model. Collectively, these service types account for greater than one third of SFY25 Medicaid payments (excluding TPL, Medicare and Cost Sharing as well as supplemental payments). These are services which are primarily available to populations that are FFS-only as well as services which are carved out of Medicaid managed care capitated payments and reimbursed under a FFS delivery model. It is expected that a change in care delivery model which increases the use of Medicaid FFS rates would have minimal impact on reimbursement rates for the following service types:
    - Behavioral Program Services
    - Buy-In Part B
    - Case Management Other
    - Child & Teen Checkup Outreach
    - Child Welfare Targeted Case Management
    - Companion Services
    - Consolidated Treatment Fund
    - Consumer Directed Care
    - Day Training and Habilitation
    - End-Stage Renal Dialysis
    - Extended Home Health Aide
    - Extended Occupational Therapy
    - Extended Physical Therapy
    - Extended Private Duty Nursing
    - Extended Respiratory Therapy
    - Family Counseling & Training
    - Foster Care
    - Hospice
    - ICF-DD

    - IEP
    - Independent Living Skills
    - In-Home Family Support
    - Mental Health Room & Board
    - Modifications And Adaptations
    - Moving Home Minnesota
    - PASARR - Mental Health
    - Private Duty Nursing
    - Recuperative Care
    - Respite Care
    - RTC - Mental Health
    - Supported Employment Services
- 8 additional provider types with SDPs that are FFS floor arrangements requiring Managed Care Plans to reimburse in accordance with FFS fee schedules already see comparable reimbursement levels across FFS and Managed Care:
    - Behavioral Health Homes
    - Certified Community Behavioral Health Clinics (CCBHCs)
    - Dental Services
    - Long-Acting Reversible Contraceptives
    - Medical Transportation
    - Designated Mental Health and Substance Use Disorder (SUD) programs
- The new pharmacy policy set to take effect 1/1/27 requires MCOs pay the same prescription drug dispensing fee as the Medicaid fee-for-service program. Consequently, future changes to the percentage of individuals covered under FFS and managed care are unlikely to impact pharmacy reimbursement.
- Certain providers are eligible for supplemental payments for services such as Hospital Inpatient and Outpatient Services as well as Ambulance Services which may be more directly impacted by shifts in supplemental payment primarily funded by providers using Provider Taxes, Certified Public Expenditures (CPE) and Intergovernmental Transfers (IGT).
- Additional services carved out of managed care contracts including waiver services are also unlikely to be impacted by a change in delivery model.
- When moving forward with a shift to an alternative care delivery model which expands FFS coverage, it will be important to assess current fee for service reimbursement in comparison to managed care reimbursement levels.

DHS performed an internal analysis using historical claims data to provide an estimate of the anticipated changes in service costs when moving to the FFS provider reimbursement rates. There were 30 service categories of claims reviewed for this analysis. The services reviewed include:

- Physician Services
- Outpatient Hospital Services
- Mental Health Services
- Personal Care Services

- Laboratory
- Radiology
- Medical Supply/DME
- Inpatient Hospital Services

From this analysis, the estimated impact of shifting to a FFS delivery system would be a 4% decrease in service cost as compared to managed care reimbursement levels. It is important to note that this analysis is a point estimate, and that final service cost change would deviate around this value. There is also variability across provider types, with some provider types showing higher reimbursement under managed care and others showing more closely aligned reimbursement levels between FFS and managed care.

VII. Implementation Timelines

A. Eliminate Non-Governmental Risk from Status Quo

Development Timeline with Major Milestones

The CBP and county HMO structure that would continue under this model is already in place. Consequently, all timeline considerations would be connected to the transition of non-governmental managed care to a CBP, county HMO or FFS model. The timeline will largely be driven by the time required to wind down existing non-governmental managed care contracts. However, there may be some opportunities for efficiency given that elements of the status quo are preserved through the ongoing operation of CBPs and county HMOs.

- **Transition Focus:** The timeline centers on shifting from non-governmental managed care to either CBPs and county HMOs or Fee-for-Service (FFS) models. The CBP and county HMO structure is already in place, so the main timeline driver is the wind-down of non-governmental managed care contracts.
- **Alignment with Plan Year:** Stakeholder feedback emphasizes aligning the transition with the start of a plan year (January 1) to minimize disruption and provide adequate notice to affected plans and providers.
- **Staffing and Support:** A significant ramp-up in clinical staff or contractors will be required, especially for care coordination and member/provider support functions. This hiring and onboarding process is expected to take at least one year.
- **Dependencies:** The timeline will also depend on statutory and regulatory changes, new procurements for counties establishing or joining CBPs or county HMOs, and the need for external support (e.g., IT systems, call centers).

Recommended Implementation Date

The plan identifies January 1, 2029 (1.1.29) as the earliest realistic implementation date for the transition. This date allows for the necessary preparatory steps, including contract wind-downs, staffing, regulatory changes, and stakeholder engagement.

The final recommended date may be further refined based on ongoing stakeholder discussions, statutory changes made by the legislature and readiness assessments.

Considerations for:

- **Sunsetting of existing delivery models:** Careful planning is needed to sunset current non-governmental managed care arrangements, ensuring continuity of care for members and providers.
- **Procurement and Contracting:** Counties may need to establish new procurement processes for CBPs or county HMOs, which require additional time and resources.
- **Statutory and Regulatory Amendments:** Legislative changes will be necessary to authorize the new model and restrict non-governmental entities from participating in Medicaid managed care.
- **Staffing and Hiring Needs:** There will be need to hire or contract clinical and administrative staff, including for call centers and care coordination.
- **Notice and Communication:** Plans and providers must receive significant advance notice to prepare for the transition, and robust communication strategies are essential to support members and providers throughout the process.

B. Multiple/Regional ASOs

Development Timeline with Major Milestones

An ASO model could possibly be implemented faster than a complete state takeover of all Medicaid Managed Care administrative functions, assuming that there are experienced vendors willing to serve as ASOs for each region or service group. The state will need to work with counties/regions to develop their procurements. Major milestones in this timeline will include:

- Determining administrative (and risk management) functions to be delegated;
- Development of State policies and procedures for services not transitioning to the ASOs;
- Developing Request for Proposals or other procurement process;
- Negotiations with selected ASOs;
- Transition of services from existing managed care vendors to the State, counties/regions and the ASOs as appropriate.

Recommended implementation date

The earliest likely timeline for full implementation of an ASO model is **January 1, 2029**. This date assumes timely completion of procurement, contracting, and transition activities, as well as readiness of both the state and selected ASOs.

Considerations for:

- **Sunsetting Existing Models:** Careful planning is required to phase out current managed care arrangements and ensure continuity of care for members and providers.

- **Geographic Scope:** The state must determine the geographic areas to be covered by each ASO, including whether counties can share an ASO.
- **Procurement and Contracting:** New procurements will be needed for counties establishing or participating in CBPs or county HMOs, as well as for ASO contracts.
- Additional external support needs including procurement timeline
- **External Support:** Additional support needs including procurement timeline and may be required for IT systems, data management, and stakeholder communication.
- **Administrative Oversight:** The state will be responsible for oversight and reporting to CMS and must build robust data collection and reporting requirements into ASO contracts.
- **Variability and Equity:** Multiple ASOs can introduce variability in outcomes and member experience across regions. The state must design oversight systems to monitor and address these variations and ensure equitable access and quality.
- **Notice and Communication**: Plans and providers must receive significant advance notice to prepare for the transition, and robust communication strategies are essential to support members and providers throughout the process.

C. Expand County-Based Purchasing Plans and County-Owned HMOs

Development timeline with major milestones

The timeline is primarily driven by the transition from non-governmental managed care to CBPs and county HMOs. The existing CBP and county HMO structure provides a foundation, but expansion will require significant planning and coordination. The timeline will be influenced by the time required for contract wind-downs, county readiness, legislative action, and stakeholder engagement.

- Winding down contracts with non-governmental managed care organizations.
- Supporting counties in expanding existing CBPs or establishing new ones, including legislative mechanisms and start-up funding.
- Aligning the transition with the implementation of the County Administered Rural Medical Assistance (CARMA) program (effective January 1, 2027), which establishes CBPs as the single MCO in their counties for non-dual Medicaid managed care products.
- Ensuring readiness for expanded enrollment, network adequacy, and administrative capacity at both the state and county levels.

Recommended Implementation Date

The plan identifies January 1, 2029, as the earliest realistic implementation date for the expanded CBP and county HMO model.

Considerations for:

- **Sunsetting Existing Models:** Careful planning is needed to phase out non-governmental managed care arrangements and ensure continuity of care for members and providers.
- **County Participation:** The success of this model depends on counties' willingness and capacity to expand or create CBPs. Legislative mandates and start-up incentives may be necessary to ensure statewide coverage.
- **Procurement and Contracting:** New procurements will be required for counties establishing or joining CBPs or county-owned HMOs, with additional support for counties lacking current infrastructure.
- **Administrative and Start-Up Costs:** Both the state and counties will incur administrative and start-up costs, especially in areas without existing CBPs. Ongoing oversight and support will be essential.
- **Network Adequacy and Member Experience:** Ensuring consistent member experience and provider network adequacy across counties will be challenging, particularly as counties operate independently and may have varying resources.
- **Regulatory and Statutory Changes:** Legislative action will be required to redefine eligibility and participation criteria, prohibit non-governmental managed care organizations, and establish oversight mechanisms.
- **Stakeholder Engagement:** Ongoing engagement with counties, providers, and members is critical to address local needs, support plan development, and ensure equitable access.
- **Notice and Communication:** Robust communication strategies are needed to inform members and providers of changes, options, and timelines.
- **Federal Approval:** The state may need to seek federal waivers or State Plan Amendments to implement the new model and ensure compliance with federal requirements.

IX. Conclusion

In summary, transitioning to an alternative care delivery model presents both opportunities and challenges. A successful shift in care delivery model will require thoughtful planning, robust stakeholder engagement, and ongoing support to address challenges such as administrative costs, network adequacy, and the need for statutory and federal approvals. By prioritizing clear communication, community partner participation, and maintaining a focus on equitable access, the state can lay a strong foundation for a successful transformation.

X. Appendices

APPENDIX A: Stakeholder Feedback

Eliminate Non-Governmental Risk from Status Quo

Feedback in Support of the Model

We received feedback from multiple stakeholder types regarding this option. When reviewing this input, we noted that counties and county-based purchasing plans are most enthusiastic. They specifically noted the localized approach that CBPs can provide, the potential for simplicity in this model, and the economies of scale via joint powers. The one note of concern from a CBP was ensuring the market did not become oversaturated with CBPs, as that could diminish the value they bring to the residents of Minnesota.

Providers and member advocacy organizations alike supported the possible simplicity of the system and an opportunity for an increased focus on serving patients by avoiding duplicative costs from MCOs.

Providers and member advocacy groups consistently rank this model as most favorable compared to the other alternative care delivery models, with some counties also ranking this model as most favorable.

One member advocacy group expressed concern over privatized managed care and the imminent importance of moving to a fee-for-service model. In their opinion, the cost savings from removing MCOs could be used to pay fee-for-service providers and cover services that are not provided by MCOs.

Areas for Further Exploration

There are multiple areas for future exploration as outlined in the stakeholder feedback. These opportunities vary based on the stakeholder type, but all bring valid points to consider.

The provider community noted the implementation or transition to this model seems large. Specifically, it was called out that some counties do not currently have a CBP, while highlighting they do not see how this model improves current issues with assessments, case management, and care coordination. This aligns with counties concerns about enrollees who moved counties, potentially facing barriers if one county has FFS while another has a CBP. HMOs framed this concern as a lack of choice for the enrollee, specifically they could be “forced” to enroll in FFS if their county does not have a CBP. This non-uniformity across counties could cause challenges with care coordination. As noted by HMOs, there could be a disruption of provider networks and services if there is differentiation in the offerings from county-to-county.

Across all stakeholder types, there was a concern over the feasibility and viability of this model, noting financial risks, administrative burden, access to specialty care across counties, and member choice.

From a cost perspective, providers noted that on average CBPs and a FFS model have lower reimbursement rates than MCOs. Hennepin Health seconded these concerns about the cost of expanding into metro counties,

and implementation costs. HMOs had extreme concern over shifting financial risk away from MCOs, and how this would impact state and local governments and by extension the taxpayers of Minnesota. A more comprehensive cost analysis is requested to determine how the model would be financially feasible.

One member advocacy stakeholder group inquired about the impact of fee-for-service rates on provider participation, referencing past fee-for-service rate freezes. These advocates emphasized the importance of considering rate alignment and potential rate increases to maintain provider access when considering the implementation of this model. Both stakeholder groups emphasized the need to estimate costs and cost savings from transition to a fee-for-service model at the highest level of granularity possible.

An additional member advocacy stakeholder group inquired about the impact of transitioning existing MCOs to an FFS model, highlighting the potential for job loss and economic impact. In addition, these advocates expressed a clear need for the state to have mechanisms and policies in place to ensure that low-income individuals and racial minorities are treated equitably across any potential model but especially models with a strong county-focus. Finally, this group emphasized the importance of quantifying how many additional services and administrative cost they state may have to take on with a large transition to FFS.

Multiple Regional ASOs

Feedback in Support of the Model

Providers, counties, plans, and member advocacy organizations had a mixed response to the ASO model, noting specifically the benefit of simplifying the administrative process. Counties, county-based purchasing plans (CBPs), and HMOs all preferred a regional or locally focused ASO model over the statewide ASO model originally proposed.

Providers and counties were most supportive of the model amongst all stakeholder groups, noting the potential for increased responsiveness and regional tailoring.

One member advocacy group highlighted Connecticut's successful de-privatization of Medicaid using ASOs, noting reduced administrative overhead and improved provider participation. The group further emphasized that existing ASO models have led to better health outcomes and lower costs for the State, which would be beneficial for Minnesota.

Areas for Further Exploration

Feedback for this model centered around two major concerns: further fragmentation of the care network and financial viability for plans and the state.

Both counties and county-based purchasing plans made note that a regional ASO model could lead to more fragmented care for members, including gaps in coverage when the member is away from the primary coverage area of the ASO. Providers additionally noted that having multiple administrators could lead to inequitable care across geographic areas.

Providers and county-based purchasing plans noted that they believed that this model could increase costs to the state and increased administrative burden for DHS for ASO monitoring and the procurement process, while county-based purchasing plans and HMOs both raised concerns about what the payment structure to the ASOs would be. Hennepin Health and member advocacy organizations raised concerns about their continued financial viability, if they were only delegated administrative functions, and HMOs questioned that if payments are not linked to utilization management, there may be less incentive to focus on quality of care.

Other questions raised by stakeholders included how the ASO would be selected, and which roles would be assigned to the ASO, and which would be retained by the State, and what the impact would be on rates to providers. Overall, stakeholders would like to have input into the design and selection process if an statewide ASO model would be put in place.

Overall, this model was least preferred by CBPs. Providers show some support for the ASO model, but across all stakeholder types, this model was ranked the most favorable the least.

Both member advocacy stakeholder groups inquired about the financial analysis for this particular model, emphasizing the importance of highlighting the costs and savings that occurred with the privatization of Medicaid in Minnesota and how moving to an ASO model would shift those costs and savings for the State. The group also indicated that an estimate of what portion of costs in the MCOs are not going directly to patient care would help strengthen this analysis.

One member advocacy stakeholder group expressed a clear need for the state to have mechanisms and policies in place to ensure that low-income individuals and racial minorities are treated equitably across any potential model but especially models with a strong county-focus.

Expand County-Based Purchasing Plans and County-Owned HMOs

Feedback in Support of the Model

As anticipated, counties and CBPs expressed a lot of support for this option, often ranking this model most favorable across all three alternative care delivery models. They highlighted that this localized approach is a positive for existing CBPs and the opportunity to give other areas that same benefit would be worth exploring. Providers also supported the opportunity for regional tailoring. The overall framing of current CBPs is positive. Providers, counties, CBPs, and member advocacy organizations were aligned on the potential for economies of scale and community reinvestment.

One member advocacy stakeholder group supported that CBPs and HMOs are not run by private MCOs and any surplus is directed to be reinvested in county-based services. An additional member advocacy group supported the expansive provider networks of these plans and their ability to address gaps in the localities through reinvestment.

Areas for Further Exploration

The areas for further exploration mostly revolved around the feasibility of expansion and implementation concerns. Providers noted that many counties do not have a CBP and the transition in those areas could be

extensive. This plays into a larger concern about provider network sustainability, and fear that the larger health systems that might be needed to serve multiple CBPs would create narrower provider networks, thus limiting the localized approach of a CBP.

These feasibility concerns were also noted by counties, and CBPs, specifically asking if all counties would want this option, or even have the resources to implement it. This was noted specifically by Hennepin Health as well. Providers also noted that CBPs on average reimburse at lower amounts than MCOs while expressing concern for enrollees that move from county to county and had to switch plans. We will note this situation exists in most care delivery models, and strong continuity of care guidelines exist to alleviate this.

HMOs noted the elimination of competition by removing MCOs from the market could limit member choice and impact level of care, while bringing to attention a potential financial risk to taxpayers and counties. This was not explained in detail.

Counties and CBPs have the same question if this would be a state-wide model, and would it involve the expansion of current CBPs or is there a potential to introduce new models.

Providers, counties, CBPs, HMOs, and member advocacy organizations were aligned with concerns over consistency across counties, noting things such as civil rights protections, provider administration burden, and member support.

One member advocacy stakeholder group inquired about the financial analysis, emphasizing the importance of highlighting the costs and savings that will be achieved with a transition to a CBP and HMO model.

An additional member advocacy stakeholder group mirrored similar concerns to Providers, CBPs, and counties about the feasibility of expansion. This group emphasized the need for an incentive for CBPs and county-based HMOs to expand across the state, especially with the small percentage of the population currently served by these county-based plans.

APPENDIX B: Supporting Data, References, and Resources

PCG's Analysis and Recommendation Process

Alternative Care Delivery Models

The three main components in establishing and determining the alternative care delivery models of focus for this project are 1) Research and Analysis; 2) Synthesis and Presentation of Findings; and 3) Selection of Three Models.

Research and Analysis of Alternative Care Delivery Models

1. Review and understand the MN legislature

a. Before presenting viable managed care alternatives, the PCG team must understand the requirements of the legislation to ensure that each potential model is well within scope. Some key components include:
    i. Not shifting financial risk to nongovernmental entities
    ii. Is up-side risk a part of "risk" when mentioned in the legislation?
    iii. Reasons behind legislation

2. Begin research on alternatives to managed care
    a. Pick subject matter experts to focus on each model/type of care delivery
    b. During kick-off meeting, "present" initial alternative care model examples
        i. These alternative care models are on a "scale" from total Fee-for-Service to Total Capitation.
    c. Propose 8 alternative care models from "Least Risk" to "Most Risk" based on review of the legislation, looking at "other" states with similar models, and more in-depth research
        i. This research includes identifying considerations, opportunities, areas of focus, fiscal impacts, timeline for implementation, and member experience.
3. Create a template for the alternative model summaries. The summaries will include:
    a. Background on model type (level of risk, lead organization, services in or out of capitation)
    b. Considerations and Opportunities
    c. Examples (states) where the model is in use (if applicable)
    d. Populations/areas of focus (if applicable)
    e. Potential type and direction of fiscal impacts
    f. Ballpark timeline for implementation
4. Narrow down PCG's (8) potential models down to five
    a. From internal discussions, DHS selects the five alternative models for PCG to focus their analysis and research on. Some "edits" to the 8 initial models include
        i. Combining "Expand County-Based Purchasing Plans" with "Expand County-Owned HMOs"
            1. Why? Operate the same today but went through different licensing structures. Similar interests, separate paths.
        ii. Eliminating "Governmental provider-led Managed Care" and "Provider-led ASO"
            1. Why? From previous discussions/decisions involving care in MN, providers did not want additional administrative work. Government-led managed care would not work in the state.
    b. DHS selected the following models: Fee-for-Service Only, Eliminate non-governmental Risk from Status Quo, Single State ASO, Multiple/Regional ASO(s), Expand County-Based Purchasing Plans and HMOs Statewide
5. Continue researching the selected five models
    a. Continual research includes incorporating any new concerns/risks that arise due to changing legislature.

Synthesis and Presentation of Findings

1. Present the Five Alternative Models to DHS
    a. Prior to the submission of the five alternative model summaries, PCG will present a brief overview of each model to DHS. This will serve as the last opportunity for DHS to give feedback on the models prior to the submission of the summary document.
2. Complete and submit alternative model summaries to DHS
    a. Each model is formatted into the summary template and checked for accessibility standards.
    b. After proof-reading and editing for clarity and consistency, the model summary document is submitted to DHS in the SharePoint.

Results/Reactions to Initial Five Model Summaries

Overall, there was a positive reaction to the alternative model summaries. Key changes that came out of our discussion include:

1. Ensure that framing is neutral when discussing different models.
    a. While DHS and PCG may lean one way, we want the summaries to be as unbiased as possible.
    b. When discussing challenges/limitations with the model, highlight how they can be overcome instead of just stating the problem.
    c. Do not overstate the ability to get clinical data when comparing FFS and managed care.
    d. When discussing the implementation of some models, highlight that the entity will have to meet pre-defined state criteria.
2. Incorporate DHS feedback into model summaries.
    a. In addition to the edits to the original summaries, DHS specifically wants PCG to address fraud waste and abuse.
        - Fraud waste and abuse have been a primary concern in the current legislature.
            i. Will need to be prepared to address any concerns within the presentation to the legislature
3. Incorporate feedback from initial stakeholder engagement surveys
    a. PCG will analyze key themes, trends, and overall reactions to the current state of care in MN and to the alternatives presented from key stakeholder groups.
    b. Notable takeaways will be added to the alternative model summaries/presentation materials.
4. Draft and finalize presentation materials for the legislature
    a. PCG will create a PowerPoint presentation to highlight key project milestones and high-level characteristics of each of the five models.
    b. In addition to information about the models, PCG will include the specific stakeholder feedback that has been received about each model.
    c. Any changes proposed by DHS will be incorporated into the slides prior to the presentation.
5. Present to the legislature
    a. In coordination with DHS, PCG will present the five alternative models to:
        i. Senator Melissa Wiklund
        ii. Senator Paul Utke

iii. Key legislative staff

b. Presentation Roles:

i. PCG will have two presenters: Trish Perazzelli and Megan Morris.

1. Megan will introduce the work that PCG has been tasked with, explaining the origin and purpose of the alternative model exploration.
2. Trish will lead a discussion on each of the models, including key stakeholder feedback.

ii. DHS will serve as the facilitator, coordinate meeting logistics, share materials to attendees, and send any questions from the Senators to PCG for clarification after the meeting.

Results/Reactions to the Legislative Presentation

Overall, there was a positive reaction to the alternative model summary presentation to the legislature. Key changes that came out of our discussion include:

1. Ensure that framing is neutral when discussing different models.
    a. While DHS and PCG may lean one way, we want the summaries to be as unbiased as possible.
2. For future presentations to the legislature, allow for more time for questions and discussion.
3. Make the processes/analysis that PCG completed throughout the process clear to the legislature.

Model Implementation (Plans)

After the State has come to a consensus on the three alternative care delivery models it wants to focus on, PCG will work to develop implementation plans for each of the models to assess the feasibility of the transition, financial impact, and overall effects on all stakeholders involved (such as providers, counties, members, etc.).

Selection of Three Alternative Care Delivery Models

1. Selection of the "top" three alternative care delivery models for further exploration
    a. After the presentation to the legislature, the MN legislature will select three models for PCG to continue researching.
        i. Important note: As required by Minn. Stat. § 256.9631, one of the three models that must be explored with an implementation plan is the "Eliminate Non-Governmental Risk Model." This model entails the removal of all non-county-based or non-county owned and operated managed care arrangements.
        ii. Due to this requirement, PCG will begin the implementation plan drafting process with this model prior to the formal decision from the legislature of the other two models.
2. Create a draft outline for DHS approval
    a. PCG will create an outline of the major topic areas that PCG intends to discuss/research for each of the three models. These topic areas include:
        i. Overview
            1. Executive Summary
            2. Description of the Selected Delivery Model

ii. Member and Provider Support
    1. Quality Measures
    2. Care Coordination
    3. Outreach Initiatives
    4. Managed Care Opt-Out
iii. Financial Analysis
    1. Payment Rate Adjustments
    2. Supplemental Payments for Hospitals and Other Provider Types
    3. Financial Analysis
iv. Operational Considerations
    1. Statutory and Regulatory Recommendations
    2. Collaboration Requirements
    3. Information Systems and Accessibility
    4. Implementation Timeline
v. Appendices

b. This outline and topic areas will be iterative, developing into more concise topic areas as PCG researches each model more thoroughly, creates in-depth financial analysis, and receives feedback from DHS.

3. Draft implementation plans for the three chosen models
    a. Following the selection and approval of the implementation plan outline, PCG will create implementation plans with a standard format for the "top" three alternative care delivery models. Each model, however, will have its own unique considerations, financial analysis, and research-based findings.
    b. Beginning with the *"Eliminate Non-Governmental Risk Model,"* PCG will analyze relevant MN legislation and statutes and conduct research to develop comprehensive implementation plans for each model.
    c. PCG will compile and analyze data sources provided by DHS to create a financial analysis for each model implementation. This analysis will include estimated costs and cost savings, cost comparisons to the existing models of care in MN, payment rate adjustments, etc.
4. Coordinate data collection with DHS
    a. Due to data sharing restrictions in MN, the process of getting the necessary data for a comprehensive financial analysis will be collaborative between PCG and DHS.
    b. PCG will begin by creating a list of "must have" and "nice-to-have" data. DHS will use this list as a jumping off point to determine what data can be provided given the data sharing restrictions. Initial data requests include:
        i. Detailed MMIS Data Extract: Claims and encounters by date, service, provider and reimbursement lever
        ii. Current Medicaid Vendor Structure: e.g. MMIS, other current vendors handling the data such as program oversight or measurement (FFS and/or MC)
        iii. Supplemental Payment Information
            1. Preprint attachments (not publicly available)
            2. FFS Supplemental Payment/UPL Information

iv. Capitation Rate Documentation

v. List of all Medicaid enrolled providers by provider type to include: *Dependent on limitations

1. Billing NPI
2. Primary Location Address
3. Provider Type Designation(s)
4. Date of enrollment

vi. MMIS data fields:

1. The following claims fields for MMIS claims and Managed Care Encounter data for all services, all members, all provider types.
    1. *0-18, 18-21, 21-64, 65+*
2. This should encompass dates of service 7/1/2022 through 6/30/25 and include the following fields at minimum:
    1. Claim status; Define as paid, denied, pended;
    2. FFS claim vs. Managed Care Encounter indicator;
    3. Insurance Type or Program name (if managed care);
    4. Medicaid Provider Number;
    5. Medicaid Provider Type;
    6. Physician/Supplier's NPI, Billing Name, Address, Zip Code, and Phone Number;
    7. Rendering Provider NPI and zip code;
    8. Procedure code;
    9. Modifier(s);
    10. *Revenue Code;*
    11. *Diagnosis Code;*
    12. Date of payment;
    13. Date(s) of service;
    14. Total charges;
    15. Allowed amount;
    16. Total quantity allowed (Days or Units);
    17. Amount Paid*;*
    18. Medicaid paid amount;
    19. Co-pay/Cost Sharing;
    20. Medicare paid amount;
    21. Other Third Party paid amount;
    22. Place of Service Code (two-digit code);
    23. Member eligibility type.

c. PCG and DHS will have ad hoc meetings between the respective data teams to discuss questions, concerns, and alternative approaches to providing PCG with each "must have" data point.

d. Any data that could be "deidentified" and allow for PCG to identify a particular provider may not be able to be provided.

e. The following approach has been presented to PCG as an avenue to receive the necessary data for financial analysis:
    i. For Managed Care Service Payments:
        1. Strip out MCO identifying information and provide PCG with a regional breakout of information.
        2. In that region, there would have to be at least three MCOs active to avoid identification.
f. MMIS data fields – most data (that is currently collected) will be able to be provided. There may be some caveats as explored below, but PCG and DHS will come up with necessary solutions to overcome these data gaps:
    i. FFS versus Managed Care indicator helps to get some plan-specific data
    ii. Hennepin Health: need to lump this in with either CBPs or Managed Care Organizations
    iii. Could take two runs of the data – one with regional and one lumping the CBPs/Hennepin Health in
    iv. Provider identifiers – tend to break down by pharmacy, inpatient, etc. - billing and rendering is sufficient for PCG analysis
    v. Enrolled versus active providers – could alleviate some of the detail PCG is looking for to uphold the MN data sharing restrictions
    vi. Revenue (and diagnosis) codes – nice to have; not needed

5. Collect continuous feedback from DHS and refine each implementation plan
    a. PCG will upload the draft implementation plans for each model into the SharePoint with DHS at least two weeks prior to the "official" due date.
    b. This approach allows DHS to provide constant feedback, which can be incorporated into the model being uploaded and the other two implementation plans as they develop.

Stakeholder Engagement

PCG is working together with Minnesota DHS to complete an exploration and assessment of alternatives to Medical Assistance (MA). Stakeholder engagement for this effort aims to solicit feedback and thoughts on what works and what needs to be improved within the current system, and reactions to potential alternative models. Ultimately, PCG and DHS will deliver three to five alternatives to the state legislature which are informed by stakeholder feedback.

PCG has five main phases of engagement:

- **Develop the Stakeholder Engagement Plan**: The stakeholder engagement plan identifies key stakeholders, determines their information needs, and defines the most effective vehicles and messaging strategies for meeting these needs.
- **Create and Distribute Initial Stakeholder Surveys** for the following groups: Providers, Tribal and Urban Indian Providers, Counties, County-Based Purchasing Plans, Health Maintenance Organizations, and Member Advocacy Groups.
- **Facilitate Focus Groups** with DHS Staff and Member Advocacy Groups

- **Create and Distribute a Secondary Stakeholder Survey**, which will go into more detail about the three models chosen for implementation plans. This survey will be distributed to the following groups: Providers, Tribal and Urban Indian Providers, Counties, County-Based Purchasing Plans, Health Maintenance Organizations, and Member Advocacy Groups.
- **Ongoing Engagement** through a variety of methods including a mail inbox for stakeholders to use for any questions, comments, or concerns and Ad-hoc conversations. PCG will conduct additional surveys and focus groups (as needed).

1. Develop the Stakeholder Engagement Plan
    a. The stakeholder engagement plan will identify key stakeholders, determine their information needs, and define the most effective vehicles and messaging strategies for meeting these needs.
    b. PCG will collaborate with DHS to develop each phase of engagement and connect to stakeholder groups.
2. Create and Distribute Initial Stakeholder Surveys (see Stakeholder Initial Survey subsection)
    a. PCG will create Jotform surveys for Providers, Tribal and Urban Indian Providers, Counties, County-Based Purchasing Plans, Health Maintenance Organizations, and Member Advocacy Groups.
        i. Jotform was chosen for several reasons:
            1. Ease of use
            2. HIPPA compliance
            3. Meets accessibility standards
        ii. The survey for Providers, Tribal and Urban Indian Providers, Counties, County-Based Purchasing Plans, Health Maintenance Organizations will contain:
            1. Questions about their experience with the current system(s) in MN
            2. Questions to gauge their opinions on the five potential alternative models
        iii. The survey for Member Advocacy Groups will contain:
            3. Questions about their experience with the current system(s) in MN
        iv. DHS will distribute the survey to the groups listed in **Stakeholder Lists for Initial Surveys** subsection.
3. Facilitate Focus Groups
    a. PCG will facilitate focus groups once the selection of the top three alternative models is chosen. These focus groups will allow for various groups to share their opinions on the selected models, which will inform the development of the implementation plans for each of the models, especially in regard to topics such as care coordination and current system capacity.
        i. PCG initially planned to have dedicated focus groups for the following stakeholders: providers, MN Health Advocacy Groups, MN County-Based Purchasing and MCO Representatives, Hennepin Health, MN's Council of Health Plans, Tribal Nations, and Counties.
    b. After discussion with the DHS team and given the tight timeline for implementation plan development, PCG will be conducting focus groups for two distinct groups.

i. DHS Staff Focus Group: PCG will facilitate an open discussion with a larger group of DHS staff who have expressed interest in sharing their opinions on a transition to a more fee-for-service model. This group was chosen due to their interest in sharing their knowledge and opinions to the PCG team.
    1. PCG will consult with the smaller DHS team on discussion topics and create slides to guide the conversation with the larger group of stakeholders.
        a. Key points of feedback PCG seeks to collect from this focus group include:
            i. Thoughts on the three models chosen for implementation plans
            ii. Opinions about moving to a more FFS model
            iii. Insight on the capacity of the current State systems to transition from the current model to one of the three chosen models
ii. Member Advocacy Organizations: PCG will facilitate a more structured focus group with Member Advocacy Organizations who have expressed interest in sharing their opinion on the three chosen models. This group was chosen as a focus group, as they have shown a desire to have their voices heard in the creation of the three implementation plans to ensure that the needs of all stakeholders are met.
    1. PCG will consult with the smaller DHS team on discussion points and participants and will create comprehensive interview guides to facilitate the focus group.
    2. Key considerations that will be taken into consideration for this particular focus group include:
        a. Timing of the focus group – this should take place after the three models are chosen
        b. In-person versus online format – given the tight timeline to collect stakeholder feedback, PCG will choose the most convenient but effective method of facilitation possible

4. Create and Distribute a Secondary Stakeholder Survey (See Secondary Stakeholder Survey subsection – this will be forthcoming, as the survey will be developed in conjunction with the development of the three implementation plans)
    a. PCG will create Jotform surveys for Providers, Tribal and Urban Indian Providers, Counties, County-Based Purchasing Plans, Health Maintenance Organizations, and Member Advocacy Groups.
        i. Several considerations were considered when deciding to administer a second survey in lieu of having a dedicated focus group for each of the forementioned groups
            1. Shortened timeline between the decision of the top three alternative care models and their respective implementation plan development
            2. Conflicts with holidays
            3. High response rate for the initial survey
        ii. These surveys will allow stakeholders to provide feedback on each of the models, assisting the development of each of the implementation plans.

iii. PCG will allow individuals to rank the models to create an objective survey for stakeholders and give stakeholders the opportunity to indicate if they prefer to keep care in MN as the status quo. This approach will reduce the potential for stakeholders to rank the three models based on pre-conceived notions.

5. Ongoing Engagement
    a. PCG will use a variety of methods to continue engagement throughout the project:
        i. Create and monitor an email inbox for stakeholders to use for any questions, comments, or concerns
        ii. Ad hoc conversations
        iii. Additional surveys

Additional Materials

This section will contain additional information that will be key to documenting as the project progresses.

Stakeholder Lists for Initial Surveys

- 14 provider organizations
    - ASPIRE – mental health providers
    - Care Providers of MN
    - Leading Age MN – Elderly provider organization
    - Long Term Care Imperative (Partnership of Leading Age and Care Providers – Sent individually)
    - MAARCH – substance use disorder providers
    - MAMES – mental health providers
    - MN Association of Community Mental Health Programs
    - MN Association of FQHCs
    - MN Dental Association
    - MN Home Care Association
    - MN Hospital Association
    - MN Medical Association
    - OT Association
    - Physical Therapy Association
    - Speech Language Pathology Association

2. IHPs
    - Allina Health
    - Avera Health
    - Breakwater Health Network (formerly Northern Minnesota Network)
    - CentraCare Health System
    - Children's Health Care
    - Health Programs [MACMHP]
    - Essentia Health
    - Face to Face Health and Counseling

- Fairview Physician Associates Network
- Federally Qualified Health Center Urban Health Network (FUHN)
- Gillette Children's Specialty Healthcare
- Hennepin Healthcare System (Hennepin County Medical Center Hospital and Clinics)
- Integrity Health Network
- Lake Region Health Care
- Lakewood Health System
- Mankato Clinic
- Mayo Clinic Health System
- Mayo Clinic – Rochester Area
- Minnesota Community Care
- North Memorial Health Care
- Northwest Metro Alliance (a partnership between Allina Health and Health Partners)
- Perham Health
- Riverwood Healthcare Center
- Wilderness Health
- Winona Health Services

3. Additional stakeholder groups
    - 8 MCOs, the Minnesota Association of County Social Service Administrators, Tribal Health Director

Stakeholder Initial Survey

MN Alternative Models Survey (https://pcgus.jotform.com/250223601221134)

Single link for all groups; upon selection of group modified questions will be shown

Background and Overview

In order to deliver services to eligible individuals, achieve better health outcomes, and reduce the cost of health care for the state, under Minn. Stat. § 256.9631, the legislature is exploring care delivery models that are alternatives to the use of commercial managed care plans to deliver health care to Minnesota Health Care Program ("MHCP") enrollees, and do not shift financial risk to nongovernmental entities.

PCG is supporting the State in the development of ***five alternative model options*** to present to the Legislature for review as required by the statute. Ultimately, PCG will support the State in the development of implementation plans for three or more models.

Models to be explored will include at minimum:

- A direct payment system model under which eligible individuals receive services through the fee-for-service system
- County-based purchasing plans, and county-owned health maintenance organizations

- County-based purchasing plans and county-owned health maintenance organizations which deliver care in geographic areas on a single plan basis.

The purpose of this survey is to solicit feedback and thoughts on what works and what needs to be improved within the current system, and reactions to potential alternative models.

There will be 7 pages total in this survey:

- The first will include 4 questions for you to include your contact information.
- The second is to gather your thoughts on your experience with the current system. There are 3 questions on this page.
- The five subsequent pages will each pertain to one of the alternative models being explored. The same 4 questions will be posed for each of the models.

Survey:

- Contact information for individual completing the survey: Text box for each data field
    - Name
    - Title
    - Organization
    - Email
- Are you a: Provider, Tribal and Urban Indian Health Care Provider, County, County-Based Purchasing Plan, Health Maintenance Organization (Health Plan)? (For this survey, you should select the group you primarily identify with.) *Skips to Group selected*.
    - Drop-down with each stakeholder group
- Do you engage with MN in any other capacities?
    - As a Provider
    - As a Tribal and Urban Indian Health Care Provider
    - As a County
    - As a County-Based Purchasing Plan
    - As a Health Maintenance Organization
    - Other
        - *Will drop down with a box for the respondent to specify*

Questions for Providers and Tribal and Urban Indian Health Care Providers*:*

Current Model

- What about Medical Assistance (MA) benefits you as a provider? What parts of the current model would you not want to change? *Free text*
- What are some challenges you have faced working with a MCO or CBP? What would you hope to improve under a future model? *Free text*
- Do you have any concerns or reservations about a transition from a MCO or CBP contract to another model? *Free text*

Questions for Counties:

Current Model

- What about Medical Assistance (MA) benefits you as a county? What parts of the current model would you not want to change? *Free text*
- What are some challenges you have faced in the current system? What would you want to improve under a future model? *Free text*
- Do you have any concerns about transitioning from Managed Care to another model? *Free text*

Questions for County Based Purchasing Plan:

Current Model

- What about Medical Assistance (MA) benefits you as a County Based Purchasing Plan (CBPP)? What parts of the current model would you not want to change? *Free text*
- What are some challenges you have faced in the current system? What would you want to improve under a future model? *Free text*
- Do you have any concerns about transitioning from Managed Care to another model? *Free text*

Questions for Health Plans:

Current Model

- What about Medical Assistance (MA) benefits you as a Health Plan? What parts of the current model would you not want to change? *Free text*
- What are some challenges you have faced in the current system? What would you want to improve under a future model? *Free text*
- Do you have any concerns about transitioning from Managed Care to another model? *Free text*

Alternative Model Questions

Fee-for-Service Only: In Fee-For-Service, payment to providers is tied directly to utilization of services. There is no capitation. Currently, a small percentage of Medical Assistance and MinnesotaCare members are covered under FFS. Under this model, (FFS) would be expanded to the entire Medicaid population and the state Medicaid agency would be the lead organization.

Questions

- Generally, how interested are you in further exploration of this model? (Mandatory: Scale, 1-4 Very interested/not interested – do not allow for neutral selection)

- How feasible do you think it would be to implement this model? (Mandatory: Scale, 1-4 very feasible (easy and quick)/not feasible (would not be possible in our state/for our organization) – do not allow for neutral selection
- What questions or concerns do you have about the model? (Optional. Free text)
- Please provide any additional feedback about the model. (Optional. Free text)

Eliminate Non-Governmental Risk from Status Quo: This model involves the removal of all non-county-based managed care. The primary goal of this option is to phase out non-county-based HMOs and transition eligible individuals to FFS or county-based managed care Medical Assistance coverage. Unlike the "Fee for Service Only" model, this option would allow for the ongoing operation of Hennepin Health, as well as the three existing County Based Purchasing (CBP) plans.

Questions

- Generally, how interested are you in further exploration of this model? (Mandatory: Scale, 1-4 Very interested/not interested – do not allow for neutral selection)
- How feasible do you think it would be to implement this model? (Mandatory: Scale, 1-4 very feasible (easy and quick)/not feasible (would not be possible in our state/for our organization) – do not allow for neutral selection
- What questions or concerns do you have about the model? (Optional. Free text)
- Please provide any additional feedback about the model. (Optional. Free text)

Single Statewide ASO: An Administrative Services Organizations (ASO), that may have overlapping responsibility as a Third-Party Administrator (TPA), is an arrangement under which an organization independent of the State manages the administration of claims, benefits, and many other functions of a Managed Care Organization (MCO) but does not assume the medical or financial risk.

Under this model, the state will contract with a single ASO for the entire state and all populations. This will create uniformity across the system regarding prior authorization of services, provider networks, and reimbursement rates for services.

Questions

- Generally, how interested are you in further exploration of this model? *(Mandatory: Scale, 1-4 Very interested/not interested – do not allow for neutral selection)*
- How feasible do you think it would be to implement this model? *(Mandatory: Scale, 1-4 very feasible (easy and quick)/not feasible (would not be possible in our state/for our organization)* – do not allow for neutral selection
- What questions or concerns do you have about the model? *(Optional. Free text).*
- Please provide any additional feedback about the model. *(Optional. Free text)*

Multiple/Regional ASOs: An Administrative Services Organization (ASO), that may have overlapping responsibility as a Third-Party Administrator (TPA), is an organization independent of the State, which is under agreement to provide administrative services to a state Medicaid program, such as Minnesota's Medical Assistance program. This includes the administration of claims, benefits, and many other functions of a Managed Care Organization (MCO). ASOs do not assume medical or financial risk.

Under this model, the state can contract with multiple ASOs to perform a range of administrative services/supports. Given that contracting can be done with multiple ASOs, there is flexibility in how the state (or county) chooses to procure for them. ASOs can support a portion of the health benefit (such as behavioral health only) or may cover only a region of the state, allowing for care to be tailored to the needs and challenges of the relevant population and/or region.

Questions

- Generally, how interested are you in further exploration of this model? *(Mandatory: Scale, 1-4 Very interested/not interested – do not allow for neutral selection)*
- How feasible do you think it would be to implement this model? *(Mandatory: Scale, 1-4 very feasible (easy and quick)/not feasible (would not be possible in our state/for our organization)* – does not allow for neutral selection
- What questions or concerns do you have about the model? *(Optional. Free text*)
- Please provide any additional feedback about the model. *(Optional. Free text)*

Expand County-Based Purchasing Plans and County-Owned Health Maintenance Organizations: The primary feature of this model is the expansion of county-based managed care. There are two county-based models: county-based purchasing plans (CBP) [a health plan operated by a county or group of counties]; and county owned and operated HMOs.

Currently there are three (3) CBPs operating in Minnesota, covering over 20 counties and 26,000 enrollees. Hennepin Health is the only county owned and operated HMO in Minnesota.

County-based managed care provides an opportunity for locally designed service delivery systems that involve the coordinated efforts of counties, providers, and consumers, as well as stabilizing and supporting existing community provider networks.

Questions

- Generally, how interested are you in further exploration of this model? *(Mandatory: Scale, 1-4 Very interested/not interested – do not allow for neutral selection)*
- How feasible do you think it would be to implement this model? *(Mandatory: Scale, 1-4 very feasible (easy and quick)/not feasible (would not be possible in our state/for our organization)* – do not allow for neutral selection
- What questions or concerns do you have about the model? *(Optional. Free text)*
- Please provide any additional feedback about the model. *(Optional. Free text)*

Thank you for your feedback and participation in the survey.

If you have any immediate questions or concerns, please contact alternativedeliverymodels@pcgus.com .

Any comments or concerns? (Free text)

Separate Survey for Member Advocacy Groups (https://pcgus.jotform.com/250343891443861)

Background and Overview

In order to deliver services to eligible individuals, achieve better health outcomes, and reduce the cost of health care for the state, under Minn. Stat. § 256.9631, the legislature is exploring care delivery models that are alternatives to the use of commercial managed care plans to deliver health care to Minnesota Health Care Program ("MHCP") enrollees, and do not shift financial risk to nongovernmental entities.

PCG is supporting the State in the development of five alternative model options to present to the Legislature for review as required by statute. Ultimately, PCG will support the State in the development of implementation plans for three or more models.

The purpose of this survey is to solicit feedback and thoughts on what works and what needs to be improved within the current system.

There will be 2 pages total in this survey.

- The first will include 4 questions for you to include your contact information.
- The second is to gather your thoughts on your experience with the current system.

Questions for Member Advocacy Groups:

- How would you rate Minnesota Medical Assistance as it operates today? (Mandatory. Scale, 1-4 very well, minor issues/poorly, major issues across multiple facets – do not allow for neutral selection)
- What is working about Minnesota Medical Assistance today? (Mandatory. Free text.)
- What are the key challenges or issues you find in the current system? What would you want to improve under a future model? (Mandatory. Free text.)
- Any additional comments? (Optional. Free text.)

Stakeholder List for Second Survey

Member Advocates:

- Allina Health EMS
- Altair ACO – Scott Hinchee
- ARRM
- Catholic Charities Twin Cities
- DHS & Red Lake Nation
- Family Tree Clinic

- Health Care for All MN
- Metro Meals on Wheels
- Minnesota Ambulance Association
- Trellis

Additional Member Advocates from Focus Groups

- COACT
- Health Access MN/O'Connell Consulting
- ISAIAH
- MN Citizens Federation
- MN Farmer's Union
- MN Nurses Association
- O'Connell Consulting
- SEIU Healthcare

Additional Stakeholders

- Minnesota Council of Health Plans
- MN Association of County Health Plans

Providers

- Allina Health and HealthPartners
- Allina Health IHP
- Avera Marshall
- Care Providers of Minnesota
- Essentia Health
- Gillette Children's
- Hennepin Healthcare
- Integrity Health Network
- Lakewood Health System
- MARRCH
- Neighborhood Health Care Network DBA FQHC Urban Health Network ("FUHN")
- One Arrow Group
- Perham Health
- Wilderness Health, Inc.

Counties

- Anoka County
- Benton County Human Services – two separate respondents
- Brown County

- Chippewa County Family Services
- DVHHS
- Goodhue County HHS
- Goodhue County Health and Human Services
- Le Sueur County Human Services
- MNPrairie County Alliance
- Nicollet County
- Rice County
- Stearns County Human Services
- Stevens County
- Wabasha County Public Health
- Wabasha County Social Services
- Yellow Medicine County
- HMOs
- Blue Cross and Blue Shield of Minnesota
- HealthPartners
- Medica
- UCare

CBPs

- Hennepin Health

Second Stakeholder Survey

MN Alternative Models Survey: https://pcgus.jotform.com/253274784351866

Background and Overview

The Minnesota Department of Human Services (DHS), through its Managed Care Contracting and Rates Division, is exploring a strategic shift in the delivery of health care services under the Minnesota Health Care Programs (MHCP). This initiative responds to legislative direction under Minn. Stat. § 256.9631 to evaluate and develop alternative care delivery models that move away from commercial managed care arrangements and eliminate financial risk transfer to non-governmental entities.

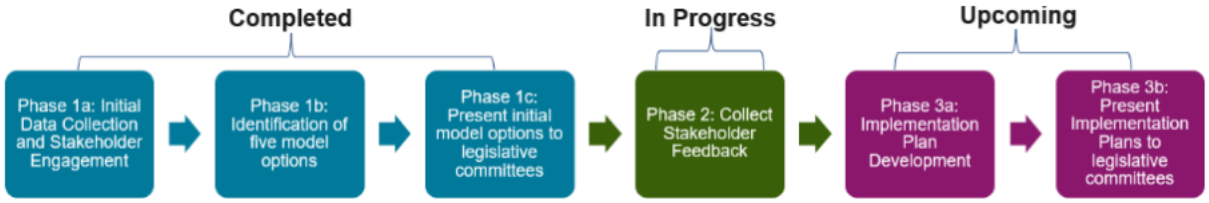
PCG is supporting the State in the development of three alternative model options to present to the Legislature for review as required by the statute. The primary objective of the detailed implementation plans developed for the three selected alternative care delivery models is to:

- Replace commercial managed care with publicly accountable systems such as fee-for-service (FFS), county-based purchasing plans, and county-owned health maintenance organizations.
- Ensure financial risk remains with governmental entities, thereby enhancing transparency and oversight.

- Improve access to care, especially for populations facing socioeconomic barriers, complex medical conditions, disabilities, or health disparities.
- Strengthen care coordination and continuity of care across counties and delivery systems.
- Provide actionable recommendations on quality measures, payment structures, statutory changes, and administrative supports necessary for successful implementation.
- Deliver cost-effective solutions that align with federal and state requirements while preserving member choice and provider network adequacy.

These models are expected to support the State's broader goals of improving health outcomes, reducing disparities, and ensuring equitable access to care for all MHCP enrollees leading to the selection of one of the models, or hybrid, to be moved into the next phase of implementation.

This engagement is a multi-phased approach, which is detailed below:



As part of Phase 2, this survey is designed to solicit feedback and thoughts on the three alternative model options to guide the development of each implementation plan. In addition, this survey will give you the opportunity to share opinions on which care delivery model (including the current system) is the best fit for Minnesota.

There will be 6 pages total in this survey.

The first will include 3 questions for you to include your contact information.

The subsequent pages will each pertain to one of the alternative models being explored. The same three questions will be posed for each of the models.

Survey:

- Contact information for individual completing the survey: Text box for each data field
  - Name
  - Title
  - Organization
  - Email
- Are you a: Provider, Tribal and Urban Indian Health Care Provider, County, County-Based Purchasing Plan, Health Maintenance Organization (Health Plan), Member Advocacy Group? (For this survey, you should select the group you primarily identify with.)
  - Drop-down with each stakeholder group
- Do you engage with MN in any other capacities?

- As a Provider
- As a Tribal and Urban Indian Health Care Provider
- As a County
- As a County-Based Purchasing Plan
- As a Health Maintenance Organization
- As a Member Advocacy Group
- Other
    - Will drop down with a box for the respondent to specify

Shift Non-Governmental Managed Care to Fee-for-Service: This model entails the removal of all non-county-based or non-county owned and operated managed care arrangements. The primary goal of this option is to phase out non-county-based HMOs and transition eligible individuals to Medicaid FFS or county-based managed care coverage. Unlike a "FFS Only" model, this option allows for the ongoing operation of Hennepin Health, as well as the three existing County Based Purchasing (CBP) plans. Collectively, Hennepin Health and the CBPs will be referred to as "county-based managed care plans" and account for roughly 10% of MA members.

Considerations for this model include:

- 90% of MA members would move to FFS, 10% would remain in county-based managed care
- Access and coverage discrepancies across counties
- Impacts on access, network adequacy, care coordination, loss of provider training and supports
- Cost control associated with loss of managed care arrangements

Opportunities for this model include:

- More direct state-level control of reimbursement rates and methodologies
- State has direct responsibility for provider quality
- Potential for improved claims processing turnaround time; simplified path to federal reporting/compliance

Questions

- What features of this model do you like? *(Required. Free text)*
- What questions or concerns do you have about the model? *(Required. Free text)*
- Please provide any additional feedback about the model. *(Required. Free text)*

Multiple/Regional ASOs: An Administrative Services Organization (ASO) is an organization independent of the State, which is under agreement to provide administrative services to a state Medicaid program. This includes the administration of claims, benefits, and many other functions of a Managed Care Organization (MCO). ASOs do not assume medical or financial risk. Under this model, the state can contract with multiple ASOs to perform a range of administrative services/supports. Given that contracting can be done with multiple ASOs, there is flexibility in how the state (or county) chooses to procure for them. ASOs can support a portion of the health benefit (such as behavioral health only) or may cover only a region of the state, allowing for care to be tailored to the needs and challenges of the relevant population and/or region.

Considerations for this model include:

- No direct financial incentive to promote care quality
- Administrative cost to state to manage and oversee ASO Multiple ASOs can introduce variability in outcomes and member experience across regions

Opportunities for this model include:

- State retains more control over service delivery and risk
- Efficiency can be leveraged where ASOs have regional or population-specific experience
- Eliminates government managed care risk while maintaining many supports currently offered by MCOs/HMOs
- Cost efficiency through outsourcing administration
- Regional autonomy to drive cost-effectiveness

Questions

- What features of this model do you like? *(Required. Free text)*
- What questions or concerns do you have about the model? *(Required. Free text)*
- Please provide any additional feedback about the model. *(Required. Free text)*

Expand County-Based Purchasing Plans and County-Owned Health Maintenance Organizations: The primary feature of this model is the expansion of county-based managed care. There are two county-based models: county-based purchasing plans (CBP) [a health plan operated by a county or group of counties]; and county owned and operated HMOs. Currently there are three CBPs operating in Minnesota, covering 32 counties and 78,836 enrollees. Hennepin Health is the only county owned and operated HMO in Minnesota.

County-based managed care provides an opportunity for locally designed service delivery systems that involve the coordinated efforts of counties, providers, and consumers, as well as stabilizing and supporting existing community provider networks.

Considerations for this model include:

- Economy of scales in rural areas
- Cost to counties and municipalities in addition to state administration cost
- Consistency of member experience across counties
- Start-up costs

Opportunities for this model include:

- Counties and public providers are uniquely well-positioned for community partnership
- Builds on existing role of counties in MN managed care

Questions

- What features of this model do you like? *(Required. Free text)*
- What questions or concerns do you have about the model? *(Required. Free text)*
- Please provide any additional feedback about the model. *(Required. Free text)*

Model Comparison

Below is a full comparison of the three alternative models.

	Option 1: Shift Non-Governmental Managed Care to Fee-for-Service	Option 2: Multiple/Regional ASOs	Option 3: Expand County Based Purchasing Plans and County-Owned HMOs
Considerations	• Access and coverage discrepancies across counties • Capacity to shift members to county-based managed care where available vs. FFS • Impacts on access, network adequacy, care coordination, loss of provider training and supports • Cost control associated with loss of managed care arrangements	• No direct financial incentive to promote care quality • Administrative cost to state to manage and oversee ASO • Cost variability owing to variability of service delegation to ASOs; oversight and reporting falls on state • Multiple ASOs can introduce variability in outcomes and member experience across regions	• Economy of Scales in rural areas • Cost to counties and municipalities in addition to state administration cost • Consistency of member experience across counties; start-up cost.
Opportunities	• More direct state-level control of reimbursement rates and methodologies • State has direct responsibility for provider quality • Potential for improved claims processing turn around time; simplified path to federal reporting and compliance	• State retains more control over service delivery and risk • Efficiency can be leveraged where ASOs have regional or population-specific experience • Eliminates government managed care risk while maintain many supports currently offered by MCOs/HMOs • Cost efficiency through outsourcing administration • Regional autonomy to drive cost-effectiveness.	• Counties and public providers are uniquely well-positioned for community partnership • Builds on existing role of counties in MN managed care.
Fiscal Impacts	• Higher MMIS and administrative costs • No incentive alignment towards cost-reduction/efficiency • More streamlined payment procedures • Potential for reduced vendor support in some areas • Maintaining existing county-based programs without statewide coverage could reduce economy of scales	• Potential cost efficiency through outsourcing administrative functions, allowing for flexibility to scale • Risk of increased cost of health services given that no financial incentives aligned to care quality exist	• State administrative cost and start-up cost for local governments • Opportunity to maximize financial stability; lower overall risk through risk pooling across counties; potential cost savings through streamlining access to care
Member Experience	• Reduced emphasis on care quality measurement and loss of administrative supports/ care coordination • Increased need for state call center management for grievances and appeals • May reduce certain optional reimbursement services beyond FFS coverage • Potential geographical discrepancies in member experience.	• Efficiency achieved by ASO could yield improvements in member experience over FFS-only • Without risk-based reimbursement member experience impact may be varied and difficult to quantify • Potential that prior authorization and utilization management standards will be less strict, and therefore more favorable to members.	• Potential for continuity in member experience; • Could be significant disruption for members moving within the state • Provider-led option could streamline ease of access, however, potential negative impact on member choice.

Which of these three models do you prefer? Rank these models from 1-4, with 1 being your most preferred and 4 being your least preferred. *(Mandatory: Ranking the new models with an option to remain the same for respondents to indicate if they prefer a model not provided)*

- Option 1: Shift Non-Governmental Managed Care to Fee-for-Service
- Option 2: Multiple/Regional ASOs
- Option 3: Expand County-Based Purchasing Plans and County-Owned HMOs
- Other Option Preferred

Thank you for your feedback and participation in the survey.

If you have any immediate questions or concerns, please contact alternativedeliverymodels@pcgus.com . Any comments or concerns? *(Free text)*

APPENDIX C: Glossary of Terms

ACA – Affordable Care Act

ACO – Accountable Care Organization

ACR – Average Commercial Rate

ASO – Administrative Services Organization

CBP – County Based Plan

CBPP – County-Based Purchasing Plan

CIN – Clinical Integration Networks

DHS – MN Department of Human Services

FFS – Fee for Service

FPL – Federal Poverty Line

GAMC – General Assistance Medical Care

HCIA – Health Care Integrity and Accountability Office

HCCS – Medicaid Health Care Consumer Support

HEDIS – Healthcare Effectiveness Data and Information Set

HMO – Health Maintenance Organization

IGT – Intergovernmental Transfer

I-SNBC – Integrated Special Needs BasicCare

MA – Medical Assistance

MCO – Managed Care Organization

MDH – Minnesota Department of Health

MHCP – Minnesota Health Care Programs

MMIS – Medicaid Management Information System

MPPS – Medicaid Payments and Provider Services

MSC+ – Minnesota Senior Care Plus

MSHO – Minnesota Senior Health Option

OMMD – Office of Medicaid Medical Director

P4P – Pay-for-Performance

SNBC – Special Needs BasicCare

SNBC-NI – Non-integrated Special Needs BasicCare

SNP – Special Needs Purchasing

SPA – State Plan Amendment

TPA – Third-Party Administrator

UPL – Upper Payment Limit

VBP – Value-Based Payment