Big Savings in a Small State

Christopher G. Donovan was the Speaker of the Connecticut House of Representatives at the time of the conversion of CT's Medicaid program from managed care run by risk-based insurers to managed fee for service, and in the years leading up to that conversion in 2011-2012.

Under the Medicaid managed care system run by capitated entities, Connecticut enrollees and their providers experienced difficulty receiving necessary care, and the payment for care provided. Legislators heard from constituents about inadequate provider networks and the routine denials of needed treatment by the MCOs. Insurers claimed to provide care coordination, but it seemed that their priority was managing their costs: every dollar of health care they denied increased their own profits. Obtaining information about how they were performing with the taxpayers' money was a major fight, involving litigation under the Freedom of Information Act and other frustrating efforts at holding them accountable.

One of the most problematic aspects of the relationship with the MCOs was their consistent demand for ever higher payments, with the express or implied threat of imminent departure if the state refused. Our Medicaid agency would sometimes negotiate to give them even higher capitated payments than we had authorized in budget legislation, because of this coercion.

Before the conversion to managed fee for service took place, I helped to draft legislation requiring our Medicaid agency to implement a pilot program of what was called primary care case management, as an alternative to having to enroll in an MCO. Under PCCM, primary care providers are paid a monthly fee to provide the care coordination, rarely delivered by the MCOs, as well as fee for service payment for office visits. While the pilot program was small, it served as a model for how to deliver quality care at a reasonable cost without the high insurance company overhead inherent with MCOs, and the conversion in 2012 included a commitment to broad use of accredited patient-centered medical homes providing care coordination, similar to the PCCM model.

(cont.)

After the conversion, our constituents on Medicaid began to see a significant improvement in access to care and their providers had far less grief in getting services approved or, once provided, in actually getting paid. Many providers newly signed up to participate in Medicaid — even those for whom the transition brought no increase in their reimbursement rates. While CT still does prior authorization for some services determined by the Medicaid agency, these reviews are conducted by non-risk administrative services organizations which have no financial incentive to deny needed care.

Our small state has literally saved billions in unnecessary MCO overhead dollars since the transition, while providing the meaningful care coordination our constituents needed. As Speaker, it was gratifying to work with Medicaid advocates in making the transition away from capitated managed care. While the program is not perfect, it is far superior to what we had under several incarnations of capitated managed care, an inadequate health care delivery system.

Christopher G. Donovan,
Member, CT House of Representatives 1993 to 2013
Speaker, CT House of Representatives 2009-2013

"As the owner of an outpatient physical therapy clinic, I wanted to provide care to patients with Medicaid. Many of the people who found me often shared that I was the tenth provider they had contacted – just to find someone who would accept Medicaid. For every Medicaid patient I treated, I knew there was a risk I might never be paid. Even after completing every requirement for pre-authorization, more than 75% of the time I was denied payment for allegedly not obtaining prior authorization, an incredibly frustrating experience. The hours of administrative work required to gain authorization and to pursue payment, nearly led me to stop accepting Medicaid altogether.

"As an elected Missouri State Representative serving on the Budget Committee, I saw firsthand how managed care was added to the state budget in 2015 without any public hearings or opportunities for public comment. There was no chance to fully explore the pros and cons of whether managed care organizations (MCOs) would truly benefit patients or serve Missouri's budgetary needs. Nearly a decade later, Missourians' overall health has not improved—we currently rank among the worst states in healthcare outcomes.

"Not only have we failed to see improvements in health, year after year in budget meetings, there is no transparency regarding the cost of managed care. We are not provided with breakdowns of how funds given to MCOs are spent—whether on actual healthcare, medical equipment, medications, versus how much the MCOs spend on general administration and overhead, staff time to deny pre-authorization, advertising, or their profit.

"As many states have utilized MCOs, and some have not, comparisons between these states provide growing evidence that MCOs do not improve the health of our citizens. In fact, there are strong incentives for them to delay care, deny pre-authorization, and underpay providers in order to maximize profit.

"Just as they refused my patients the healthcare they needed, they also refused legislators the information needed to oversee them. They claim it's 'proprietary,' but as we're the ones paying them, we should be entitled to their information.

"If Missouri is going to continue spending taxpayer dollars on managed care, we need honest, public conversations about whether we are truly getting what we're paying for."

Deb Lavender (Physical Therapist and former Missouri State Representative)

March 16, 2026

Chair Bierman, Chair Backer, and members of the House Health Finance and Policy Committee:

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, advocating for evidence-based public policies to reduce the cancer burden for everyone. We want to express our support for portions of HF3476, specifically the language around establishing coverage for care coordination.

In Minnesota, nearly 40,000 people will be diagnosed with cancer in 2026 and 10,660 are expected to die from the disease. Navigating the health care system can be confusing and complicated, especially after receiving a complex medical diagnosis like cancer.

ACS CAN appreciates the inclusion of patient navigation, a form of care coordination, in the bill as a covered service. Patient navigation provides individualized assistance that helps patients overcome barriers in the healthcare system. Oncology patient navigation spans the full cancer continuum, ensuring that patients receive the health and psychosocial care they need.

Although cancer death rates have been declining for several decades, not all people have benefited equally from the advances in prevention, early detection, and treatment. Patient navigation can help eliminate health disparities by addressing the needs of people who have been historically marginalized and excluded, as well as those living in under-resourced communities.

Patient navigators have been shown to help increase cancer screenings rates, help patients better understand treatment options, and help ensure patients receive needed post-treatment care. Additionally, patient navigation has demonstrated a proven return on investment by identifying cancers at earlier, more treatable stages. Early-stage diagnoses often lead to less invasive and more cost-effective treatments, resulting in better patient outcomes and reduced overall healthcare costs.

Unfortunately, patient navigation services are still absent or limited in many cancer programs and hospital settings due to cost concerns and lack of clinical reimbursement. A patchwork of coverage exists depending on the where patients live and the type of insurance coverage they have and is not consistent throughout the cancer care continuum. Access to patient navigation services will only be achieved by ensuring payment for patient navigation services is available across both public and private payers.

Thank you for considering this legislation and the value of care coordination to Minnesota's cancer patients, survivors, and caregivers.

Sincerely,

Emily Myatt
Minnesota Government Relations Director
American Cancer Society Cancer Action Network

March 10, 2026

Re: Organizational letter of support for SF3612/HF3476 the **PATIENT-CENTERED CARE AND DIRECT PAYMENT FOR MEDICAL ASSISTANCE AND MINNESOTACARE**

Dear Members of the Minnesota Senate Health and Human Services Committee,

We, the undersigned unions and organizations, urge you to support the Patient Centered Care and Direct Payment for Medical Assistance and MinnesotaCare bill, authored by Sen. John Marty and Rep. Tina Liebling (SF 3612/HF 3476).

What it does: This bill will remove HMOs from the Medical Assistance and MinnesotaCare programs. In the present system, the HMOs are paid a monthly premium per enrollee (often called a capitation payment) by the Department of Human Services (DHS). The HMOs, in turn, pay the medical providers. This bill will instead shift all current HMO enrollees to a direct payment system, under which DHS pays doctors, hospitals, and pharmacies directly for medical goods and services.

Counties with County-Based Purchasing systems would serve as payment administrators on behalf of DHS in those counties. Counties that wish to create or join a County-Based Purchasing system will be allowed to do so. The state will also pay for care coordination of all enrollees, including payments to primary care providers.

Why do this? The key reason is to save the state up to a billion dollars per year that are currently wasted on HMO administrative expenditures and net income (which research shows to be somewhere between 10 and 15 percent of total expenditures by Medicaid HMOs). This is a common-sense reform in its own right, but it has now become essential in light of the large federal HR 1 cuts coming to Medicaid. For Minnesota, these cuts are projected to average $2 billion per year over the next decade.

The PCC–Direct Payment bill will offset a large portion of these cuts. This can help protect against reductions in benefits and eligibility that would otherwise likely occur. It could also be crucial for the survival of rural medical providers in our state.

Can the state do this? DHS already does this for about 250,000 people, which is approximately 20 percent of our total Medical Assistance enrollment. The systems are already in place to pay medical providers directly, without the expense of paying HMO net income and many excessive administrative functions.

What about fraud? The insertion of HMOs into our public programs, known as privatization, has increased the risk of fraud. This is because it is difficult for DHS to hold the HMOs it contracts with fully accountable. Under state law, the payments that HMOs give to medical providers are secret. The legislature has tried—and failed—to determine whether privatization has actually saved the state money.

Proof that de-privatization saves money: Connecticut removed the insurance companies from (i.e., de-privatized) its Medicaid program in 2012 and reduced its per-person costs by 14 percent while also improving the quality of care. Oklahoma did the same thing in

2005 with similar results (although that state recently yielded to insurance industry interests and is in the process of returning to a privatized system).

Minnesota has been experimenting with HMOs in our public programs for four decades on the theory that they would save money and provide good quality. Unfortunately, this experiment has clearly failed. Before the legislature privatized Medical Assistance, DHS was the only source of administrative costs within the program, and DHS spent 4 to 5 percent of its Medical Assistance expenditures administering the program.

The insertion of HMOs added additional administrative costs along with HMO net income, raising the total to an estimated 15 to 20 percent of total spending.

It is time to acknowledge that the experiment did not work, that billions in taxpayer funds have been wasted, and that we should return to what we previously did for all enrollees: direct payment of providers by DHS.

We urge you to vote **yes** for the Patient Centered Care – Direct Payment to Providers bill.

Sincerely,

Afton Indivisible
Arrowhead Indivisible
Brainard Lakes Indivisible
Chicago Lakes Indivisible
Claddagh Indivisible
Comunidades Organizando el Poder y la Acción Latina (COPAL)
Detroit Lakes Area Indivisible
Duluth Indivisible
Engines for Economic Justice
Health Care for All Minnesota (HCA-MN)
Indivisible Bemidji
Indivisible Blue Brigade
Indivisible 507
Indivisible Kandiyohi County
Indivisible Left
Indivisible Morris
Indivisible North Metro
Indivisible Saint Peter/Greater Mankato
Indivisible Shakopee, Prior Lake, Savage
Indivisible West Metro
Indivisible Twin Cities
ISAIAH Minnesota
Isanti County Indivisible
Linden Indivisible
Minnesota AFL-CIO Retiree Council
Minnesota Association of Professional Employees (MAPE)
Minneapolis Regional Retiree Council (MRRC)
Minneapolis Retired Teachers (MRT)
Minnesota Farmers Union (MFU)

Minnesota Nurses Association (MNA)
Minnesota Unitarian Universalist Social Justice Alliance
No Kings Indivisible North Side
Northfield Indivisible
OutFront Minnesota
Protect Minnesota
Physicians for a National Health Program – MN (PNHP-MN)
Red River United Indivisible
Saint Croix Valley Indivisible (SCVI)
Saint Paul Corner Drugstore/Pharmacy
Saint Paul Federation of Educators
Service Employees International Union Health Care Minnesota and Iowa (SEIU HC MN & IA)
Sherburne County Indivisible
Spirit River Indivisible
Students for a National Health Program – MN (SNaHP-MN)
WARR Indivisible
W7th Gardeners of Resistance
Winona Indivisible
Wright County Indivisible
Zenith City Indivisible

Contact information:
Rose Roach, Chair, Health Care for All Minnesota
Rose.roachLCSP@outlook.com
651-233-3604

March 17, 2026

Minnesota House Health Finance and Policy Committee
Minnesota House of Representatives
658 Cedar St.
St. Paul, MN 55155

Dear Chairs Bierman and Backer, and Committee Members:

I'm writing to strongly encourage you to advance the Patient-Centered Care Act. HF 3476 will improve care, enhance accountability, increase access, reduce fragmentation, and save taxpayer dollars. It will end a 30-year demonstration project, known as PMAP (Prepaid Medical Assistance Program), which has failed to demonstrate sufficient justification for you to continue wasting public money on it.

My background includes 49 years of acute care nursing, law, public health, bioethics and interprofessional higher education of our state's healthcare providers. I served on the Minnesota Health Care Commission under Governor Arne Carlson following the enactment of MinnesotaCare, shortly before the state began contracting with private managed care organizations (MCOs) to run multi-billion dollar, publicly funded safety net healthcare programs.

Minnesotans know it makes sense to eliminate middle men in the purchase of goods and services, especially when those intermediaries' own overhead costs make those goods and services more expensive, while adding no real value to the public. There is little political downside to reducing overhead costs while removing unhelpful barriers to Minnesotans choice of healthcare providers and improving continuity of care.

Unlike public entities, private managed care organizations have for too long hidden the management of public dollars behind their right to protect what they deem their proprietary information. In other words, their right to protect their profits, or what nonprofit organizations refer to as operating margins. In the current and appropriate climate of reducing public dollar mismanagement, such internal shielding of how tax dollars are spent, or misspent, is unacceptable.

County-based direct contracting with healthcare providers strongly suggests there is a net gain from eliminating private MCOs from publicly funded healthcare. Improved reimbursement of dentists, therapists, physicians, hospitals, etc., keeps providers from closing their doors or reducing services. That improves access and economies throughout the state, and is a much better use of tax dollars than buttressing up private MCOs who depend on public funds to subsidize otherwise failing businesses.

The Patient-Centered Care Act is vitally important to the fiscal welfare of our state and the healthcare of some of our most vulnerable people. Please advance HF 3746.

Sincerely,

Dr. Eileen Weber, DNP, JD, PHN, RN
Clinical Associate Professor Ad Honorem (retired)
University of Minnesota School of Nursing

MINNESOTA COUNCIL of HEALTH PLANS

CAPITOL OFFICE BUILDING
525 PARK STREET
SUITE 140
ST. PAUL, MINNESOTA 55103
651-645-0099 FAX 651-645-0098

March 16, 2026

House Health Finance and Policy Committee
Centennial Office Building
St. Paul, MN 55155

Chair Bierman, Chair Backer, and Members of the Committee:

The Council is testifying today in opposition to HF 3476 (Liebling) which would end managed care in Minnesota. We have significant concerns around patient health and access to care, increased fraud in public programs, and financial impacts to the state if this bill were to be implemented. At the March 9th House Fraud Committee, the Director of Program Integrity testified, "there's an opportunity here to partner with MCOs yet still oversee their activities. They have a vested interest in preventing fraud." This bill contradicts the work and recommendations of the report.

To supplement today's testimony and provide further details on the oversight of MCOs, Appendix 1 includes a list of statutes which outline these requirements. Appendix 2 includes a list of the 72 areas of data MCOs are required to submit to DHS for state oversight and for reports the state must submit to the Centers for Medicare and Medicaid Services.

Under the current system, these programs are exclusively served by nonprofit entities. Our members are dedicated to the work we perform on behalf of the state to provide access to care for those Minnesotans who use the Managed Care and MinnesotaCare programs. We are looking forward to working on strengthening the program to maintain broad access to needed care for Minnesotans while preventing fraud and holding down administrative costs.

Sincerely,

Lucas Nesse
President and CEO

Appendix 1

PROGRAM OVERSIGHT

256B.69, Subd. 6 – Service delivery

Requirements to provide care coordination.

FINANCIAL OVERSIGHT OF MCOs

256B.69, Subd. 5i - Administrative expenses

State statute caps MCO administrative expenses at 6.6% and excludes certain expenses from the administrative cost calculation such as executive compensation, charitable contributions, penalties and fines, and indirect marketing or advertising expenses.

256B.6928, Subd. 8 - Medical loss ratio.

The commissioner shall require that each managed care organization calculate and submit to the commissioner a medical loss ratio report for each contract year. The numerator must be the sum of the managed care organization's incurred claims, the managed care organization's expenditures for activities that improve health care quality, and fraud prevention activities. The denominator must be calculated as the managed care organization's adjusted premium revenue minus the managed care organization's federal, state, and local taxes and licensing and regulatory fees. Reports sent to CMS.

256B.69, Subd. 5a – Managed care contracts

Includes language requiring annual contracting and compliance with the signed contract, 5% performance withhold and 3% payment delay, use the assessment and authorization processes required by DHS, a six-month timely filing standard, DHS access to all subcontractor documentation.

PROGRAM AUDITS

256B.6927, Subd. 3 - External quality reviews.

(a) The commissioner shall contract with an external quality review organization in accordance with Code of Federal Regulations, part 42, section 438.354, to conduct an annual external quality review of each managed care organization.

256B.69, Subd. 9d and e. Financial and quality assurance audits.

MCOs must submit to and fully cooperate with the independent third-party financial audits by the legislative auditor. The OLA shall audit MCOs to determine if a MCO used public money in compliance with federal and state laws, rules, and in accordance with provisions in the plan's contract DHS.

PMAP NETWORK REQUIREMENTS

256B.69, Subd. 31. Networks

DHS shall ensure that a MCO's network providers are enrolled with DHS as medical assistance providers. A MCO may add a provider to its network if it is not a medical assistance provider for a period of up to 120 days pending the outcome of the medical assistance provider enrollment

process. A MCO must terminate the contract upon notification that the provider cannot be enrolled as a medical assistance provider or upon expiration of the 120-day period if notification has not been received within that period. The MCO must notify each affected enrollee of the provider contract termination.

PRESCRIPTION DRUGS ACCESS

256B.69, Subd. 6d – Prescription drugs

Allows DHS to exclude or modify coverage for prescription drugs in MCO contracts entered in order to increase savings to the state by collecting additional prescription drug rebates.

256B.69, Subd. 6i. Directed pharmacy dispensing payment

Sets dispensing fees.

DENTAL ACCESS

256B.69, Subd. 6e-g

Dental requirements.

PROGRAM PAYMENTS

256B.69, Subd. 5k – Actuarial soundness

Rates paid to MCOs must be neither inadequate nor excessive, be appropriate for the populations to be covered and the services to be furnished under the contract.

Each year within 30 days of the establishment of plan rates DHS report to certify how each of these conditions have been met by the new payment rates.

These rates must also be reviewed and approved by CMS as actuarially sound (256B.6928, Subd. 2).

256B.69, Subd. 5a – Capitation rates

Sets increased amounts.

256B.69, Subd. 5g – Payment for covered services and *Subd. 5h – Payment reductions*

Sets payment reductions.

256B.69, Subd. 31. Payment reductions

More payment reductions to MCOs.

REGULATIONS ON ENROLLEE COMMUNICATIONS

256B.6925, Subd. 2 - Information provided by managed care organization.

The commissioner shall ensure that managed care organizations provide to each enrollee the following information: ....

256B.6925, Subd. 5 - Enrollee communication.

(a) The commissioner shall ensure that the managed care organization:

(1) submits all marketing materials to the commissioner for approval before distribution and that marketing materials are accurate and do not mislead, confuse, or defraud;

MCO REPORTING REQUIREMENTS

256B.69, Subd. 9f. Annual report on provider reimbursement rates

DHS, December 15 of each year, shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance a report on MCO provider reimbursement rates.

256B.69, Subd. 9 – Reporting

Each MCO shall submit information as required by DHS, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. This includes encounter data for each service provided, using standard codes and unit of service definitions set by DHS. Each MCO shall report to DHS on the extent to which providers employed by or under contract with the MCO use patient-centered decision-making tools or procedures designed to engage patients early in the decision-making process and the steps taken by the MCO to encourage their use.

256B.69, Subd. 9a. Administrative expense reporting

Work with MDH to collect this data.

256B.69, Subd. 9c. Managed care financial reporting.

DHS shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by DHS. Each MCO must report the following every quarter to DHS:

(1) an income statement by program;
(2) financial statement footnotes;
(3) quarterly profitability by program and population group;
(4) a medical liability summary by program and population group;
(5) received but unpaid claims report by program;
(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;
(7) utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services;
(8) pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services;
(9) subcapitation expenses by population group;
(10) third-party payments by program;
(11) all new, active, and closed subrogation cases by program;
(12) all new, active, and closed fraud and abuse cases by program;
(13) medical loss ratios by program;
(14) administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies, including Minnesota Supplement Report #1A;
(15) revenues by program, including investment income;
(16) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan under this

section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan, including but not limited to:
(i) individual-level provider payment and reimbursement rate data;
(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;
(iii) data on implementation of legislatively mandated provider rate changes; and
(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;
(17) data on the amount of reinsurance or transfer of risk by program; and
(18) contribution to reserve, by program.

Appendix 2

MCO Reports to the State	Frequency
Encounter Claims Data	Biweekly
Provider Network Information.	Monthly
The MCO will submit to the STATE a complete listing of its Provider Network in accordance with the specifications outlined in the STATE's provider network template posted on the STATE's web site. The MCO will submit its entire Provider Network on the fifth (5th) of every month to the STATE's provider data repository. The MCO will work with the STATE to ensure that its monthly provider network data submission is complete, accurate, and timely and will resolve any issues necessary to successfully submit the data.	
Date of Death Reports	Monthly
The MCO shall promptly notify the STATE if the MCO receives information about changes in an Enrollee's circumstances that may affect the Enrollee's MHCP eligibility.	
Equity Engagement	Monthly
The MCO shall participate in the STATE's Equity Partnership through assignment of a staff member to participate in meetings as requested by the Partnership	
Enrollees Resident in IMD for SUD and MH	Monthly
Adverse Provider Actions	Monthly
Provider Fraud, Waste and Abuse Log	Monthly
The MCO shall maintain a detailed log (in a form approved by the STATE) of all reports of provider and Enrollee Fraud and Abuse investigated by the MCO or its Subcontractors which shall be submitted to the STATE	
Note: this was a quarterly report that was amended to monthly in the 2026 MCO Contract language	
Program Integrity Disclosure-9.5.1 Exclusions of Individuals and Entities; Confirming Identity	Monthly
9.5.1.1 The MCO and its Subcontractors must search monthly, and upon contract execution or renewal, and credentialing, the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System for Award Management (SAM), (and may search the Medicare Exclusion Database), and the MHCP Excluded Group and Individual Providers Lists maintained by the STATE, for any Providers, agents, Persons with an Ownership or Control Interest, affiliates, and Managing Employees to verify that these persons:	
(1) Are not excluded from participation in Medicaid by the STATE nor under §§1128 or 1128A of the SSA; and,	
(2) Have not been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the programs under Title XX of the SSA. [42 CFR §§455.436; 438.602(d); 438.610]	
Tort Settlement Tracking	Monthly

Quarterly Financial Report	Quarterly
Financial and other information as specified by the STATE to determine the MCO's financial and risk capability.	
Financial Report-Comparison to FFS	Quarterly
The MCO shall identify aggregate payment information for specific Provider categories and assess the information as to how it compares to FFS payment information. As part of the assessment the MCO will also be expected to provide an explanation of the basis for how the Provider category payment was determined. The STATE will provide the Provider categories in the financial reporting template.	
Health Care Home and HCH Alternatives.	Quarterly
HCH payment is reported on the quarterly financial report	
Drug Utilization Review Report	Quarterly
As a quarterly summary meeting the requirements of 42 USC §1396r 8 (d)(5), including the number of authorization requests received; the numbers completed and not completed within the timeframes required; and what corrective action has been taken for authorization requests not completed within the timeframes required.	
MCO input requested by the Transforming Maternal Health model quarterly work group, in Hennepin County.	Quarterly
Dental CHIPRA Data Files	Quarterly
Information about dental providers in the MCO network.	
Claim-level data on all post-payment recoveries for pharmacy claims from liable third parties	Quarterly
The MCO shall submit individual-enrollee specific, claim-level data on all post-payment recoveries for pharmacy claims from liable third parties on a quarterly basis, in a format determined by the STATE.	
County Engagement	Quarterly
Meetings offered at least as frequently as quarterly with County health and human services leadership in the MCO's contracted service area. The meetings may be collaborative with other counties and/or MCOs at the County's discretion	
Reporting of Appeals, Grievances and DTRs	Quarterly
The MCO must submit to the STATE electronic reports of all DTRS, oral and written Grievances, and oral and written Appeals	
Restricted Recipient Program Reports	Quarterly
Communications	
PMP Access Criteria Audit	
Eight Months Recoveries Report.	Quarterly
The MCO shall, on a quarterly basis, disclose to the STATE all Post Payment Recovered amounts occurring after the eight-month timeframe	
Privacy reporting	Quarterly
Any use or disclosure of PHI, which is not a breach, that requires reporting under this agreement shall be reported in a form and manner determined by the STATE. The MCO will submit the information on a quarterly basis consistent with the instructions included in the STATE's Non-Breach reporting template	

EIDBI Audit Sample	Biannually
The MCO must provide an audit sample each six months, including reports, claims data, and supporting documentation (ITPs and CMDEs) to the STATE to verify provider adherence to these clinical supervision and observation and direction requirements. The audit form and format will be specified by the STATE as advised by the EIDBI work group.	
Drug Utilization Review Program Report	Annually
Annually, in a format approved by CMS and the STATE, on DUR activities from the previous federal fiscal year. The STATE will review the MCO's report prior to the CMS submission; the report is due to the STATE by May 15 of the Contract Year. In addition to the submission directly to CMS, the MCO must submit this report in PDF format to the STATE by June 30 of the Contract Year.	
Federal and State MLRs	Annually
The MCO shall calculate and report a federal Medical Loss Ratio (MLR) for all Medicaid programs, and for MinnesotaCare, an MLR under state law. The federal and state MLR reports are due August 31 of the Contract Year	
Federal and State MLR	Annually
The MCO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCO within one hundred and eighty (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the MCO, whichever comes sooner, regardless of current contractual limitations.	
Federal and State MLR	Annually
In the event that the STATE makes a retroactive change to the capitation payments for an MLR reporting year where the report has already been submitted to the State, the MCO must re-calculate the MLRs for all reporting years affected by the change and submit a new report(s) meeting the requirements of this section	
Federal and State MLR	Annually
In the event that the MCO fails to meet the federal or state MLR of eighty-five percent (85%), the MCO must provide a remittance to the STATE to meet the MLR of eighty-five percent (85%).	
Health Care Home and HCH Alternatives.	Annually
HCH Alternatives Descriptive Report. Reporting requirement if using an alternative arrangement for Health Care Homes. The MCO shall annually provide a description of each comprehensive payment arrangement and its proposed outcome or performance measures that the MCO uses as an alternative to Health Care Homes payment, in a reporting template provided by the STATE.	
The name of the MCO's parent company	Annually
MCPAR required report. The MCO shall provide reports or data as required by the CMS Managed Care Program Annual Report template	
The location on the MCO's web site (the URL) where the MCO posts the Patient Access API	Annually

MCPAR required report. The MCO shall provide reports or data as required by the CMS Managed Care Program Annual Report template	
The URL where the MCO posts Enrollee educational resources for the Patient Access API	Annually
MCPAR required report. The MCO shall provide reports or data as required by the CMS Managed Care Program Annual Report template	
The total number of unique Enrollees whose data are transferred via the Patient Access API to a health app designated by the Enrollee for the previous calendar year	Annually
MCPAR required report. The MCO shall provide reports or data as required by the CMS Managed Care Program Annual Report template	
The total number of unique Enrollees whose data are transferred more than once via the Patient Access API to a health app designated by the Enrollee for the previous calendar year	Annually
MCPAR required report. The MCO shall provide reports or data as required by the CMS Managed Care Program Annual Report template	
4th Quarter Financial Report	Annually
The fourth quarter report shall also include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements.	
Subcontractors for Third Party Liability and Subrogation Interests	Annually
The MCO shall provide a report on subcontractors related to TPL and subrogation.	
Documentation that the MCO has complied with the STATE's requirements for availability and accessibility of services.	Annually
Limited English Proficiency Plan.	Annually
The MCO must annually by November 1 of the Contract Year, submit a Limited English Proficiency (LEP) Plan	
Report on the initial screening of each Enrollee	Annually
The MCO must make a best effort to conduct an initial screening of each Enrollee's needs. The MCO must make a best effort to notify each Enrollee of the availability of the initial screening questions within ninety (90) days of the effective date of enrollment. The annual report for the initial screening of each Enrollee will be due to DHS by April 30 of the following Contract Year.	
County Engagement Strategy and Report	Annually
The MCO must develop and implement a County Engagement strategy that is available for County or STATE review, and which must be updated at least annually	
Annual PMI numbers of Enrollees	Annually
If the Enrollee's PMI does not appear on the remittance advice the MCO shall provide to the STATE an annual report using technical specifications published by the STATE.	
Drug Formulary Changes	Annually
The MCO must provide the STATE with the online formulary web site link, annually on December 15th, so that it can be made available on the DHS managed care web site.	
Quality Assurance Work Plan	Annually

The MCO shall provide the STATE with an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the year.	
Annual Quality Assessment and Performance Improvement Program Evaluation	Annually
The MCO must conduct an annual quality assessment and performance improvement program evaluation consistent with state and federal regulations, and current NCQA "Standards and Guidelines for the Accreditation of Health Plans." This evaluation must review the impact and effectiveness of the MCO's quality assessment and performance improvement program	
HEDIS Measures	Annually
Oral Evaluation Dental Services	
7.12.1.2 Topical Fluoride for Children	
7.12.1.3 Childhood Immunization Status	
7.12.1.4 Immunizations for Adolescents	
7.12.1.5 Well-Child Visits in the First 30 Months of Life	
7.12.1.6 Child and Adolescent Well-Care Visits	
7.12.1.7 Breast Cancer Screening	
7.12.1.8 Cervical Cancer Screening	
7.12.1.9 Prenatal and Postpartum Care	
7.12.1.10 Colorectal Cancer Screening	
7.12.1.11 Controlling High Blood Pressure	
7.12.1.12 Blood Pressure Control for Patients with Diabetes	
7.12.1.13 Glycemic Status Assessment for Patients with Diabetes	
7.12.1.14 Eye Exam for Patients With Diabetes	
7.12.1.15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	
7.12.1.16 Follow-Up After Hospitalization for Mental Illness	
7.12.1.17 Follow-Up After Emergency Department Visit for Mental Illness	
7.12.1.18 Plan All-Cause Readmissions.	
7.12.1.19 Depression Screening and Follow-Up for Adolescents and Adults	
7.12.1.20 Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	
Accreditation Status reports	Annually
The MCO must inform the State whether it has been accredited by a private independent accrediting entity	
Annual Performance Improvement Proposal, Interim or Final PIP Report	Annually
The MCO must conduct PIPs designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction.	
Annual reports on Population Health Management	Annually
Structure and processes to maintain and improve health care quality, and measures in place to evaluate MCO's performance on its process outcomes (for example, clinical care, or Enrollee experience of care).	
Annual Quality Program Update web link notification	Annually

Annually, the MCO shall demonstrate how the MCO's Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the MHCP Enrollees	
MCO Solvency Standards Assurance	Annually
All MCOs must meet the solvency standards established by the State for Health Maintenance Organizations or be licensed or certified by the State as a risk-bearing entity. MCOs must provide written assurance to the State by April 30th of the contract year	
Annual schedule identifying Subcontractors and delegated functions	Annually
Deficit Reduction Act Training Assurance Statement	Annually
If the MCO receives or makes Medicaid payments totaling five million dollars ($5,000,000) or more within a Federal fiscal year (October 1st through September 30th), the MCO must establish, implement and disseminate written policies and procedures to all employees including management, contractors and agents that includes detailed information pertaining to the False Claims Acts (federal and state) and other provisions named in §1902(a)(68)(A) of the SSA. These policies must include detailed provisions regarding the MCO's procedures for detecting and preventing fraud, waste, and abuse.	
Program Integrity Disclosure-9.5.2 Disclosure of Ownership and Management Information (MCO)	Annually
MCO Disclosure Assurance. The MCO must submit to the STATE by September 1st of the Contract Year a letter of assurance stating that the disclosure of ownership information has been requested of all Subcontractors, and reviewed by the MCO prior to MCO and Subcontractor contract renewal.	Annually
Compliance with the Mental Health Parity Rule	Annually
Physician Incentive Plans Disclosure	Annually
Birth of Child to an Enrollee	Ad Hoc
Contact Center Data	Ad Hoc
Documentation of Care Management	Ad Hoc
The MCO shall maintain documentation sufficient to support its Care Management responsibilities. Upon the reasonable request of the STATE, MCO shall make available to the STATE, or the STATE's designated review agency, access to a sample of Enrollee Care Management plan documentation	
Enrollee Eligibility-Related Change Report	Ad Hoc
The MCO shall promptly notify the STATE if the MCO receives information about changes in an Enrollee's circumstances that may affect the Enrollee's MHCP eligibility, including changes in the Enrollee's county of residence or the death of an Enrollee	
Enrollee and Marketing Materials	Ad Hoc
The MCO must report changes in web site links to the STATE before the links change for materials required to be made available electronically, including Enrollee Handbooks, Provider Directories, and Formularies.	
Requests for Time-Sensitive Data.	Ad Hoc
The STATE may collect data or contract with external vendors for studies, including but not limited to data validation, service validation, and quality improvement. The STATE will give the MCO at least forty-five (45) days' notice	

Material Modification to Service Delivery Plan	Ad Hoc
Drug Formulary Changes	Ad Hoc
MCOs must also provide the STATE with an updated online formulary web site link within seven (7) calendar days of a web site link change.	
Formulary Change	Ad Hoc
Upon the submission of a formulary change, the MCO must also submit a formulary change summary in a format approved by the STATE.	
Formulary Change	Ad Hoc
The MCO shall notify the STATE of any changes in its Medical Assistance Drug Formulary within thirty (30) days of the changes, and for deletions shall submit the justification for the change. The MCO shall also submit a copy of any Prior Authorization criteria used to limit access of Enrollees to drugs.	
Under- and overutilization Report	Ad Hoc
The MCO shall submit to the STATE upon request a written report that includes performance measurement data summarizing identified under-utilization and overutilization of services	
Subcontractual Delegation of SIU Responsibilities	Ad Hoc
Disclosure of Transactions.	Ad Hoc
The MCO must report to the STATE or CMS information related to business transactions with Subcontractors	
The MCO shall report to the STATE, within ten (10) business days of receipt of the following:	Ad Hoc
(1) Any information regarding excluded or convicted individuals or entities, including those in paragraph 9.6.3 above; and,	
(2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a Provider.	
The MCO shall promptly notify the STATE of any administrative action it takes to limit participation of a Provider in the Medicaid program as mandated by 42 CFR §§455.106(a)(2) and 1002.4(a).	Ad Hoc
Third Party Liability resources	Ad Hoc
Change of Emergency Preparedness Response Coordinator, and any other Emergency Preparedness Response reports	Ad Hoc
Incident Reporting	Ad Hoc
A report to the STATE of a breach of Protected Information must be in writing and must be sent to STATE not more than fifteen (15) business days after discovery of such non-permitted use, access, or disclosure	

Managed Care in Medicaid and MinnesotaCare

Minnesota Council of Health Plans

In Minnesota, over 80% of Medicaid and MinnesotaCare members are enrolled in managed care

Managed Care is the National Standard

Managed care is the preferred delivery system for Medicaid programs in the United States, representing 72% of all Medicaid enrollees nationwide. As of July 2022, 41 states capitated managed care models to deliver Medicaid, with both North Carolina and Oklahoma moving their Medicaid programs to managed care in 2023[1]. States have turned to the use of managed care models to increase budget predictability, limit growth in Medicaid spending, and improve access to care and value for enrollees.

Minnesota Excellence

Minnesota moved to managed care in the 1980's to address severe provider shortages and an unpredictable budget. Since then, managed care in Minnesota has grown to cover additional populations and services, and was made a permanent fixture of Medical Assistance in 2001.

Minnesota has long been recognized as a national leader in delivering Medicaid, in partnership with the state's managed care organizations (MCOs).

In 2020, DHS and the MCOs formed a unique public-private partnership to reduce gaps in COVID-19 vaccination rates among public program enrollees in high-risk zip codes. The partnership also distributed over 500,000 masks to communities most in need.

·For the first time, the 2022 MCO contracts incorporated dedicated health equity metrics. Building on that, the 2023 contracts added incentives to address racial disparities in healthcare and adopt anti-racist principles. This work is considered a national model in how to use contracting as a lever for health equity.

Minnesota's MCOs are unique in collaborating together on performance improvement projects (PIPs). Currently, MCOs are working on improving care and outcomes for moms and babies under the Healthy Start PIP by focusing on areas with the most significant racial and ethnic disparities.

Case Study: Nation Leading Model

The Minnesota Senior Health Options (MSHO) program is a standard-bearer for fully-integrated special needs plans for dually-eligible seniors.

MSHO offered a new level of benefit coordination between Medicare and Medicaid, leading to stark improvements in how seniors accessed medical, dental, vision, transportation, pharmaceutical, case management and long-term care services seamlessly under one health plan and one benefit card.

Under the management of Minnesota's MCOs, the program is still considered a leading example of fully-integrated care.

[1] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

	Managed Care	Fee-for-Service (FFS)
Payments	MCOs receive a per member per month capitation payment. These payments cover expected utilization of covered services, administrative costs, and contribution to reserves and surplus. MCOs must meet an 85% medical loss ratio (MLR), meaning they spend at least 85% of their payment directly on medical care for members.	Providers bill for each service they provide and receive reimbursement for each covered service based on the Medicaid State Plan rate, typically set by the legislature and DHS.
State Budget	In a managed care payment system, prepaid health plans take on the risk of their members so the state can set a heath care budget and stick to it.	Under FFS, the state bears the risk for enrollees within a legislatively-approved budget. If program costs are unexpectedly high, the state has to absorb the additional cost and risk.
Rates	MCOs negotiate rates with providers. In some cases, MCOs must pay at least FFS rates and at times are required by legislation to pass through additional payments from the state directly to providers. In practice, MCOs often pay much higher rates than FFS.	Providers are paid at the set fee schedule rate. Rates are set by the Minnesota legislature and must be approved by CMS each year.
Benefits	MCOs not only cover state required benefits, but offer additional tailored benefits such as car seats, dental cleanings and fitness benefits. MCOs coordinate care for pharmacy, dental, transportation, and interpreter services to best meet the evolving needs of their members.	FFS cannot pay for benefits outside the required Medicaid benefit set.
Networks	MCOs use a variety of strategies to offer robust provider networks, including direct outreach to providers, financial incentives, uniform credentialing applications, and prompt payment policies. MCOs also pay for services from non-enrolled or out-of-network providers.	Members must receive care only from enrolled providers or in-network providers. DHS does not pay for services from non-enrolled or out-of-network providers and use limited alternative payment arrangements.
Social Drivers of Health (SDOH)	Managed care addresses social drivers of health. For example, MCOs can provide members access to support services such as meal delivery/food support, programs to reduce isolation for seniors, discharge support for members who are unhoused, and bringing care directly to members through mobile clinics.	FFS cannot reimburse for non-medical services.

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Program Integrity

Health Plans have dedicated staff utilizing the latest technology to detect and prevent fraud

Managed Care is the National Standard

Managed care is the preferred delivery system for Medicaid programs in the United States, with more than 40 states utilizing the model to ensure private sector efficiencies and best practice technology is utilized in management of public programs. Manged care organizations (MCOs) contract with the State to provide oversight resources the State otherwise lacks—dedicated staff utilizing the latest technology to proactively detect and prevent fraud.

Minnesota has long been recognized as a national leader in delivering Medicaid, in partnership with the state's managed care organizations MCOs.

Provider Enrollment and Validation.
MCOs review credentials of providers to verify they are who they claim to be and qualified to deliver the service. They review, track, and collect ownership details, business transactions, social security number validation, and cross-check data against the excluded provider list.

Pre-Payment Validation.
MCOs validate information before a service is provided to make sure a service meets recognized standards for care, including monitoring inpatient and high-dollar services to validate appropriateness.

Post-Payment Audits.
MCOs scrutinize bills and medical records to validate that billed services were delivered, documented, and compliant with medical standards.

Case Study:

Housing Stabilization Services

In 2020, Minnesota became the first state to offer state program coverage for housing stabilization services. The benefit was projected to cost $2.6 million annually.

- Unlicensed providers.
- State policy bypassed MCO review of provider credentials and network development.

The program grew to more than $100 million before being shuttered due to widespread fraud.

SOLUTIONS

Structural Integrity

Benefits should be launched only after a formal process to develop standards, including licensing of providers.

Empower Oversight

Utilize proven MCO methods: network development, pre-service reviews, pre-payment validation, and post-payment audits.

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