..... moves to amend H.F. No. 237, the first engrossment, as follows:

Delete everything after the enacting clause and insert:

"Section 1. **[256B.0759] DIRECT CONTRACTING PILOT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner shall establish a direct contracting pilot program, to test alternative and innovative methods of delivering care through community-based collaborative care networks to medical assistance and MinnesotaCare enrollees. The pilot program shall be designed to coordinate care delivery to enrollees who demonstrate a combination of medical, economic, behavioral health, cultural, and geographic risk factors, including persons determined to be at risk of substance abuse and opioid addiction. The commissioner shall issue a request for proposals to select care networks to deliver care through the pilot program for a three-year period beginning January 1, 2020.

Subd. 2. **Eligible individuals.** (a) The pilot program shall serve individuals who:

(1) are eligible for medical assistance under section 256B.055 or MinnesotaCare under chapter 256L;

(2) reside in the service area of the care network;

(3) have a combination of multiple risk factors identified by the care network and approved by the commissioner;

(4) have elected to participate in the pilot project, as an alternative to receiving services under fee-for-service or through a managed care or county-based purchasing plan or integrated health partnership; and

(5) agree to participate in risk mitigation strategies as provided in subdivision 4, clause (4), if determined to be at risk of opioid addiction or substance abuse.

(b) The commissioner may identify individuals who are potentially eligible to be enrolled with a care network based on zip code or other geographic designation, utilization history,

or other factors indicating whether an individual resides in the service area of a care network. The commissioner shall coordinate pilot program enrollment with the enrollment and procurement process for managed care and county-based purchasing plans, and integrated health partnerships.

Subd. 3. **Selection of care networks.** Participation in the pilot program is limited to no more than six care networks. The commissioner shall ensure that the care networks selected serve different geographic areas of the state. The commissioner shall consider the following criteria when selecting care networks to participate in the program:

(1) the ability of the care network to provide or arrange for the full range of health care services required to be provided under section 256B.69, including but not limited to: primary care, inpatient hospital care, specialty care, behavioral health services, and chemical dependency and substance abuse treatment services;

(2) at least 25,000 individuals reside in the service area of the care network;

(3) the care network serves a high percentage of patients who are enrolled in Minnesota health care programs or are uninsured, compared to the overall Minnesota population; and

(4) the care network can demonstrate the capacity to improve health outcomes and reduce total cost of care for the population in its service area, through better patient engagement, coordination of care, and the provision of specialized services to address risk factors related to opioid addiction and substance abuse, and address nonclinical risk factors and barriers to access.

Subd. 4. **Requirements for participating care networks.** (a) A care network selected to participate in the pilot program must:

(1) accept a capitation rate for enrollees equal to the capitation rate that would otherwise apply to these enrollees under section 256B.69;

(2) comply with all requirements in section 256B.69 related to performance targets, capitation rate withholds, and administrative expenses;

(3) maintain adequate reserves and demonstrate the ability to bear risk, based upon criteria established by the commissioner under the request for proposals, or demonstrate to the commissioner that this requirement has been met through a contract with a health plan company, third-party administrator, stop-loss insurer, or other entity; and

(4) assess all enrollees for risk factors related to opioid addiction and substance abuse, and based upon the professional judgment of the health care provider, require enrollees

determined to be at risk to enter into a patient provider agreement, submit to urine drug screening, and participate in other risk mitigation strategies; and

(5) participate in quality of care and financial reporting initiatives, in the form and manner specified by the commissioner.

(b) An existing integrated health partnership that meets the criteria in this section is eligible to participate in the pilot program while continuing as an integrated health partnership.

Subd. 5. **Requirements for the commissioner.** (a) The commissioner shall provide all participating care networks with the enrollee utilization and cost information provided by the commissioner to integrated health partnerships.

(b) The commissioner, in consultation with the commissioner of health and care networks, shall design and administer the pilot program in a manner that allows the testing of new care coordination models and quality-of-care measures, to determine the extent to which the care delivered by the pilot program, relative to care delivered under fee-for-service and by managed care and county-based purchasing plans and integrated health partnerships:

(1) improves outcomes and reduces the total cost of care for the population served; and

(2) reduces administrative burdens and costs for health care providers and state agencies.

(c) The commissioner, based on the analysis under paragraph (b), shall evaluate the pilot program and present recommendations as to whether the pilot program should be continued or expanded, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by February 15, 2022."

Amend the title accordingly