HOUSE RESEARCH

Bill Summary

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Overview

This bill requires the Commissioner of Human Services to establish a three-year, direct contracting program under which the commissioner would contract with up to six community-based collaborative care networks, to deliver services to MA and MinnesotaCare enrollees with multiple risk factors. Enrollment in the direct contracting program would be an alternative to receiving services through fee-for-service, managed care, county-based purchasing, or an integrated health partnership.

Section

1 **Direct contracting pilot program.** Adds § 256B.0759.

Subd. 1. Establishment. Requires the commissioner of human services to establish a direct contracting pilot program, to test methods of care delivery through community-based collaborative care networks to MA and MinnesotaCare enrollees. Requires the program to be designed to coordinate care delivery to enrollees with a combination of risk factors. Requires the commissioner to issue an RFP to select care networks to deliver care for a three-year period, beginning January 1, 2020.

Subd. 2. Eligible individuals. (a) Provides that the pilot program shall serve individuals who: (1) are eligible for MA or MinnesotaCare; (2) reside in the care network's service area; (3) have multiple risk factors; (4) have elected to participate in the pilot program as an alternative to fee-for-service, managed care or county-based purchasing, or an integrated health partnership; and (5) agree to participate in risk mitigation strategies if determined to be at risk of opioid addiction or substance abuse.

Section

(b) Specifies methods the commissioner may use to identify eligible individuals. Requires the commissioner to coordinate pilot program enrollment with the enrollment and procurement process for managed care, county-based purchasing, and integrated health partnerships.

Subd. 3. Selection of care networks. Limits participation to no more than six care networks and requires care networks to serve different geographic areas in the state. Specifies criteria to be used by the commissioner in selecting care networks.

Subd. 4. Requirements for participating care networks. (a) Requires the care networks selected to: (1) accept the prepaid medical assistance program (PMAP) capitation rate; (2) comply with PMAP requirements related to performance targets, capitation rate withholds, and administrative expenses; (3) maintain adequate reserves and demonstrate the ability to bear risk, or demonstrate that this requirement has been met by contracting with a third-party; (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 at-risk enrollees to enter into a patient provider agreement, submit to urine drug screening, or participate in other risk mitigation strategies; and (5) participate in quality of care and financial reporting initiatives.

(b) Allows existing integrated health partnerships that meet program criteria to participate in the pilot program while continuing as an integrated health partnership.

Subd. 5. Requirements for the commissioner. (a) Requires the commissioner to provide care networks with the enrollee utilization and cost information provided to integrated health partnerships.

(b) Requires the commissioner, in consultation with the commissioner of health and care networks, to design and administer the pilot program to allow testing and evaluation of care models and quality of care measures, in order to compare the care delivered to that provided by managed care and county-based purchasing plans and integrated health partnerships.

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