Minnesota Association of County Social Service Administrators

Position Statement

For 2022 Session

Managed Care Procurement and County Based Purchasing

Proposal

Issue:

In 1997, a bipartisan coalition of the Minnesota Legislature passed landmark legislation specifically establishing County-Based Purchasing (CBP) in State law as a unique and beneficial model different from Health Management Organizations (HMOs). Currently there is no statutory separation for County Based Purchasing (CBP) in terms of operation and procurement. It is embedded in the Prepaid Medical Assistance Program (PMAP) statute and fails to recognize the essential differences between HMOs and CBPs. CBPs are owned and operated by the counties they serve specifically to ensure locally responsive, timely access to quality health care for their eligible residents and are governed by the County Board or a Joint Powers Board (JBP). Currently Minnesota has 22 counties, that participate in CBP with another 11 counties choosing the CBP model and waiting to implement. MACSSA supports the proposal of creating a new chapter of State law for CBP recognizing CBP as an alternative model for delivery of Minnesota Health Care Programs (MHCP). These changes would include a procurement process that would recognize CBPs as separate from HMOs and mitigate barriers to implementing CBP with the Minnesota Department of Human Services (DHS) for eligible county residents. MACSSA supports federal legislative changes and/or waivers necessary to allow for procurement and full implementation of State CBP laws (256B.692). The existing process makes no allowance for locally driven initiatives such as county-based purchasing. MACSSA seeks protection of County authority throughout the procurement processes and implementation of State CBP laws.

Implementation Strategy:

Continue active implementation of an overall managed care procurement process that is transparent and reflects county authority, input, and decision making per Minnesota statute 256B.69, Subd. 35, and provides a fair and unbiased process for appeal. The procurement process should not present barriers to full implementation of CBP State statute 256B.692. Support the State developing a separate procurement process for CBPs and support federal waivers for any aspect of current State statutes that may conflict with federal law or regulation. Support seeking any federal and State statutory changes that would clarify and affirm county authority, including proposed, new, Chapter 62W.

Systemic Priority Alignment (highlight all that apply and explain why)

- **Equity**
- **Integrated Services**
- **Fiscal Framework**

From the GARE Toolkit (See www.racialequityalliance.org): What are the racial equity impacts of this particular decision? Who will benefit from or be burdened by it? Are there strategies to mitigate unintended consequences?

Comments:

Minnesota counties, most of them rural, elected to select the County-Based Purchasing (CBP) model so that enrollees would have a health plan based in greater Minnesota that prioritized access to local care and providers where enrollees would benefit from the seamless coordination between health plan benefits and county human and public health services. The CBP model seeks to stabilize the local provider network and partner with innovative community services. The integration between owner counties and the CBP health plan creates an operational framework where enrollee wellness, preventive services, and holistic care can be accomplished by leveraging the expertise of county staff who work within and know the needs of the local communities in CBP counties; this allows for continuity with county-managed programs and ensures that care is culturally-appropriate and specific to the community. Many enrollees with a disability or those age 65 or older benefit from having the

service of care coordination provided by a county-employed care coordinator. CBP counties chose to assume the responsibility for purchasing health care services for enrollees who are eligible for MHCP. Because of the fiscal relationship, the CBP health plan and counties share ideas and co-implement strategies to improve quality and can tailor health plan programming to meet the local need. The CBP framework allows for more cost-effective and resilient outcomes for all enrollees and has a focus on bringing health equity to underserved areas of the State. Good health is clearly determined by more than just medications or therapies paid for by the health plan. Good health requires access to safe drinking water, nutritious foods, adequate housing, education, and safe working conditions. CBPs are uniquely positioned as a partner within their counties to offer comprehensive, enrollee-centered programming that directly impacts those mutually served persons. CBPs, governed by the counties, are more transparent and accountable to the local public.

Relevant Committee (highlight all that apply and explain why)

- **Adult Services**
- **Behavioral Health**
- **Children's Services**
- **Modernization**
- **Policy**
- **Self-Sufficiency**
- **Health Care**
- **Equity**

Why:

Enjoyment of the highest attainable standard of health and access to quality health care is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic condition and is critical to achieving health equity within our communities. The right to good health for all people means that everyone should have access to the health services they need, when and where they need them, without the burden of financial hardship. Medical Assistance is an important funding mechanism that allows for service provision to occur in many social service programs.

Rationale/Background:

More than 30 years ago, Minnesota was a national leader in developing prepaid, capitated managed care models in Medicaid service delivery and payment as a part of the demonstration project of an alternative to the traditional fee-for-service model. The Prepaid Medical Assistance Program (PMAP) was structured as a strategy to reduce the growth in costs and improve health outcomes. At the time, for example, Dakota County went with the traditional PMAP model and Itasca County chose the CBP model. Hennepin County was/is licensed as an HMO; while not recognized as a CBP, they are county owned and operated.

Recognizing the inherent difference between HMOs and CBPs will lend critical support to stabilizing, clarifying, and strengthening the statutory environment and basis for CBP. The current statutory environment ties CBP too closely to Health Maintenance Organizations (HMO), creating unintended complications and harm each time a policy maker wants to change laws pertaining to HMOs.

Minnesota Senate Counsel has advised that the CBP statutory language needs to be updated and consolidated. Minnesota DHS has suggested federal law and rules prevent them from fully implementing state CBP laws and county authority in the procurement process; however, they have not sought a federal waiver as specified in law. This has created barriers for CBP implementation, lack of transparency and lack of county voice. This underscores the need for clarifying and enabling federal language. Counties utilizing CBP have saved state money by delivering dependable access to high quality, cost effective care, re-investing in strengthening local providers, and improving access to scarce providers. It also greatly improved the relationships, planning, cooperation, communication and integration among the health plan enrollees, health plans, county public health and social services, and healthcare and long-term care providers. The CBP has been a part of the PMAP landscape in Minnesota for over 30 years and is a growing, trusted model especially in rural settings.

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Approved on: