Patient Centered Care (PCC) SF 3612 - HF 3476
Summary 2026

Goal: Reduce waste and improve care in Minnesota Medical Assistance (Medicaid) and MinnesotaCare by removing control of these from managed care organizations (MCOs) and returning to a state **direct provider payment** system.

Background: MCO administration of Medicaid for the past three decades has resulted in excessive administrative costs, reduced transparency in financial and clinical decision-making, and created barriers to timely access to medical care. Minnesota's Medicaid is facing a crisis, due to a 2025 federal law that cuts federal spending from Minnesota's Medicaid by an average of $1.9 billion annually over 10 years.

Proposal: The PCC bill saves money and improves care by removing the MCOs from Medicaid and MinnesotaCare. Instead, Minnesota would pay providers of care directly and pay primary care providers a fee to coordinate care for a savings of about $1 billion annually.

This model will restore public ownership and accountability of Medicaid data, reduce the risk of fraud, and ensure that care decisions are made in the interest of patients rather than insurance companies.

Key Points: A fifth of Minnesotans are enrolled in Medicaid and MinnesotaCare. Through direct payment, the Department of Human Services (DHS) would:

- **not renew the contracts** with MCOs, accountable care organizations (ACOs), or Integrated Health Partnerships (IHPs) for either MinnesotaCare or Medical Assistance;
- **pay primary care providers a small monthly fee for coordinating care** for which patients would be encouraged to choose a provider as a care coordinator;
- **collaborate with community clinics to do outreach** to people not receiving care;
- **greatly reduce the risk of fraud** by eliminating the bureaucratic complexity of MCOs where a severe lack of accountability and transparency has existed for decades.

Benefits of eliminating MCOs and directly paying for care:

- **saves money**, which can be used for better care of patients. Connecticut, which eliminated insurance companies from its Medicaid program in 2012, has saved an enormous amount of money while improving care for low-income people. According to a national Medicaid report entitled, *"Removing the Middlemen from Medicaid. A blueprint for lower costs and better care",* private insurers within Medicaid programs waste 10-15% of the tax dollars they receive on unnecessary administrative costs and bureaucracy.
- **ends MCOs'** denial of treatment to Medicaid patients that state and federal governments pay for;
- **removes limited MCO networks of care**, which increase serious health inequities and add challenges to seeking care, especially for dental and mental health. This particularly affects low-income people and residents of rural communities where people have difficulty accessing care. It allows patients their choice of providers.
- **eliminates MCO-inflicted instability in coverage that can disrupt patients' lives**, particularly when the MCOs decide to drop out of the program at the end of a contract period, leaving patients scrambling to find coverage;
- **improves care coordination** by directly paying primary practices (not MCOs). Also, savings from the change could fund more community health workers to deliver case management for more intensive support.
- **improves outreach to people with complex social needs** by using some of the saved money to fund health clinics and county social services to do outreach to low-income people who are unlikely to access care due to homelessness, mental illness, or other challenges.

Minnesota Health Plan Other Side